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Too Familiar for Words: An Analysis of "Invisible" Nursing Work

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LOYOLA UNIVERSITY CHICAGO

TOO FAMILIAR FOR WORDS:
AN ANALYSIS OF "INVISIBLE" NURSING WORK

A DISSERTATION SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

SCHOOL OF NURSING

BY
FRANCES R. VLASSES

CHICAGO, ILLINOIS
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The real voyage of discovery consists not in seeking new landscapes but in having new eyes.  

Marcel Proust

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CHAPTER I
STATEMENT OF THE PROBLEM

Introduction

Nurses often claim that their work is poorly understood and inadequately represented to health care administrators. Therefore, it is necessary to examine the thesis that there may be additional dimensions of nursing work that remain undefined and are essentially “invisible.” “Invisible” work is used in the current study to refer to work that may or may not be visible but is not recognized. The quotation marks are used throughout the study to remind the reader that the invisibility has been created by the social, historical and epistemologic constraints that influence how we think about work. Other terms such as hidden, unrecognized, unaccounted-for or taken-for-granted serve as proxies for “invisible” work. Several nurse researchers (Leininger, 1991; McCloskey, 1992; Wolf, 1989) speak about “invisible” nursing work and validate the difficulties examining such phenomenon due to the embedded, contextual nature of nursing work. (Leininger, 1991; Benner, 1989).

Tripp-Reimer and Brink (1985) and DeSantis (1991, 1994) recognize a nursing skill they call “cultural brokerage” which includes linking, bridging, negotiating, or translating between the health care system and the client. DeSantis (1994) notes that little is known about how cultural brokerage takes place as the nurse mediates “between
colleagues from different cultural and/or health care delivery systems" (p. 173). Their work and the broader literature review done for this study both indicate that one area to pursue in such an investigation is an exploration of nurses in relation to the environmental context of their work within the health care system.

The difficulties of articulating nursing work is heightened in an era of reform because the work of nursing will continue to change as long as nursing practice remains tied to a social organization. There is a concern that there are dimensions of nursing which have not yet been clearly defined and will not be factored into the work redens and, therefore, be lost or irreparably altered for the future.

How can nursing be assured that the redesigned systems will have roles for nurses to practice fully? The answer to the question seems simple at the outset. If nurses can clearly articulate all dimensions of their work and demonstrate positive outcomes, then a case can be made to include them in new roles within the health care system. Unfortunately, areas of nursing work remain unexplained. The language to describe work that involves caring/connecting phenomena is limited although beginning attempts at description are occurring in nursing and women's studies. In order to know the undefined or as yet “invisible” dimensions of nursing work, knowledge systems will need to be developed which allow us to locate the nurse as a knowledge worker within the social organization of the workplace and see her “experiences of connection rather than individuation” (Jacques, 1993, p. 8).

This paper presents a framework for investigating the work of nursing from this last perspective, a framework which includes a focus on caring. Caring work within a
cultural perspective allows us to look at interventions the nurse performs and meanings associated with them. By reflecting on the work of nursing in this way, it is hoped that we will move into an area to allow nurses to articulate hitherto undefined or unexplained dimensions of their work so they can be analyzed. In the words of Audre Lorde to “help give name to the nameless so it can be thought” (Lorde, 1984, p. 37).

**Purpose**

Conceptualizing nursing work as patterns of care within Leininger's Theory of Culture Care Diversity and Universality is proposed as a way to examine the nurse's interaction and interchange with the broader cultural context of health care. Since the nurse’s role in this area is not clearly articulated, use of the theory as a guide would take the investigation to an area that seemed likely to yield information regarding undefined dimensions of nursing work. This is a first step in the process of conceptualizing additional dimensions of nursing work.

The main purpose of the present descriptive, exploratory project is to increase our understanding of the patterns of care/work that direct and describe the nurse interaction with the broad context of the client situation. In the language of the theory of cultural care diversity and universality, this is referred to as contextual care work (Leininger, Personal communication, 1994).

The domain of inquiry for this study is the cultural meanings and patterns related to the experience of delivering nursing care in complex social organizations. An open discovery method was used to obtain information regarding nurses’ work. However,
questions were formulated from the theory to serve as general guidelines for the investigation and are listed as:

1. What are the characteristics, meanings, expressions and functions of contextual care for EuroAmerican nurses?

2. What caregiving practices and patterns are used by EuroAmerican nurses when performing contextual care work?

3. How do the influences of the cultural context and social structure dimensions of the health care agency constrain or enhance the performance of contextual care?

4. What work-related stresses and conflicts are experienced by EuroAmerican nurses who are involved in the caregiving patterns and practices of contextual care work?

5. What are the influences of nursing experience and education on the expression and meaning of contextual care work?

6. How are the three modes of cultural care decision/making and action, preservation/maintenance, accommodation/negotiation, repatterning/restructuring used by nurses to perform contextual care work?

**Significance**

The work of the professional nurse in connecting needed resources for patient welfare and system maintenance is documented (Jacques, 1993; Thomas, 1983; Wolf, 1989). However, because such activity is not usually seen as an area of special expertise and is not generally compensated economically, this dimension remains essentially "invisible." As the literature review will demonstrate, "invisible" work is neither theory-
based nor languaged through scientific theory. While the need to assist clients to make their way through an exceedingly complex and decentralized health care system has increased in the last decade, nonetheless nursing positions have been cut. The remaining nurses are more focused on delegation or direct patient care. The need to have nurses maintain an important role in the provision of continuity of care is paramount. Therefore, it is necessary to elucidate the "invisible" dimension of nursing work.

A clear articulation of the full scope of nursing work should enhance curriculum, research, nursing service delivery systems, nursing resource development, budget allocations and outcome evaluation. Ongoing debates and difficulties in each of these areas are symptomatic of a foundational problem related to the lack of a clear definition of all dimensions of nursing work.

Investigations of nursing work also have value for nursing administrative services. It is important "to consider ways to get new knowledge in order to develop new administrative organizations and practices" (Leininger, 1991, p. 381). It is necessary to understand the care delivery process in order to build nursing systems which truly enhance it. Nurses often do work that others need done. Campbell (1992) gives examples of this. In work redesign we must be careful to understand action that is significant to the nursing role and that which is not and redesign accordingly. Nursing organizations should reflect nursing's agenda (Hall, 1993).

The present project seeks to affirm how nursing work takes place within the environmental context as defined by Leininger and contributes to creating a way to place value on caring work by making it more visible. As a result, our understanding of how
caring looks in practice would be enhanced (Roberts, 1990) and a contribution would be responding to a call to improve nursing’s overall visibility (Anderson, 1993).

The study of “invisible” dimensions of nursing work would help to clarify the relationship between nursing and the social organization of the health care system. “Delivering care” is a common explanation of the work of nursing. As the health care system is redefined, much speculation is occurring about how the work of nursing will change. The fact that it will change, however, is undisputed because the role of the nurse has always been inextricably tied to the form and function of the public health and hospital system (Diamond, 1984; Hall, 1993; Melosh, 1982; Reverby, 1979). In fact, nurses identify themselves by location, i.e., hospital nurse, community health nurse. This process of being defined in relation to a type of social organization, increases vulnerability in times of change, because as health care changes, nurses must accommodate the prevailing economic requirements (Campbell, 1992). For example, the focus of the hospital nurse since DRG’s is on the technological practices needed to discharge the patient within a defined period of time. Although the nurse may believe that the patient needs education and counseling in order to change lifestyle and enhance recovery, these aspects of her work must be subjugated to the prevailing priorities for rapid discharge. The nurse's beliefs about the work of nursing may not have changed from a philosophical standpoint, but her actual work certainly has changed. That is, the nurse's work is defined by the organization. Campbell (1992) states that:

Individual nurses cannot separate themselves and the remnants of their peculiarly humanistic (previously one of the hallmarks of professional) interests from the solutions being applied to the (health care) crisis. They are articulated into these
managerial practices as professionals even if, as individuals, they deplore their effects on health care. (p. 763-4)

Campbell’s remarks are presented as an example of the practical explanation of the concept expressed by several authors when they say that nursing’s extant commitment to care and humanistic services seems at odds with a technologically focused, economically driven corporate health care system (Bland-Jones & Alexander, 1993; Campbell, 1992; Leininger, 1993; Ray, 1989).

**Foundational Beliefs**

A journey through the world of work and nursing work is intimidating, indeed. The terrain is rugged, spanning multiple disciplines and the lay literature. The traveler who explores the territory can be “blinded by the sights” and misled because the idea of work has a conceptual foothold in theory, as well as, an anchor in everyday life.

While the idea of work is a sweeping landscape, it does not have well-charted theoretical territory. Consequently, to see a clear path, a traveler needs compass settings, a mighty walking stick, a sense of adventure and a tolerance for ambiguity.

For this traveler, the compass settings are found in some of the tenets of postpositivism and reflect the influences of social scientists such as Habermas, Strauss and the philosophical school of Pragmatism. My understandings of these are as follows:

1. Reason is important as a guide to knowledge,
2. Reason operates through a reflective process,
3. Reason encompasses many enterprises of which science is one,
4. Knowledge gleaned through reasoning has technical, practical and moral interest,
5. Man and society at large are inextricably linked and the development of
   consciousness is primarily affected by their continual interaction,
6. Work is both a social practice and an epistemological category since it occurs in
   social organizations in the context of larger society,
7. Humans experience a lifeworld where, “social and economic structures
   interpenetrate with action and consciousness... to say that... social structure is
   'institutionalized' is just another way of saying that it structures there our conscious
   actions and worldview” (Pusey, 1987, pp. 58-9),
8. Reflection provides tools to more fully understand the interpenetration and
   contribute to our knowledge and progress,
9. Complete explanations should include attention to the individual's experience and
   meaning as well as the objective and material environment. Methodologically,
   social phenomena must be understood by using sources within the individual as
   well as external data on the social, political and economic environment. “All
   significant social events and processes are directly or indirectly reflected in the
   lifeworld” (Pusey, 1987, p. 59) and must “take account of social structures that
   shape the lifeworld ‘from the outside in’ ” (Pusey, 1987, p. 65).
These understandings contribute to the critical consciousness which guides this traveler.
The walking stick for the journey is hewn from the experience of being a
participant in the work of nursing. The traveler uses the walking stick to maintain
connection during the journey. It grounds reflections on the ongoing contrast between
nursing's work and theoretical worlds. Reflections on the experience of caring for others has precipitated a belief in antidualistic philosophical commitments which enhance an understanding of humanness. These commitments force a questioning of the many bifurcated concepts co-existing in nursing such as, body/mind, technology/caring, and theory/practice. Antidualist beliefs at least allow one to examine the theory/practice dichotomy and consider the possibility that theory and practice could stand in a different type of relationship. Such philosophical commitments give permission to recognize that there are sources of wisdom in care which may express nursing's uniqueness in daily practice even if the vision of nursing is often confounded.

The fact that there is not a crystal clear and monocular vision of nursing is the point of departure for the journey. Visions of nursing are clouded by the methods, or lenses, we use to focus on nursing. Vision is also clouded by the interacting effects and demands of the social organization of nursing work. When vision is so limited, the traveler will surely find herself in precarious locations. Hopefully, a sense of adventure will prevail and the locations will not bring the journey to an end, but to the beginning of scholarship that builds clear pathways to an understanding of the work of nursing.

One of the most "precarious locations" within the territory of work lies within a problem I call work and knowledge. Because of its paradoxical nature, the problem receives special attention in the next section.

**The Paradox Within: Knowing About Work**

The journey begins at a puzzling crossroad where ideas about knowing and work
intersect and produce special challenges for a study on nursing work. Three areas in particular require the explorer to rely heavily on a walking stick for guidance and reflection. These topics include: views on the nature of reality or what can be known; methods of inquiry or how can we know something or study something; and the institutionalization of knowledge systems or what counts as knowledge. Obviously the three areas are related but are dealt with individually in the next section so issues related to each can be more carefully outlined.

Burrell and Morgan (1979) offer a framework of two great intellectual traditions, positivism and antipositivism or relativism. Positivism views social reality as external to consciousness, in keeping with DesCartes' commitment to thought as primary and internal. In this view, the rules of logic combined with the split between subject and object will lead to objective truth. Philosophers following Kant in the Continental tradition reconceptualize social reality as "much more the product of individual cognition" (Draper, 1993, p. 559). Here, perception of social reality participates in an ongoing development of consciousness. Therefore, the subject is placed within and interacts with a social reality "that can only be understood in terms of the subjective meanings held by the individuals whose activities are the focus of the study" (Draper, 1993, p. 559). In addition, positivism tends toward a more deterministic view of man and environment, while antipositivism places more emphasis on free will and independent action (Burrell & Morgan, 1979). These traditions are clearly evident in the theoretical discourse on work and impact our formulations of how we conceptualize work as well as the methods used to study it.
The next issue, how we know or methods of inquiry, flows directly from the intellectual traditions. The methods become various lenses and tools for seeing work. Each lens, in showing one part of the picture, leaves out another part. The applications of the methods with their necessary epistemological requirements ultimately determines what counts as knowledge. As they are applied to nursing work, they also determine what counts as nursing. It is my position that the overuse of quantitative lenses in understanding nursing work has greatly inhibited our ability to develop a more complete definition. For example, ways of knowing that focus on task aspects of nursing do not account for other aspects of nursing that are less visible such as judgement. The way we know the work, through activities, prevents us from admitting judgement as tangible evidence that work has taken place. It follows that any attempts to portray aspects of nursing work that have to do with the cognitive, emotive, aesthetic and ethical dimensions are also problematic. In order to make the later aspects of nursing visible, nursing must be willing to legitimate lenses from philosophy, women's studies and other fields to assist in appropriate theory-building.

Consequently, the scholar who wants to research nursing work finds herself/himself in the dilemma of having to wrestle with both the lens and the object of study. The dilemma is evidenced in the work of many researchers who are building scholarship from within the context of practice (Benner & Wrubel, 1989; Maeve, 1993; Street, 1992). These researchers often build and defend their positions on the nature of reality, nursing reality and the methods used to examine the phenomenon. Of course, the dominance of positivism as the received view is thereby reflected because projects in this
tradition rarely include epistemological argumentation. Such claims support the next issue; the institutionalization of systems of knowledge.

The answer to what counts as knowledge in the era of modernity is clearly scientific knowledge. As science became valorized it became more than an approach to research. It became a belief that scientific problem-solving applied to human concerns was superior. Schon (1983) calls it a case of “Technical Rationality,” with origins in positivism. He states that as the model became “embedded in the context of professional life” (p. 26), it formed “the Positivist epistemology of practice” (p. 31).

Scientific thinking as a knowledge system became a process in society to direct social practices and, within our culture, contributed to support for continued technology advancement (Sandelowski, 1993). Work and social groups that were based in abstract scientific principles were granted the title, profession. Knowledge development in the form of empiricism evolved in administrative science as scientific management, a process of applying scientific thinking in the workplace. Scientific management gave rise to the development of administrative philosophy and structure which, when operationally defined, produced procedures and expectations about how work is done. Herein lies the bridge between knowledge and work.

As institutionalized scientific thinking and scientific management was applied in hospitals, nursing responded by developing models of care delivery such as team nursing (Reverby, 1979) and the nursing process which reflect the values of scientific method. In fact, Reverby (1979) claims that nursing provided leadership in introducing scientific management techniques to hospitals despite the fact that “they were constantly confronted
by the objective difficulty of transforming service work into commodity production" (p. 219). The development of intensive care units, growing out of a traditional nursing practice of "watchful vigilance" is another example of how nurses have organized to incorporate science and technology into their work (Fairman, 1992).

Nursing realized the necessity of adopting an agenda to develop a scientific base essential to earning status as a profession. In this way, the knowledge system of science became institutionalized and affects what counts as nursing work. Hence the complete link between knowledge and nursing work is created.

For these reasons, I consider the intersection between the reality of work and knowledge to be the major methodological issue for research on nursing work. Since "scientific and administrative knowledge do not adequately represent what is important in nursing work" (Jacques, 1993, p. 6), we must use knowledge systems which will allow all dimensions of nursing to be made visible.

It is not my goal to develop a knowledge system in this paper. However, I do emphasize considerations of the knowledge systems from which studies arise. These knowledge systems contain the values and implicit definitions which drive the research and, therefore, are important points for examination in the literature review. In other words, it is not enough to ask if the measurement tool is reliable and valid. Such questions are appropriate when the overarching rationale for the method is justified within positivism. I am also concerned about how the actual methodology chosen drives the formulation of the question (Greiner, 1993) and the resultant impact on definitions of nursing since these definitions will interact with institutional definitions of nursing work.
This is the primary philosophical question which undergirds the project. It is operationalized as a question about how what counts as knowledge interacts with what counts as nursing work and adds a level of analysis to the literature review that is woven through the paper.
CHAPTER II
REVIEW OF THE LITERATURE

Introduction: Dimensions of Nursing Work

Taking leave of the previous reflections, the journey turns sharply into more strenuous terrain in order to directly examine nursing's territory. A sense of adventure and a tolerance for ambiguity are necessary for the exploration because the construct, nursing work, has multiple dimensions. The dimensions are defined differently by scholars in the field using different theoretical and philosophical frameworks (Benner, 1984; McCloskey & Bulechek, 1993). Consequently, there is no clear agreed upon list. Moreover, attempts to define the construct have been primarily concerned with the work of nursing in direct relationship to the patient or direct care interventions. It is clear that physical, technical and educational dimensions are the most highly developed. Psychological dimensions are less well defined, but there is a strong emphasis throughout the nursing profession on the importance of caring; the nurse-patient relationship and attention to psychosocial aspects of the illness experience. Yet, each of these areas alone do not adequately represent the scope or depth of nursing's professional expertise.

Little is known about the nurse's role "outside" of the patient's room or beyond face-to-face, "hands-on" encounters. Some evidence exists that there are activities in this realm, often called indirect interventions (McCloskey, 1996), that, if understood, may
lead to an additional dimension(s), filling in a full view of the scope of the work of nursing.

The Work of Nursing: A Black Box/White Box Paradox

The aspects of things that are most important for us are hidden because of their simplicity and familiarity. Wittgenstein, 1953, p. 50e

The fact that the profession has not been able to directly link intervention with outcome lends a black box mystique to the practice of nursing. The linkages between diagnosis, intervention and outcome have not been fully explicated. Consequently, nursing's direct effect on patient outcomes is not clear. Yet, nurses individually are often very sure of what they do and that "it" makes a difference, the white box. "It" refers to a common term nurses use to describe their unique role. The fact that nursing work is discussed in generalities symbolizes the struggle to articulate a complete explanation of nursing work even though nurses are sure that their work impacts lives.

Nurses express frustration in making "it" visible to others and with balancing "it" or "all the things" that take up their time. Interestingly, many do not call the "things" nursing (S. Haas, personal communication, 1994). The "things" are a given in nursing work. These two perspectives form the basis for a paradox which is woven through the study of nursing theory and nursing work—that nursing is so clearly understood by those experiencing it and yet "it" stubbornly hides from collective, formal investigation. Said another way, Curtin (1994) states that "what nurses contribute seems as obvious as it is difficult to measure and to differentiate from [the contributions of others]" (p. 7). The paradox is explored further in the next section.
Invisibility

A sense of adventure is needed to confront the possibility that there are dimensions of nursing that are not readily discernible. In this section, analysis of the literature and pilot interview data from nurses yields clues that highlight the possibility of their existence. First, the literature frequently refers to nursing as an “invisible” profession and nursing work as “invisible” work. In 1990, an article in The Journal of the American Medical Association asked the question, “How can such a pervasive element of health care be so invisible” (Freidman, 1990a, p. 2851) and recounts nursing’s historic struggle with its ambiguous identity. As recently as December, 1993, Anderson, in an editorial on health care reform, invokes essentially the same query. Paradoxically, Fagin postulates that “As patient needs become greater, requiring more and better educated nurses, the invisibility of the nursing profession seems to increase in equal measure” (Fagin, cited in Freidman, 1990a, p. 2851). Further, Misener and Biskey (1989) argue that health care financing systems (Diagnostic Related Groups and Ambulatory Visit Groups) ignore nursing’s contributions thereby institutionalizing nursing’s invisibility from a financial perspective.

It seems that nursing’s invisibility on the national scene parallels its invisibility in practice. Although invisibility is commonly attributed to gender issues which associate nursing’s caring, nurturing functions with the traditional female (Baer, 1992) and maternal roles (Fagin, 1983), such claims imply that nurses, as women, are assigned to care by virtue of biology. Therefore caring actions are “taken for granted,” a result of
role assignment, and consequently not considered real work in a “society that currently undervalues caring” (Baer, 1992, p. 19).

It is important to note that many critical aspects of nursing practice are also “invisible.” Wolf (1989) documents at least six different types of unseen nursing work. Especially significant in her categorization is the inclusion of the intellectual functions of nursing (Gebbie, cited in Kauffold, 1993; Wolf, 1989) and the advocacy role (Baker, 1993; Wolf, 1989). Roberts (1990) claims that the caring dimensions of nursing are essentially “invisible” by definition. Street (1992) invokes the vision metaphor to discuss the failure of nurses to speak and document their clinical practice. This failure, she claims, is a major contributor to nursing’s invisibility. She presents a provocative argument supporting the claim that nurses, while very much in the public eye, are functionally “invisible” to many, including each other (Street, 1992).

An additional indication of invisibility can be attributed to the nurse’s flexibility and dynamic focus that crosses individual, group and organizational frames of reference. The nurse’s focus is often defined by the changing needs of patients and agency demands. Such work, and its associated knowledge, is poorly represented in discussion about nursing. The work looks beyond a patient focus to the surrounding organizational and social systems and assesses problems in these realms. It, too, is often described as “invisible” or taken for granted and frequently associated with caring and women’s work. Wolf (1989) refers to such work as system maintenance and safety work. Jacques (1992, 1993) calls it caring/connecting work and documents such activities as occurring every six minutes. He defines the work as a structural practice and claims that, despite its frequency, even nurses
defines the work as a structural practice and claims that, despite its frequency, even nurses fail to articulate these functions as work. Jacques (1992) describes the concept as:

Doing now a complex activity, now a simple one, now three activities at once, the nurse 'manages' to bring everything together, then disappears from the outcomes of others, her work largely (un)represented by the sequencing, ordering and coherency of a unit whose operation can be (and dependably is) taken for granted within organizational and clinical discourse. (p. 26)

Jacques (1992, 1993), challenging the very substructures of theory and representation, tells us that "It is precisely form that is critical to representing caring/connecting work. To see it at all, one must look away from the content of practices and develop an appreciation of the 'sequence, order or coherence'" (p. 254). He proposes that "it is necessary to theorize caring as a way of seeing in research and administration" (Jacques, 1993, p. 1). Focusing on the themes of invisibility may give nursing clues to its needed vision correction.

In the Words of Nurses'

Nurses' comments describing their work, some of which are presented below, add further evidence that the dimensions of nursing work have not been fully explicated. Twelve pilot interviews were conducted with individual nurses to further explore their perspective on the experience of their work in both acute and non-acute settings. The nurses' reasoning through reflection provides a tool for eliciting clues about how their actions represent the interpenetration of nursing knowledge with the health care system.
These comments arose in conversations when the nurses were asked simply to “tell me about your work”:

P1: “Creating an environment for other work to take place.”

P2: “I can’t put it into words, you have to watch me.”

P3: “It’s like I have about 40 decision-trees in my mind.”

P4: “My job is to get the patient where they need to be.” Interviewer: “You’re saying ‘Nurses do whatever they need to do to get the job done’”? P4: (nods yes) Interviewer: “What do you call this?” P4 “Prioritizing.” (This nurse could not guess how much time it takes.)

P5: “Anybody can get data, but the nurse turns it into realistic terms. What’s its significance for the patient?...interpret the significance for the patient. Create a picture of the patient for the rest of the team. I teach patients how to manage the system. Decreasing anxiety in patients is a common focus. This is where I see nurses being really effective across settings. We do a lot of this--it is not focused on in school”. Interviewer: “Is this the caring relationship?” P5: “Yes.”

P6: “Put it together for the patient--I have a hard time putting it into words especially this putting it together stuff and it changes. They don’t teach you this stuff. It comes from somewhere. You wonder how you are going to do it but somehow it comes.”

P7: Interviewer: “You seem to constantly pay attention to now and later?” P7: (nods and tells a story about looking into the future with a patient about going to a nursing home). “This is something that just comes out naturally. We try to teach how to problem solve. We get to teach the patient about their body and getting to know their bodies.” Interviewer: “This is different than the teaching you learned in school?” P7: (nods “yes” vigorously) “It’s hard to put into words. I don’t know where I learned it.”

“Nurses believe their work is frustrating... (it) is exhibited by their talk related to their belief that no one really understands what they do” (Byers, 1990 p. 93). These comments and others imply that there are types of nursing work that do not fall neatly
within the commonly accepted parameters of nursing activities. Of specific interest are those comments which reflect a value for doing whatever is necessary to get the work done. Rarely conceptualized, the value seems to resonate with Jacques' conclusion that "nursing's distinctive competency...is that the nurse is the one person on the unit whose job is to care about anything that might happen in the universe of the patient and to connect any parties who need to be connected in order to assure a successful outcome for the patient" (Jacques, 1992, p. 260). However, "doing whatever is necessary" is more commonly seen as an altruistic goal. Such work needs to be languaged differently to be credited in an economy driven by commodity production.

There is evidence that much of the work (thinking, planning and evaluating) occurs while nurses are simultaneously doing one or more nursing interventions. A nurse from the pilot interviews describes this as "mental gymnastics" saying, "You always have to be thinking, you have to be thinking ahead. You can't allow you mind to get sloppy." She goes on to recount a very detailed process of assessment that she did while administering medications to a patient. She notes that while giving pills she is "doing more than one thing at a time" such as checking armbands, checking identity, checking circulation, monitoring her approach to the patients. While watching a patient take some pills she makes "observations of how [the patient] is handling it" [the pills were in a cup] indicating to the communication therapist (nonverbally) to watch, also. "This gives us a clue as to what we’ll have to adjust in her therapy." Most interesting about this story is that it took place in the presence of a speech therapist showing the therapist what the nurse considered important patient information. In effect, the nurse helped another professional see a
picture of the patient from which the therapist could then proceed to do her work.

Although the event may sound like a fairly sophisticated assessment and co-ordinating activity, it took place around a simple intervention (medication administration). Notably, the nurse was unable to decide if what she had done was really work. Perhaps on the nursing intensity measure she would mark “Giving meds,” a dependent nursing function, and get no credit in either time, payment or expertise for the actual nursing intervention she performed. The type of nursing intervention described in the nurse’s example may represent another dimension of nursing work which, in the nurse’s words, is “not in any textbook” and not on any reimbursement form.

Visions and Complexities

A sampling of quotes from the professional literature demonstrates how the nursing community itself reflects diverse visions and understandings of the nursing role; perhaps, testing one’s tolerance for ambiguity:

Nursing is a strange occupation. It has many strengths and in general is practiced by a body of people who enjoy their work and who believe the work they do has an intrinsic value to society. If you ask all these very same people to explain their work, to explain what is “good nursing,” to explain how they make judgements and decisions in their day-to-day work, most of them flounder...There has been, and still is, a gap between what we as administrators and teachers believe is needed to maintain and improve nursing care and how the practitioners view their work, their world of nursing practice. (Patten, 1992, p. ix)

The complexity of nursing practice is another theme within the nursing profession. “One of the most challenging features of managing nursing ‘objectively’ is the intense subjectivity of bedside care-giving-- its quality of being interactive and interpretive. It is
impossible to accurately and fully document nursing action" (Campbell, 1992, p. 761).

Also, there is general dissatisfaction with paper and pencil instruments to measure and capture nursing work.

PCSs [Patient classification systems] could not address the emotional needs of patients, the needs of the elderly, or unpredictable events that require intensive nursing interventions. Other aspects of the nurse's work that could not be measured on a PCS were interactions with patients as a reassuring presence, attentive listening, and providing information. (MacPherson, 1989, p. 36-7)

For over a century, "it has been an absolute article of faith in organizations that understanding work involves breaking activities into their components and measuring them" (Jacques, 1993, p. 6). Therefore work had to be defined in ways amenable to quantifiable measurement. Work articulated as such can be legitimizied, claimed and reimbursed. Unfortunately, the requirement for quantification has served to camouflage "invisible" nursing work. It is important to bring these dimension(s) to the foreground. Until nursing can name its service in a way that represents the full scope and depth of nursing work, the discipline will not gain value and status in the health care economy and nursing will not function as a major player in the health care arena for "naming is power, the power to shape a culture's way of perceiving and thinking about reality so that they serve the interests and goals of those doing the naming" (Dodson Gray, 1994, p. 6).

Nurses describe work situations inscribed with invisibility and silence. Meanwhile, staff nurses talk about aspects of their work that do not fit neatly into quantifiable measurement categories and are characterized by complexity. One concludes that there are dimension(s) of nursing work that are still left to be visualized, articulated and
explained. However, there is a dearth of information that addresses the unseen, unnamed and undefined dimension(s), a dimension(s) that appears elusive because it is masked by a common activity and traditional methodology. Conceptual frameworks have not examined it.

**Have We Attempted To Articulate The Dimensions Of Nursing Work?**

In an effort to strengthen the professional foundations of nursing, diverse conceptual frameworks that include both philosophies and theories of nursing have been used in scholarly efforts to examine the nature of nursing from an abstract, theoretical viewpoint. Economic forces have placed emphasis on the need to quantify nursing work. Therefore, nursing intensity instruments were developed to predict demand for nursing care. Nursing work was defined by activities in an attempt to get "objective data" about what nurses do so that the time consumed in nursing work could be measured.

As the profession began to expand its repertoire of research methodologies, non-traditional or qualitative approaches have been applied to nursing questions. These methods have also been applied to the study of nursing by researchers such as Benner and Wrubel (1989), Lawlor (1993), Marcus (1989) and Wolf (1988). Their studies and others helped to create images of nursing that shimmer with a depth and complexity that had not been articulated in empirical measures of nursing work.

Non-nurse scholars have brought additional methods to the study of nursing. Methods such as genealogy, labor process analysis, sociological research, historical analysis, and investigative journalism have provided even additional perspectives and
examine factors affecting the theoretical world of nursing (Jacques, 1992), the everyday world of nursing experience (Campbell, 1992; Stelling, 1991), the moral claims and responsibilities of the profession (Melosh, 1982; Reverby, 1987) and society and caring (Gordon, 1991, 1997).

Unfortunately, each of these areas of investigation have proceeded independently reflecting highly diverse levels of discourse and analysis. Little attempt has been made to integrate or to understand the implications of such findings for a meaningful understanding of nursing work. In the next section, the journey follows more familiar paths where definitions of nursing work are most likely to be found.

Where In the World is the Definition of Nursing Work?

Surveying the Theoretical Landscape

Nursing work in this project is conceptualized as an overarching construct which represents the scope and depth of a phenomena. The construct is then made up of multiple dimensions, some easier to observe than others. However, each dimension contributes equally to a full understanding of the construct’s definition. Finding definitions of nursing work has been a challenging quest. Much is written for and about nursing but clear articulations about the actual work of nursing are scant. The literature offers the explorer many captivating vistas. However, a panoramic view of nursing work is not among them. To achieve such a view, this explorer would like to discover a completely excavated, well-designed pyramid in her travels. The base would be formed by a theory to explain the phenomena which then supports the next level where models of
care delivery operationalize the theory for practice. The capstones would be set with instrumentation that can measure nursing work. If such a model exists, nursing work would indeed be well conceptualized. In its absence, however, such logic does provide the roadmap to guide the literature review which samples nursing theory; organization of nursing for models of care delivery; specifically primary, team and case management; and nursing intensity systems as measures of nursing work. The review is summarized and critiqued in the next three sections.

Theories of Nursing: Explanations, Philosophies or Visions?

The journey proceeds, then, with an inspection of what one would hope to be the most foundational elements delineating nursing work, nursing theory. The development of nursing theory has been motivated by the professional agenda to establish itself as a scientific discipline and to articulate its unique expertise. Ten theorists were reviewed to answer the question, do nursing theories explain the phenomena of nursing work? Theorists included Nightingale (1860), Peplau (1952), Levine (1969), Henderson (1970), Rogers (1979), Leininger (1978/1991), Orem, (1980), King (1981), Parse (1981) and Newman (1986). A chronological summary chart is represented in Figure 1 showing definitions presented in the theorists’ words and related concepts. (See Figure 1 below)
## FIGURE 1

### Nursing Definition Grid of Selected Theorists

<table>
<thead>
<tr>
<th>Theorist</th>
<th>Definition</th>
<th>Related Concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nightingale 1859</td>
<td>“put the patient in the best condition for nature to act upon him”</td>
<td>Claimed by both totality and simultaneity paradigm, clear focus on environment, attention to social organization, the hospital</td>
</tr>
<tr>
<td>Peplau 1952</td>
<td>“Inquiry points to the fact that nursing is not only what it does but also what it can and ought to be doing.” “Nursing is significant, therapeutic, interpersonal process. It functions co-operatively with other human processes that make health possible for individuals in communities.”</td>
<td>Focuses on therapeutic relationship theory for psychodynamic nursing, but later applied to the nurse-patient relationship in general.</td>
</tr>
<tr>
<td>Henderson 1970</td>
<td>“The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible.”</td>
<td>Focuses on relationship, spells out basic nursing care in terms of satisfactory patient functioning, encourages nurse to look for “hidden” meanings in patient response and to develop her own personal concept of nursing.</td>
</tr>
<tr>
<td>Levine 1969</td>
<td>“Nursing is a human interaction. It is a discipline rooted in the organic dependency of the individual human being on his relationships with other human beings.”</td>
<td>Mentions the hospital, traces theories of health historically and notes nursings’ dependence on prevailing theories of health, discusses a unified view of health/illness, primarily discusses patient care</td>
</tr>
<tr>
<td>Rogers 1970</td>
<td>“A science of unitary human beings basic to nursing requires a new worldview and a conceptual system specific to nursing’s phenomena of concern.” “The practice of nursing is the utilization of nursing’s body of abstract knowledge in service to man.”</td>
<td>Clearly articulates interactive relationship between man and environment, humanistic, humans as focus of nursing’s concern rather than explaining nursing, sees man as more than sum of parts, illness as part of life process, very general guidelines for practice, credited with inspiring alternative paradigm debate in nursing</td>
</tr>
<tr>
<td>Theorist</td>
<td>Definition</td>
<td>Related Concepts</td>
</tr>
<tr>
<td>----------</td>
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</tr>
<tr>
<td>Leininger 1978/1989</td>
<td>&quot;Care is, indeed the essence of, and the major concept to explain nursing... care is unique, dominant, and unifying factor of nursing, and the most powerful concept for explaining, interpreting, and predicting nursing outcome. Care as a noun is the phenomena to be explained; caring is the action component.&quot;</td>
<td>Care acts are nursing work; nurses are people so they, too, need care; caring is expanded with the concept of culture; nurses work within the organizational culture; social structure gives order, meaning and constancy to people yet changes over time; provides a framework for looking at the structures of caring; acknowledges influence of culture on health/environment.</td>
</tr>
<tr>
<td>Orem 1980</td>
<td>&quot;...the product of nursing practice is a nursing system(s) through which the capability of patients to engage in self-care is regulated and self care is continuously produced explains how persons can bee helped through nursing.</td>
<td>Attempts to answer questions about what nursing does and when people need nursing care; does look at all aspects of care but does not acknowledge the environment directly as an influence on the nurse or the patient; represents a traditional model of the nurse assessing a passive patient most amenable to hospital nursing</td>
</tr>
<tr>
<td>King 1981</td>
<td>&quot;Nursing is a process of human interactions between nurse and client whereby each perceives the other and the situation and through communications, they set goals, explore the means to achieve them, agree to the means, and their actions indicate movement toward goal achievement&quot;</td>
<td>Focuses on interaction; defines personal, interpersonal and social systems in interaction.</td>
</tr>
<tr>
<td>Parse 1981</td>
<td>&quot;The goal in the practice methodology of the theory of Man-Living-Health is in the quality of life as perceived by the person and family.&quot;</td>
<td>Focus of nursing on interaction for the &quot;illumination&quot; of meaning to determine personal definition of health; builds on Roger's; man in open interchange with the environment, challenges received view and places patient in charge; Not directly focused on the work of nursing but changes the work of nursing if implemented; calls for new research methodology.</td>
</tr>
<tr>
<td>Newman 1986</td>
<td>&quot;...the essence of nursing, the one to one personalized care of the earlier days. Health as expanding consciousness.&quot;</td>
<td>Nursing supports patients in the development of meaning; pattern recognition; new paradigm will place nurse in conflict but they already are caught between two paradigms; no mention of what kind of organizational structures support new paradigm nursing work; health, person, environment connected; illness as opportunity for expanded consciousness; documents that personal experience influenced her definition of health; research methodology to explicate pattern.</td>
</tr>
</tbody>
</table>
The theme of how knowledge systems affect definitions of nursing work is also evident in these theories. When viewed on a continuum, they reflect movement from the assumptions of positivism to anti-positivism. Parse (1987) classified theories as dwelling either in the totality (positivism) or simultaneity (anti-positivism) paradigm. The paradigms reflect a definition of man/environment interaction as either mechanistic or continuous. Consequently, the notion of patient autonomy would have a more restricted definition in Orem than in Parse. However, only Rogers, Newman and Parse are clearly situated within the anti-positivist category (Parse, 1987). While these three theories have definitions of man/environment interaction which are somewhat more consistent with the worker/organization interaction expressed above, they say the least about the nursing role and nursing work because they focus more directly on health and person.

There are several reasons why these theories do not seem to adequately explain the work of nursing. The reasons can be categorized as value conflicts, theories as visions or descriptions, and utility for research on nursing work. They are discussed in this order.

Values Conflicts

All of the theories support the idea of the nurse in relationship with patients which is consistent with nursing's philosophical discourse as well. However, the emphasis in itself points up a failure to acknowledge both the practice setting where the relationship is located as well as all other necessary interdisciplinary relationships. Therefore, a major paradox is presented because the actual circumstances and organizational operations in health care settings (such as assignment patterns, length of stay and patient transfers)
discourage the development of such relationships in terms of time and continuity. Perhaps
nurses discount these theories as not immediately relevant because they do not account for
the everyday organizational facts of life. Unfortunately, the situation surely contributes to
nursing’s theory/practice gap. Further, many of these theories espouse values and beliefs
for caring and connectedness that are not part of the prevailing competitive nature of the
workplace. Thus, implementation of such theories requires nurses to model behavior that
is at odds with organizational expectations. One wonders if nurses are prepared to live
such a dilemma in their everyday work lives and how this may contribute to burnout and
role stress.

Nursing Theory as Vision or Description

It is unclear whether nursing theories are to function as descriptions of nursing
process or visions of how nursing ought to be. They vary greatly in degrees of specificity
and levels of abstraction. Consequently, their usefulness from both research and practice
standpoints is questioned.

Attempts are being made to implement nursing theory (Cody & Mitchell, 1992;
Forchuk, Beaton, Crawford, Ide, Voorberg, & Bethune, 1989; Frey & Sieloff, 1995;
Nunn & Marriner-Tomey, 1989) but these contributors do not represent a major agenda
in nursing service delivery. On the other hand, they do function well as visions of what
nursing ought to be, especially formulations like Rogers (1970), Parse (1987) and
Newman (1986) which incorporate new models of knowledge and health. In this regard,
they stand as somewhat revolutionary because nursing work would radically change if
such theories were implemented. These theories have philosophical merit as discussions of the central values and major themes of interest to the nursing profession.

From a research perspective, the theories in general do not offer the specificity to predict and test the outcomes of nursing interventions although some theorists do not claim such a goal. Pendleton (1989) distinguishes a model of professional practice from a theory that explains or predicts nursing outcome. A model of professional practice would appropriately include definitions of nursing and nursing activities. A theory for nursing outcomes would more likely center on the phenomena of patient experience and response. Pendleton (1989) offers a helpful delineation. Many nursing theories try to do both and, as a result, are difficult to classify as theories, philosophies or models. Even theories that claim to center more directly on the patient/environment interface like Rogers, Newman and Parse, have implicit assumptions in them which direct how nurses should “be” with patients.

While it is clear that nursing needs a theoretical base to insure its professional status as a unique discipline, it remains unclear what role theories play in establishing a base. What is clear is that additional philosophical investigation is needed about the nature of nursing and that separating theoretical inquiry about nursing from theoretical development about patient response to nursing care may be a fruitful project.

For over forty years, nursing has worked to establish a theory base for its science. The theories represent the heart of the struggle. The development of nursing science is critical to the professional agenda and reflects once again how knowledge systems have influenced the articulation of nursing work. Many of the theories represent attempts to
articulate the profession's unique work in a way that will meet the standards of positivism and its requirements for testable theory. Although they represent major intellectual projects, in general they do not seem able to adequately explain the full scope or depth of the work of nursing.

Utility for Research on Nursing Work

Within the nursing theories, one finds attempts to explain the phenomenon of nursing as a professional discipline; a focus on phenomenon of concern to the discipline such as human response to illness. In a limited way, some theories attempt to describe the activities of nursing. With the possible exception of Orem, however, the last point is more often inferred than articulated.

Some theories do draw our attention to factors which have an impact on the work of nursing such as culture, organization, relationship, environment, goals, change and knowledge development systems. For this reason, the theories could be applied to the management of nursing services by refocusing the theory on the nurse as a person. Environment would also need to be reconceptualized (Meleis & Jennings, 1989). But even if the reconceptualization could be accomplished, nursing theory as currently developed may not be appropriate because the nurse at work interacts and experiences the health care environment in fundamentally different ways than the person who is in need of service. Leininger's nursing theory (1991), which will be discussed further in Chapter Three, however, does provide a framework to begin to explore the context of and setting for nursing care delivery.
Nursing Care Delivery Systems: Operationalizing Theory in Practice?

By leaving the foundation to follow passages created by pioneers who established nursing care delivery systems, the explorer moves up the pyramid to seek definitions of nursing work at the next level. Such definitions were sought by sampling literature on nursing care delivery systems sometimes known as nursing practice models. Articles comparing different models or discussing models based on a nursing theory were of special interest. The designs currently in use are identified as team nursing, primary nursing and case management. (Brett & Tonges, 1990; Bowman, Webster, & Thompson, 1991; Brannon, 1988; Dienemann & Gessner, 1992; Forchuk, Beaton, Crawford, Ide, Voorberg, & Bethune, 1989; Gardner, 1991; Giovanetti, 1986; Jelnick & Dennis, 1976; Koerner, Bunkers, Nelson, & Santema, 1989; Kron, 1971; Lamb, 1992; Leach, 1993; Mark, 1992; McPhail, Pikula, Roberts, Browne, & Harper, 1990; Pearson & Schwartz, 1991; Ritter, Fralic, Tonges & McCormac, 1992; Sandhu, Kerouac, & Duquette, 1992; Schroeder & Maeve, 1992; Thomas & Bond, 1990; Williams, 1991; Zander, 1988).

Overall, the literature reviewed on nursing care delivery systems does not explicitly define the work of nursing. It clearly supports, however, organizational systems as an important variable impacting the nursing role and quality of care (Giovanetti, 1986). Jelnick and Dennis (1976), acknowledging how systems change nursing activities, state that "nursing productivity might be more accurately viewed as the productivity of the organization" (p. 9). Dienemann & Gessner (1992) provide an overall conceptual review of delivery systems. It is evident that, as the delivery system changes from work
redesign (primary nursing) to system redesign, the impact on nursing activities and role increases. They emphasize how system redesign strategies such as case management have more clearly defined evaluation criteria, encourage interdependence and affect the interaction of the nurse and other providers by improving the nurses’ status in the group. Despite such admissions, however, research has not been able to offer clear descriptions or predictions regarding the efficacy of different delivery systems.

In the literature on team and primary nursing, several themes emerge as persistent methodological and measurement problems (Giovanetti, 1986; Leach, 1993). These are listed as:

1. Inadequate conceptual and operational definitions of the models and related concepts such as authority or responsibility,
2. Inadequate instrumentation,
3. Equivocal results despite isolation of appropriate variables such as quality of care, nurse satisfaction, time spent with the patient and cost,
4. Influence of stress in primary nursing due to increases in workload and accountability,
5. Equivocal findings regarding increasing professional autonomy, and
6. Primarily descriptive, quantitative studies with few exceptions despite the fact that qualitative design would help resolve conceptual and philosophical ambiguity.

Primary nursing does offer some delineation of nursing work as “activities in conceptualizing, organizing and performing the complete range of patient care tasks”
The broader scope, which includes the coordinating nursing actions, becomes more obvious in case management systems where the function is formalized along with an additional expectation for economic responsibility.

Case management evaluation studies include an emphasis on outcome variables such as length of stay, quality of care, patient and job satisfaction and workload. Lamb (1992) summarizes the methodological issues in the research as:

1. Lack of definition and theoretical base for case management,
2. Lack of clarity about the process of care,
3. Failure to obtain meaningful, comparable samples,
4. Reliance on quantitative designs failing to show relationships, and
5. Instrumentation that is not sensitive to nursing case management interventions.

Such problems are consistent in research on nursing care delivery systems. The case management projects, however, are more aggressive in their research approach with a major emphasis on cost variables.

The above observations summarize the brief review of the literature on nursing care delivery systems. The research is primarily applied evaluation research. Since it is driven by economic forces and is often done as part of implementation projects, Hawthorne effects are a constant threat. As such it may be motivated by an agenda to justify a change in addition to knowledge development. Only one article outlined a logically articulated program of research (Lamb, 1992).

The lack of conceptual definitions for the organizational modes is a foundational problem. The problem is sometimes even reflected in lack of knowledge among study
subjects (Thomas & Bond, 1990) and is related to the failure to fully conceptualize facets of a definition of nursing work. It has not prevented, however, a proliferation of inadequate designs with large numbers of variables and inadequate tools. Consequently, research results are confounding at best. The methodological problem clearly calls for the development and use of diverse strategies for research and inquiry into nursing care delivery systems and impact on practice. But such efforts without a broad conceptual definition of the model of delivery will not immediately produce the type of quantitative results required for administrative purposes.

Nursing Workload Measurement Systems as Sources for Definitions of Nursing Work

Hopes for a panoramic view of nursing work from the pinnacle of the pyramid may now be somewhat diminished since the critique of the literature shows that the fittings for the supporting structures are not totally secure. Still, scaling upward to instrumentation to measure nursing work is in order. The area is primarily made up of a considerable literature on the cost of nursing services. Instruments used for such analysis have been called patient classification or patient acuity systems and will be discussed as they are currently referred to in the literature, nursing intensity measures. A sampling of the literature covers areas of related concerns but not explicit definitions of nursing work. The studies are motivated by cost-effectiveness and the need to determine and justify nursing resources in a cost conscious health care environment that does not automatically accept the worth of nursing. The studies primarily define nursing by what a nurse does,
identifying nursing care requirements based on patient dependency and need for nursing intervention. The model does not adequately attend to work that is focused on wellness or the integrative, connecting functions of the nurse for the patient and the organization. The next section will address the following issues related to nursing intensity: the implicit definition of nursing work as task; exclusion of context and environment as an important variable; failure to acknowledge the professional nurse as a valid reporter of work load; and problems of the interplay on knowledge systems and work system measurement.

Measuring What Can Be Seen: Work as Task

Patient acuity is measured by prototype (3 to 5 ranked categories of patient care needs) or factor systems (a multi-item scale with patient interventions tagged with time allotments) and measures of nursing intensity (a scale that includes time, severity, dependency and complexity). The ongoing development of systems has been driven by a goal to refine objective measurement of nursing resource consumption. Factor and intensity measures are considered more objective. The various benefits and shortcomings of factor and prototype systems are discussed and debated in the nursing literature (Armstrong, Simpson, Nield, Lentz & Mitchell, 1991; Bigbee, Collins & Deeds, 1992; Edwardson, S. R. & Giovanetti, P. B., 1994; Giovanetti, P., 1979; Haas, 1984, 1988, 1990; McHugh & Dryer, 1992; Phillips, Castorr, Prescott & Soeken, 1992; Soeken & Prescott, 1991; Verran, 1986).
Primary concerns with reliability are noted due to the nature of the rating systems and variability among the raters. A major difference is noted between the tool's ability to measure estimated or actual nursing resource consumption. Definitions of nursing resource (skill mix) and time parameters vary across classification system, agency and type of nursing unit. Therefore, potential for measurement error is increased with the rater and calculator's ability to apply terms and calculate definitions as well as decreasing generalizability across settings. The importance of the context of the work, a variable which is generally ignored in the discourse on intensity, could well be related to such difficulties.

The validity of nursing intensity systems is fundamental to the problems associated with their use. If a tool claims to measure how much nursing work is required on a particular shift, it is logical that the tool would articulate a definition of nursing work or that the construct would have a theoretical base. Explicit definitions are absent. The systems define the construct primarily as the intervention actually performed and the activities in primary association with the dependency needs of the patient. Therefore, what counts as nursing work is only what can be seen and then primarily what can be seen in relation to the patient. Some tools have some calculation of "indirect" nursing time but these measures also vary and may account for activities that relate to the completion of a defined nursing intervention, such as charting.

Evidence exists that nurses spend a great deal of their time in activities which enable the functioning of the hospital system (Byers, 1990; Jacques, 1993). The activities may be centered on procuring supplies or communicating information so someone else can
do their work. The overall outcome may be related to the general patient good but the actions are not readily identified with nursing intensity systems that focus directly and exclusively on patient dependency needs. The issue raises a philosophical question about "what counts as nursing work?" In a rationalized system where a product is only an empirical measure of something that can be seen, then activities that go on via communication and clearly those that are less tangible will be disregarded as "not real work." For example, what may be measured is the nurse talking on the phone for ten minutes. The skill, knowledge and energy consumed in knowing the patient’s problem, who to call, when and how to connect people and resources for the patient’s good are surely missed in a task-focused measure of phone time.

Byers (1990) and Jacques (1993) both describe a phenomena of nurses doing more than one thing as a time; a type of simultaneous processing of tasks and mental work. Such activities as well as the hidden or “invisible” dimension(s) of nursing work discussed earlier are not accounted for in measurement tools focused primarily on observable tasks.

It has been argued that without a theory or a construct of nursing work as a foundation, intensity measures lack construct validity (Haas, 1988). As has been shown, nursing theory per se does not adequately explain the work of nursing. Therefore, nursing theory cannot provide the grounding for measurement.

Contributing to Invisibility? The Exclusion of Context and Environment

Nursing intensity measures fail to account for the importance of context and environment. The significance of the two factors is supported by several scholarly
endeavors. A measurement of nursing work that focuses on activity only ignores the interactive relationship between the actual work, the nurse, the organization and the broader social and professional environment.

Davis, Kramer and Strauss (1975) acknowledge that “work behavior is... greatly influenced by organizational and structural elements in each place of work, as well as by social and cultural features in the society at large” (p. vii). They imply that nursing as a profession is even more vulnerable to external factors. Byers (1990) recognizes the importance of understanding the work environment to aid in reconceptualizations of nursing work. In fact, the literature on organization of nursing care delivery strongly supports the impact of the environment on the work of nursing. Failure to consider context weakens the validity of nursing intensity measures because if we only measure what is discernible we cannot be sure if we are measuring actual work or actions that result from the nurse negotiating outside influences such as delivery system problems.

Lest this be considered a theoretical point, let us consider the problem of support services, an important issue in the nurse’s work environment on nursing care delivery. Most nurses agree that a great deal of time is wasted because housekeeping or pharmacy has not provided needed service to the patient unit. Phone calls to these departments are often considered “indirectly” related to patient care (a category which in itself should be challenged) and may or may not be measured in nursing intensity. Yet, Byers (1990) reported problems with support services as clearly problematic. She states “support services and nursing services have many complex and continual problems which impact nursing practice” (p. 110). Shamian, Hagan, Hu, and Fogarty (1992) provide empirical
support for the relationship between support services and nursing hours per patient day. Primarily, they document the impact of environmental changes (via support services) on the demand for nursing work. The study was done by looking at seven additional variables in relation to patient acuity measured by GRASP, an accepted nursing intensity system.

Therefore, we can see that measures of nursing intensity alone do not adequately explain nursing productivity, cost or resource consumption. Second, they fail to adequately acknowledge important environmental factors which contribute significant variables which affect the work of nursing.

The Nurse as Rater

Another measurement problem concerns the nurse as rater of nursing intensity. In addition to the common measurement problems of rater reliability raised previously, I raise a concern found in the literature about the nurse’s ability to judge patient need. The assessment of patient’s needs is a primary focus of nursing practice and an area of nursing expertise. Assessment is a highly refined skill and critical thinking activity regarding the nurse’s wholistic involvement with the patient. Edwardson and Giovanetti (1994) state that “an experienced nurse manager is a finely tuned measurement instrument, an assumption readily accepted by most nurses but less acceptable to skeptical policy makers outside of nursing” (p.116).

It is logically inconsistent that nursing judgment plays such a critical role in patient care, yet their ability to use the same skill in the determination of nursing intensity is not
accepted. Haas (1990) cites research findings that support the accuracy of nursing judgment in determining patient acuity and challenges the belief that “subjectivity” is really a problem.

Subjectivity is a necessary component of patient care but becomes problematic in a measurement system based in a positivist intellectual tradition. Nurses live the dilemma as they are asked to be one way with patients and another way with the administrative tools which justify their existence. Once again the dilemma of knowledge development systems and work systems appears and the following questions emerge.

What do we say to nurses when we ask them to be objective about the measurement of their work yet also remain subjective and involved? Unfortunately, the nursing intensity system tells the nurse what she is being paid for. It outlines “what counts as work.” The intangibles generally do not appear on factor systems, although prototype systems are more responsive to nursing judgment and critical thinking. Therefore, the nursing intensity system may become the standard for nursing work, the self-fulfilling prophecy discussed by Haas (1988).

What the nurse believes she ought to do becomes less influential if it is not on the nursing intensity system. So the system, based on activity, begins to play a guiding role in the evolving definition of nursing practice in an institution, a definition that may be used by nurses and, more important, to define nursing to all other disciplines. The intensity measure itself, as a demonstration of administrative policy becomes part of the context of nursing practice. Of course, with the positivist lens, context doesn’t count. It is outside
of the line of vision. However, on the relativist view, the possibility is real and operative and nurses' frustration with nursing intensity systems support the claim.

However, perhaps because of the role nursing intensity systems play in justifying what counts as nursing work, a dilemma is created for the nurse as rater and evaluator of her own practice against somewhat opposed sets of standards of objectivity and subjectivity. Further, one questions whether the intensity systems, in shaping what counts as nursing work, do not simply measure the results of the shaping. A study by Soeken and Prescott (1991) based on the refinement of a new patient classification instrument, the Patient Intensity for Nursing Instrument (PINI) offers further evidence of how such a phenomenon could take place. The development of the PINI has followed careful standards for instrument development. The study reports results of the factor analysis done for construct validity. The researchers expressed concern that, on a ten item scale, patient teaching showed low reliability and attributed the finding to error. Time for patient education, however, has been impacted negatively by implementation of DRG's. Such possible explanations are not addressed because system variables are not included in the underlying construct of nursing work. Perhaps the change in nursing time allotment was being expressed as decreased statistical evidence for patient education; perhaps, less patient education was actually taking place.

The Interplay of Knowledge Development Traditions and Definitions of Work

Once again we must pause to reflect on the interaction of knowledge development systems and the problem of nursing work. An objectivist view accepts measurement of
activity as empirically correct perhaps because such views provides practical data (albeit of questionable validity) for communication with hospital administrators who speak the same language. In this view, the problems of context and environment become a problem of "too many variables." We must question the rationale for the variables chosen for study, however, if the choice so clearly reduces the concept of nursing work to an inadequate representation of reality.

The nominalist (or constructivist) view supports an epistemology that requires acknowledgment of these mutually influencing factors of environment and context and challenges the task orientation as invalid because a theory of nursing practice must be able to account for the type of work that cannot be seen; caring work related to the patient; work related to the organization; work connecting people and resources; and mental work that includes judgment, scientific knowledge and intuition. Currently, such theories do not exist. Some writers are just beginning to discuss such a need in relation to the nature of work in general. If they did exist, such theories would help to explain the very different images of nursing. Such representations would have to reflect nursing actions in response to the changing situation of a patient, a group of patients, other providers, and/or a unit or system milieu. Theoretical constructions are needed to account for the nurse's ability to take actions which anticipate and prevent complications and to permit an appreciation of the nurse's ability to constitute and reconstitute the ever changing work flow processes and networks present in today's complex health care system for the patient's good. In order to expand the vision of nursing work, such corrections will have to be made in our scientific lenses.
In the previous section, we considered whether or not nursing intensity systems developed in a era of cost-effectiveness provide theoretical definitions of nursing work. Based on the discussion we conclude that:

1. Nursing intensity systems as cost measures do not provide an adequate definition of nursing work. Edwardson and Giovanetti (1994) state that “Nursing intensity systems include variables that correlate with workload rather than variables that explain the work of nursing” (p.115).

2. Estimation of patient needs is a nursing judgment. Measures of nursing work must somehow account for actual and desired nursing care delivery.

3. Nursing intensity systems that focus on visible nursing activities are atheoretical, providing neither construct or predictive validity. They require a degree of objectivity that may not be achievable in nursing and their reliability is problematic. Also, they do not attend to environmental variables that may affect nursing work.

4. Nursing intensity measures in themselves do seem to have an environmental impact on the work of nursing. They developed out of the intellectual tradition of positivism, a tradition that is not totally consistent with the world view of nursing practice. Therefore, such measures become problematic in their daily use creating inconsistencies in how nurses use them. They are not sensitive to many aspects of practice that are not obviously task centered. Therefore, these measures create a dilemma for nurses because the data they yield represents a powerful symbol in relation to the nursing budget. These measures also symbolize what counts as
nursing work to both the nurse internally within the department and to the hospital community at large, even though the nurse may disagree with the representation.

5. Nursing must be defined as directly related to the patient, indirectly related to the patient, and related to the organization. Perhaps, nurses have a way of "making sense" of actions in each of the spheres which could best be explained within a theory of professional practice (Pendleton, 1989). Edwardson and Giovanetti (1994) agree that the measurement of nursing could be more consistent if data elements were derived from a conceptual framework of nursing practice.

Summary

After completing a passage through rather arduous terrain, an opportunity to reflect and regain perspective is warranted. Construct definitions of nursing work were not accessible in nursing theory. Glimmers of a fuller construct definition of nursing work begin to appear in the nursing practice models, particularly case management as described by Lamb (1992) which focuses on the work involved in making necessary connections within segments of the health care system on behalf of patients. However, team nursing, as a modified application of Taylorism (Brannon, 1990) reflects management theory, a particular concern since many redesigned nursing delivery systems call for the use of assistance workers in essentially a team model.

Perhaps the most intriguing observation is the remarkable absence of theoretical grounding expressed in both nursing care delivery and nursing intensity systems. There seems to be no construct validity in instruments that measure demand for nursing work
nor is there recognition of the need to modify nursing intensity instruments in relation to practice models, possibly a clear demonstration of the theory/practice gap in nursing. Bowman, Webster and Thompson (1991) claim that the situation reflects a basic difference in that the theories place the nurse-patient relationship as central and methods of nursing care delivery place the organization central. Such observations, while distressing, certainly speak to the significance of practice models as a powerful influence on nursing work.

Perhaps further research will demonstrate how nurses reconcile the two disparate views in their daily work lives. In fact, it seems that a definition of nursing work should also be a functional component in operationalizing nursing care delivery systems.

Finally, it is interesting to note that new types of nursing care delivery systems continue to be implemented with scarce research evidence of their efficacy (Giovanetti, 1986), despite nursing's strong value for research-based decision making. Perhaps other extrinsic social/economic and environmental factors (Brannon, 1988) join with nursing's agenda to move certain programs. Brannon's complex argument based in a labor process analysis identifies how these factors, as part of life world and system processes, have affected the implementation of both team and primary nursing. Explanations such as Brannon's (1988) will continue to serve nursing by improving the profession's understanding of how complex systems impact nursing care delivery and subsequently, the work of nursing. Nursing will continue to be at the mercy of system forces that will force change in nursing delivery systems, and may constrict nursing, until nursing is comfortable with a clear vision of nursing work and willing to argue and negotiate for it.
The Abyss in the Land of Nursing Work

A point of clarity becomes evident while passing through and carefully examining territory primarily constituted by the traditional literature on nursing work. The region demonstrates efforts that have helped to define dimensions of nursing work that are readily visible, accessible, the "hands on" face-to-face encounters. The readily identifiable nursing role dimensions include educator, clinician, manager and advocate. There is no solid theoretical base in nursing, however, which carefully articulates the actual practice of nursing work by attending to it as an integrative, dynamic type of work involving knowledge, critical thinking, judgment, caring, technical skill and responsiveness to individual patient and organizational dynamics. Therein lies the abyss in our understanding of nursing work.

The domain concept of environment, which is the most congruent with these ideas, is also not well theorized in nursing. As a result, discussion of nurses interacting with environment/social systems are limited.

The literature review also clearly identifies the atheoretical nature of research and discussion of nursing work. Interpretive studies (Benner, 1984, 1989; Marcus, 1989; Wolf, 1988) in the antipositivist tradition are beginning to articulate the significant presence of the nurse within the research project. Such studies are clearly contributing to a fuller understanding of the complexity of nursing practice. But they represent a view that, in admitting the presence of the nurse, also looks only at where the nurse directs her gaze. Therefore, the studies are still focused primarily on meaning and nursing work related to a particular patient. If we know that nurses also discount parts of their work as "not real work" because of societal influences, these definitions will have limitations of a
different sort. The limitations commonly fall within the acknowledgment of the social and organizational context of the work.

These factors and others contribute to the abyss in our understanding of nursing work which is essentially unexplored. The purpose of the next section is to begin an exploration of the abyss by discussing two issues which have affected the development and perception of modern nursing. These two issues, nursing as a female profession and the development of nursing science with its associated commitments and agenda, are usually discussed separately. However, here they are discussed together and in interaction with a wider perspective drawn from the role of women and the professions in society, thereby re-locating nursing work within a broader context. Consequently, we are not so interested in plumbing the depths of the abyss in order to measure it but rather searching to understand the reasons for its creation. Such understandings are necessary to inform future investigations of nursing work.

Does Nursing Have A Complete Explanation Of What Nurses Do?

The nursing profession has a growing body of knowledge about its scientific, technical, procedural competence and its caring emphasis. Yet each of these areas alone do not represent the scope and depth of nursing’s professional work. The work of nursing takes place within a nursing consciousness or identity that allows for a type of discretionary judgment and decision-making that gives rise to the attainment and interpretation of data in a typically “nursing” way. It is this consciousness, a cognitive architecture or conceptual framework, that ultimately we must understand because the
framework differentiates the nurse, provides a more complete view of nursing work and substantiates the value of nursing. Until this occurs the question of nursing’s uniqueness will continue to surface as a central dilemma and is inextricably tied to a failure to clearly communicate a picture of what nurses do. As Lynaugh states: “Nursing is still open to the accusation of being vague about itself because being a nurse is a very amorphous, all-inclusive kind of activity” (Lynaugh, cited in Freidman, 1990a, p. 2858).

Why Does This Occur?

Despite the lack of clarity about definition, the nursing research agenda has focused on limited segments of clinical practice, emphasizing the nursing direct care relationship with the patient. From such a starting point, all other research is classified as non-nursing and inadvertently contributes to the silence regarding the actual experience of many nurses’ work lives. Unfortunately, the agenda prematurely closes investigation which may further develop understanding of the construct, nursing work.

Looking beyond a disciplinary perspective understandings of nursing work are also influenced by broad-scale definitions and theories of work. The definitions result from complex societal and historical dynamics and serve as filters for our understanding of nursing work. The next section provides an examination of several of these dynamics to determine how they obscure or reveal images of nursing work.

The Devaluation of Nursing

An old rabbinic prayer states: “Praise be God that he has not created me a gentile;
praised be God that he has not created me a woman; praised be God that he has not created me an ignorant man” (Swidler, 1979, p. 155). With this prayer we are reminded that matters of gender, religion (or morality) and the intellect have long influenced the role of women in society. The devaluation of nursing work by its association with “women’s work” is well documented (Baer, 1992; Freidman, 1990a, 1990b; Lynaugh, 1991; Ray, 1989; Street, 1992; Wolf, 1989). Gender presents only one explanation, however, in a complex tradition that has set the conditions causing historian Reverby to conclude that nurses have an “order to care in a society that refuses to value caring” (Reverby, 1987, p.5). The next section considers several perspectives on the traditions that have become reified by social and economic structures that extend well beyond gender.

From Invisible People to “Invisible” Work

Lack of recognition for women’s work can be traced to antiquity. Only men who were economically able to establish self-sufficient households were granted citizenship in Greek society (Stone, 1991). Women and slaves who performed the nurturing and household maintenance tasks could not become citizens. Matters of the home were given secondary status to the productions of real citizens.

Such secondary status was concretized in the Industrial Revolution when work and production moved formally out of the home and into factories. A nation’s economic success became a function of its industrial productivity. Consequently theoretical discourse on work and organizational science focused on the mechanisms and outcomes of production and organizational science grew without a language to represent activities of
societal maintenance. The care and function of the home, considered against this backdrop, could not be considered “real” work. The home was not, after all, tied directly to financial success. It served instead as a reflection of a man’s success.

The work of nursing, while valued in a time of need, became undervalued by association. Originally located in the home (Freidman, 1990a) and thereby out of the mainstream of industrial production, its products also contributed to societal maintenance. Therefore, such products too could not be considered “real” work. Such work was “invisible” to the thinkers and scientists of the day. If it took place in the home and was not a viable option for study.

Nursing and Dichotomy: Seeing through Bipolar Lenses

The foundations of dichotomized thinking are laid down in the western philosophical tradition of the separation of reason and emotion. Values were assigned, the reasonable became the rational and controlled. The emotional became the irrational and chaotic (Jaggar & Bordo, 1989). Further, Cartesian and mechanistic thought expands the use of dichotomies by adding a view of the “whole to be composed of individual, separable units which can be taken apart and put back together again, the entire machine operating in a repeatable, predictable fashion” (Berman, cited in Jaggar & Bordo, 1989, p. 240). Attitudes about reason and emotion affect what type of knowledge is valued as well as what type of work is valued. Often the value for empirical science and its strict adherence in the separation of subject and object is related to the dichotomy. The process of dichotomizing itself has a dynamic purpose in the social system of nursing and in the
development of thought. Separation, linearity and polarity are the markers of dichotomous thinking. Our ability to define is often guided in categorization by opposites, and stepwise operations. Such a "one thing at a time" approach to inquiry leaves out notions of interaction, dialectic and relationship. In problem solving, the first move of the dichotomous thinker is to separate things out. Dichotomous thinking forces definitions by placing issues at opposite ends of a dilemma. Thus, making solutions often seem impossible.

A range of possible solutions that might arise from synthesis are automatically eliminated by keeping issues separate. In our culture the tendency for dichotomy is strong, strong enough to resist attempts at synthesis, connection and integration. It must be strong because it serves as the linchpin for what little security and control some feel in their ability to interpret the world. In fact, a metaphor exists for the "machine as man’s (defined as male) drive to dominate nature. Nature itself is associated with the female principle" (Berman, cited in Jaggar & Bordo, 1989, p. 241). Thus, the foundation for the man-machine/nature-female dichotomy is created.

The claim that machinery can be humanized may sound curiously familiar to nurses having been mandated to "care in high tech environments." What is implied is that nurses can call up nature’s responses to enhance the work of the machine which is primary. The process also plays out in mandates such as; "Be objective in problem identification,” “Don’t let emotion get in the way of caring for patients,” “Leave personal problems separate from work problems.” It takes energy to keep all these things sorted out and separate.
Next, consideration is given to three dichotomies and how they veil the work of nursing. Of specific interest is the split between reason and emotion, mental and manual labor and theory and practice.

Hand Work and Heart Work

The traditional role of women as nurturers is at the base of nursing’s problems with knowing and work. The logic of the above tenet, in brief review, is as follows. Recall the root dichotomy of reason and emotion and associated values. It follows that the demonstration of caring either in personal relationship or work, demonstrates an inferiority. Demonstrations of caring serve as proof of emotion, as proof of a less rationale being. So the expression and action of caring, actions associated with the female/nature end of the dichotomy, are to be guarded against. They carry the curse of inferiority. Schopenhauer (cited in Ashley, 1980) says it most succinctly:

The weakness of (women’s) reasoning faculty explains why it is that women show more sympathy for the unfortunate than men do, and so treat them with more kindness and interest; and why it is that...they are inferior to men in point of justice, and less honorable and conscientious (p. 8).

Ashley continues “Religious teachers and philosophers have overwhelmingly argued that it was women’s nature to be kind, gentle, loving and nurturing, but many at the same time argued that the behavior was an outgrowth of their defective nature (Ashley, 1980, p. 8). Since women’s thinking was believed to be faulty, it would also follow that women’s work, her productions, would also be inferior. Such notions gave rise to the devaluation of women’s work which persists today.
The problems of caring work are present in nursing’s history and literature. From the highly structured hierarchical hospitals of the 1800’s to the present day facilities that represent the best of the medical-industrial complex, caring work defies the structure imposed upon it. Of course, patriarchal systems assume that nurses work could be administered, controlled, prescribed and ordered, in keeping with the reason/emotion dichotomy. The problem is that the human, interaction aspects of health care do not fit nicely into mechanistic models.

The reason/emotion dichotomy lives on in nursing in the many ways that “caring” is associated with affective traits. In this view, caring work in its association with emotion is disqualified as “real” work. It is too often considered a biological instinct. Testifying to the continuation of the tradition is the common practice of accepting rational “objective” data in lieu of nursing judgement (Campbell, 1992). This is a common issue in the development of nursing intensity measures.

The challenge broached by this dichotomy is expressed by Gordon (1992) who reminds us that “attending to the human dimension of disease is far more than a feminine nicety” (p. 42). Nursing practices done in the name of care must be framed in such a way that they reveal both their knowledge source and contribution to society.

There is a natural division in types of work separating mental and manual labor. The split can be traced to Socrates (Magdoff, 1982) and has significance for how work meanings are generated and status is assigned. Manual labor has negative connotations since it is associated with routine, unpleasant work and relegated to the lower class.
Mental work is thinking work and is often associated with scholarship and the professions. It is interesting to note that nursing work encompasses both aspects.

Women's work, associated with housework, or an "ideology of domesticity" (Hughes, 1990, p. 25) was necessarily manual labor. Women's work is more labor intensive, and therefore, has lower productivity per worker associated with it (Greenleaf, 1980). Women in traditional types of caring roles often perform their work in response to the needs of others, so demand for such work is often difficult to quantify and unpredictable. These factors provide the justification for the creation of heavily structured work environments for nurses. Reverby (1987) states that prior to Nightingale, nurses were "undermined by the nature of their onerous work, the paternalism of the institutions, class differences between trustees and workers, and...the lack of a defined ideology of caring" (p. 7).

Nightingale developed a hierarchy compatible and parallel to the hospital patriarchy in an attempt, not to change nurses' work, but to gain entree' into the hospital politic. Essentially the dynamic continues today. Hospital departments of nursing continue to struggle to find styles of departmental management which are suitable to professionalism and yet tolerable to the dominant hospital power groups.

It should be noted that nursing is struggling to break out of the mold of structure. However, our long history of the "female hierarchy" has left its imprint in nursing's continued division of mental and manual labor; leading to the development of a working class and a professional class in the discipline. Within these large general groups, some nurses value thinking and education with an aim to professionalization, a position
Reverby (1987) called “caring with autonomy” (p. 10). Others found the notion of education incompatible with their value that nursing was based in experience, an innate art called forth from women in the care of the sick and obligated by a duty to care (Hughes, 1990). What was born in the dichotomy between reason and emotion, bore fruit and lives on in the way we educate nurses, organize ourselves, think about our work and our patients.

Several nurse authors provide evidence that the manual side of nursing, that part of nursing associated with bodily functions for example, are part of nursing’s “invisible” work (Wolf, 1989) and are not represented adequately or theoretically (Lawlor, 1993) as a part of nursing. Wolf (1989) claims that the “dirty work” associated with physical care and nursing’s association with death and society’s derelicts create stigmatizing images for the profession. Further, Fagin and Diers (1983) reminds us that in our intimate relationships, nurses “do for others publicly what healthy persons do for themselves behind closed doors” (p. 117). In a society where independence is highly valued, reminders of dependency such as the need for care are not welcome (Fagin & Diers, 1993). Consequently, such practice remains hidden.

Some of the “thinking” or cognitive types of nursing work are represented in theory such as nurse-patient communication, stress, and types of physiologic response. Although Wolf (1989) argues that a nurse’s cognitive work in practice remains hidden, the ability to represent nursing theoretically is a requirement for professionalization. Nursing has aggressively pursued the goal to develop a science in an attempt to improve the status of nursing. Within the context of professionalism, however, theoretical
knowledge has higher status than practical knowledge (Schon, 1983). So issues related to the practical work world of nursing are inadvertently placed in a secondary position of value in the name of a more significant social gain.

If nurses do, in fact, use both manual and mental assets, integrating thought and action in being with patients and, therefore, bifurcating definitions of work are clearly counterproductive. In fact, the difficulty in studying nursing work lies in its complexity, discretionary, dynamic and integrative nature which requires multiple ways of knowing as well as subjective and objective skills. In this light, definitions of work which dichotomize mental/manual labor, reason/emotion, and theory/practice issues create internal contradictions for nursing.

Theory/Practice: Nursing In The Blind Spot

Discussions of nursing work and practice unavoidably reflect themes from the theory/practice problem which are often articulated within the profession in discussion on appropriate theory development strategies (Benner, 1984; Meleis, 1991). Viewing the dilemma through a wide-angle lens allows us to see that it, too, has philosophical origins in discourse about types of knowledge; knowing how is clearly different than knowing that (Benner, 1984). As proxies for practice and theory, they do not in and of themselves seem to have particular valences. However, as discussed earlier, the dichotomy is fueled by the contextual requirements for professions to have an abstract scientific base which provides the abstract representation of a discipline’s uniqueness. Practice is the application of the abstract knowledge to solving real world problems (Schon, 1983). The
theory requirement presents an interesting quandary in light of how difficult it has been and continues to be to find a way to capture the uniqueness of nursing work in an abstract, theoretical way.

Street (1990) raises questions about the relationship between practice and theory. She argues that the dichotomy is unproductive because it is unexamined. Further, she claims that the separation is an artificial one which is "recreated and maintained by the dominance of the positivist paradigm" (Street, 1990, p. 9). Schon (1993) claims that positivism spawned an epistemology of practice and even upon entering the university "professionalizing occupations paid a price" (p. 36) by being required to accept the hierarchy of purely theoretical over applied knowledge.

Jacques (1992) raises questions about the utility of the theory/practice division as it is translated into the agenda to professionalize. He claims that dimensions of nursing cannot be adequately presented within current scientific representations. Therefore, in order to be considered professional, nursing has cut off aspects of practice, essentially helping to maintain the invisibility by not working to represent them theoretically. If theoretical articulations resonating from the practice arena could be communicated, changing how the nature of nursing is depicted would ultimately be accomplished.

The theory/practice dichotomy supports the professional agenda but continues to mask, and perhaps inadvertently devalue "invisible" dimensions of practice. Discussions like Jacques’ and Street’s at least raise the question that perhaps nursing does not have to remain on the horns of the dilemma. Definitions of "professional" and "work" are representations of reality developed out of disciplines other than nursing. However,
nursing does not automatically have to accept these definitions as a nursing problem. Nursing's main "problem" is the development of a science that is philosophically consistent with the discipline's values and mission and that accurately reflects the discipline's knowledge and thereby reflects its contributions to society.

Perhaps in the search for developing nursings' philosophical foundations, representations can develop which do not limit the definition of professional to scientific expertise. Of course, a move away from positivism would be required but this has already begun in nursing research. Next, the move must go beyond research traditions and enter the social fabric of nursing's educational and workplace systems. Such claims do not infer that nursing is not a profession but that current definitions of profession do not adequately represent important and significant contributions of nursing. Words like professional must be deconstructed so that new language can develop to reflect new frameworks that at least consider the possibility that nursing as a discipline can allow for the "interpenetration of theory and practice" (Street, 1990, p. 9).

How is this problem relevant to the research project at hand? Readers of the text will also try to situate it within the theory/practice dichotomy. It could be argued from both sides. If there is a theoretical framework, one might say that the author is aligning with the professional agenda. If the study is based in practical experience, others may criticize it as not relevant to theoretical nursing. But the author situates the project within the third position, the possibility that by relinquishing the dichotomy, we may come up with abstractions which are congruent in nursing's theoretical and practice world. For, as Harding (1986) has written, "I doubt that in our wildest dreams we ever imagined we
would have to reinvent both science and theorizing itself in order to make sense of women’s social experience” (p. 251).

Reliance on Empiricism

Schon (1983) claims that professions, in order to be included in the university had to be committed to positivist science. This holds true for nursing as well. Knowledge gained from the positivist paradigm according to Polkinghorne (1983) is “formal, theoretical, functional and quantitative” (p. 202). Empirical methods attempt to maintain strict objectivity; the object of study and the researcher must be clearly separated from the situation. Most important, the methods required mathematics, logic or empirical proof to justify propositions and proceed from an assumption that the specific object of study can be separated from the whole (Polkinghorne, 1983). Empiricism is clearly the application of principles inherent in the superiority of reason over emotion. The success of the approach earned it a position as the received view of science.

Although empiricism also became the received view in nursing and forms the underlying assumptions for nursing intensity measures, questions about nursing work with its characteristic embeddedness and complexity do not lend themselves easily to its requirements. Campbell (1992) speaks to the problem of objectivity when, in discussing computerizing nursing, she credits Fitzpatrick and states “This is a point that is either missed or rejected by computer analysts who call for more ‘conceptual clarity’ in describing what nurses do. I continue to take the position that nursing knowledge itself is social and not antiseptically scientific” (p. 761). Building on her own research data she
claims that nurses have to translate their actual experience into various objective forms such as patient classification systems to meet management requirements (Campbell, 1992). Strauss (1993), citing “The Social Organization of Medical Work”, also cautions that nursing work is “fundamentally nonrationalizable” (p.83) by definition due primarily to the unpredictable set of conditions presented by any individual patient.

These factors suggest that the study of nursing work does not fail to meet the standards set by positivism but that positivism does not allow consideration of such characteristic to be admitted as evidence. If the paradigm does not allow nursing a language of expression, invisibility is maintained and nurses become like silent knowers, described by Meleis (1991) as competent but unable to conceptualize their knowledge or make it available to theoreticians due to lack of language and representation. Belenky, Clinchy, Goldberger and Tarule (1986) remind us of the importance of dialogue in the development of representational thought. The language, theory and representation of nursing has been primarily built on a knowledge industry which is based in an empirical-analytic model. Perhaps appropriating lenses and constructing bifocals or trifocals from non-empirical paradigms will lead to more insightful dialogue on nursing work.

**Bridging The Gap**

As the reason for the gaps in knowledge about nursing work begin to be envisioned, the journey turns to research strategies to bridge the gap. A beginning conceptual definition of the “invisible” dimension is proposed and a conceptual framework
is suggested as a useful set of lenses to bring the dimension more sharply into focus. These research strategies are tools to further our understanding of nursing work and are discussed in further detail in the next chapter.

**Broad Characteristics of the “Invisible” Dimension(s): What We Know**

Because of the many optical illusions which swirl around the idea of nursing work, it is necessary to clarify the broad characteristics which will serve as a starting point for a basic type of investigation to see if another dimension(s) of nursing practice can be conceptualized. It is assumed that the vision must come from nurses reflecting on the experience of their work. The dimension(s) is being hypothesized as comprised of patterns of care. Pattern is defined in the Random House Dictionary of the English Language (1987) as “a combination of qualities, acts, tendencies...forming a consistent or characteristic arrangement as in the behavior pattern of teenagers”(p. 1423). Pattern can be thought of as a template for thinking, valuing and acting that is consistent with the idea of directed nursing action over time. Pattern better denotes the nature of nursing action since it is assumed that the “invisible” dimension is made up of a series of cognitive and behavioral actions which come together around a specific goal.

Fundamental to the present investigation is the assumption that “invisible” work, while done in the name of a particular client or group of clients, is not necessarily done in the client’s presence, where nursing work has traditionally been located. Since the proxemics may contribute to a failure to see and name the dimension, it is important to hold locating the work as problematic. However, it can be located conceptually by
building on Jacques' (1992, 1993) idea of structural practices defined as work that takes place at the boundaries or intersection of nursing work and other work in an organization or system.

Characteristics of the invisible dimension(s) have been synthesized from both the literature and pilot interviews with nurses unless where specifically cited. Characteristics include but are not limited to:

1. Primarily indirect interventions which radiate from, but are not focused only on a one-to-one client relationship;

2. A type of knowledge work, embedded in task, context-driven, dynamic, responsive, reactive, discretionary, which contributes to the patterns of nursing decision/making;

3. Structural practices (Jacques, 1993) such as effort that links patient need with other services and providers in an organization and encounters which are based in the nurse's ability to adapt, coordinate and accommodate the needs of the organization and other providers - making connections;

4. Maintenance of a "continual presence at the interface between patient and service delivery i.e., where the service interchange occurs" (Curtin, 1994, p.8);

5. Knowing the patient as an individual and through communication mechanisms;

6. Both immediate and long-term thinking for the patient and other service providers, temporality; and

7. Focus on management of the environment.

A beginning conceptual definition of “invisible” dimension(s), which will need to
be validated through research, can be summed up as “Being active in developing a system [or pattern] of care that will benefit the client at the personal level (C. Hutelmyer, personal communication, April, 1994). The role is demonstrated through patterns, defined as thinking, valuing and acting, directed toward maintaining a presence within a specific health care network that seems to coordinate service in the best interest of one or more patients.

An Alternative to Work as Task: Strauss’ Definition of Work and Interaction

As the literature review has shown, nursing has primarily relied on empirical methods and rational approaches to identify dimensions of nursing work. The characteristics listed above seem to suggest that the idea of work as task does not fully explain nursing work. Alternative methodology and conceptualizations of work exist in other fields (Habermas, 1971; Gini & Sullivan, 1989) and can be incorporated by nursing to enhance understanding of work. The pioneering research of Anselm Strauss provides a format for beginning this type of conceptualization in nursing. His “theory of action helps the researcher to organize and understand the interactions that are specific to the phenomenon under study” (Strauss, 1993, p. 48). Strauss(1993) offers a conceptual analysis of work that is attuned to nursing work and is introduced here as an alternative definition to anchor the study.

Strauss (1993) considers work a universal form of action. Actions can be overt or covert. Strauss’ worldview as a sociologist focuses on social networks and organization. Therefore, interaction is a primary concept in his formulations and his theory of action is
presented from an interactionist perspective. Interaction is action directed towards others although it does not necessarily take place in the presence of others. Reflexive interaction is a type of interaction within the self that represents an internal dialogue between the self and the object of thought.

According to the definitions, nursing work can be covert, overt and reflexive. The "invisible" dimension(s) of nursing work discussed in the current study would be considered interactional by definition. Strauss (1993) calls this focusing on "the social mechanics of work" (p. 52) rather than the more traditional focus which has been on the occupation and the tasks alone.

**Definition: Interactionist Theory of Action**

An interactionist theory of action provides a way to study phenomena that allows one to consider the person within institutions. It is the statement of a set of assumptions about the interrelatedness of action and interaction, that they are essentially inseparable and that they arise from beliefs and values. For example, caring, a philosophical stance and commitment in nursing, gives rise to a type of interaction and action on the part of the nurse that we have not explained, defined, and do not entirely understand.

One of Strauss' assumptions is that "Actions are embedded in interaction of past, present and imagined future. Thus actions carry meanings and are located within systems of meanings. Actions may generate further meanings, both with regard to further actions and the interactions in which they are embedded" (Strauss, 1993, p. 24). The assumption is very consistent with the often expressed idea that the work of nursing is best understood
in context (Benner & Wrubel, 1989; Leininger, 1991) and that attempts to objectively define the work fail to capture the essence of the work. Jacques (1993) explains: “The problem for nursing is that nursing tasks are most often not meaningful as isolated acts, they take on meaning only in relation to each other, to the patient’s needs and to the entire health care system” (p. 7). A framework combining Strauss and Leininger calls for an analysis of work as action taking place within a system of beliefs and values or culture in order to generate meaning.

Several of Strauss’ assumptions (1993) are important to a discussion of nursing work. Overt and covert action can be “preceded, accompanied, and/or succeeded by reflexive action” (p. 29). Strauss’ claim allows for ongoing thinking and evaluation to take place within a series of acts that may or may not be represented in summarizing activities.

Actions may not be rational or obviously rational to observers and action has emotional components. Strauss rejects the dualist position that separates thinking and emotion, an idea which may prove to be a productive view when applied to an analysis of nursing as an integrative type of work.

Strauss (1993) places emphasis on the importance of time and duration. He states “Various actors’ interpretations of the temporal aspects of an action differ, according to the actors’ respective perspective” (Strauss, 1993, p. 32). When an individual perspective on duration of action is considered rather than an objective measure of time, one can ask how nurses themselves parcel quantities of work and define related activities. Would a nurse define a patient discharge as transporting the patient or could she, within Strauss’
(1993) framework, include appropriate related activities? Adding temporality allows us to ask how nurses would define a parcel of work with its attending actions and value.

Definition: Trajectory

Building on the assumption of temporality and specifically relating it to the concept of work, Strauss (1993) developed the important idea of trajectory. Trajectory allows us to consider work as a course of action; extending over time and that continual interaction within a trajectory shapes both the ongoing action and the actors. He states "this central concept...gives life and movement to studies of phenomena and the related interactions; it forces one to view interactants as active in attempting to shape the phenomena" (p. 54).

Strauss' (1993) idea, sometimes expressed as a line of action or an arc of action, allows the analysis of an aspect of nursing work to include change over time and a process orientation. For example, changing a patient's diet is a common nursing action and is often defined as a task. The concept of trajectory allows one to consider the series of actions, thoughts, values, decision-making and communications within the work process necessary to address a patient's nutritional status. It would also allow a nurse to define a specific unique unit of work.

Definition: Biography and External Conditions

By definition biographical work recognizes that certain types of actions and events
require a kind of inner work that relates to identity formation and maintenance (Strauss, 1993). The work can exist for both individuals, groups and organizations. For example, by its very nature, the grief process would require biographical work.

If biographical work explains the influence of work at the personal level, then Strauss’ writing on conditional matrices and paths (1993) attempts to develop a logical procedure for at least tracing the interacting influences of the social and cultural context. In this regard, Strauss, as a Pragmatist, is consistent in acknowledging the presence and impact of context but extends Leininger’s thinking into a more specific, in depth approach to levels of analysis. He defines context as “conditions” influencing action and interaction. It is incumbent upon the research to elucidate how and which external conditions are interrelated to the phenomena of study.

Nursing Work and the Antipositivist Paradigm: A Logical Fit

As the literature review demonstrates, our scholarship about the nature of nursing and nursing work does not consider the influence of context on nursing action. Strauss (1993) offers an alternative way to think about work. By adopting Strauss’ conceptualization and Leininger’s conceptual framework, context is admitted in recognition of the individual’s ongoing interaction in a socially constructed world. The researchers both reflect an epistemology that rejects the polar dichotomies of the received view. By abandoning polarities, more inclusive definitions can be utilized to explore work experience as action that can and does include thought, values, and behavior and places value on knowledge gained by reflecting on the experience.
Nursing work for the present study is conceptualized as coordinating/connecting patterns and located within Leininger's (1991) framework to recognize and explore the nursing role in interaction with the environment. Hopefully, the design of the study will yield information about how nursing practice shapes and is shaped by the social organization of health care. Further, it will explain the processes used by nurses as part of their work to adapt health care agencies to client needs.

Philosophies of nursing must include foundations for ontology and nursing epistemology. At least, foundational values must be included from nursing's practice world. In other words, our science must be able to answer practice questions and it is incumbent upon scholars to develop methods toward this end. The present study seeks to illuminate the "invisible" dimension(s) of practice for additional sources of knowledge and values. Gordon (1984) states that "Research progresses through new concepts, theories, paradigms, and methods that in turn make new data visible" (p. 225). The construction of the necessary orientational definitions and conceptual framework as discussed in the next chapter represents a way of grinding lenses to fit a set of glasses enabling us to visualize "invisible" dimensions of the work of nursing.
CHAPTER III

METHODOLOGY

In the American economic system, work is measured by production, a visible outcome. Caring, on the other hand, is often a covert phenomenon frequently denigrated as emotional and taken for granted. Discussing work that is caring is a dilemma because our understanding of work is often economic and empirical while the meaning of work is culturally and interpersonally based. Caring comes from a more philosophical, humanistic base. Caring as work must be articulated from both perspectives in order for it to be securely established in reformed health care systems. Therefore, it is necessary to begin an initial investigation to determine how nurses themselves define caring work.

The nurse as part of the social order deals with the bureaucracy in order to maintain an environment for nursing services to take place. Descriptions of the dealings are scarce. Therefore, attempts at definition need to remain grounded in the experiences of those who live them. The transcultural framework is broad enough to allow for the experiential perspective to emerge and can support the development of definitions with attention to all aspects of the cultural context.
Grinding the Lens: A Conceptual Framework To Further Knowledge Development

Although the goal of the work of nurses is a positive health outcome for a particular patient, little is known about the nurse’s effort in the context of the organizational environment, that is, the meaning and value of certain interventions to both the nurse and the organization she represents. The nurse’s effort to make the organization effective for the patient is why she is often described as the “glue” (Thomas, 1983, p. 67) in an organization. But, such work has not been defined as legitimate. Wolf (1989) reminds us that “Glue can be ‘invisible’ and taking care of things to maintain the flow of work goes unnoticed” (p. 464). Studying such a problem requires a struggle to conceptualize it as well as the adjustment of research lenses to improve its visibility. The conceptual framework described here provides assistance on both counts.

Since traditional research methodology has not proved sufficient to bring all dimensions of nursing work into focus, the primary lens for the present study is appropriated from Leininger’s (1991) Theory of Cultural Care Diversity and Universality. Leininger’s theory was chosen because, as a nursing theory, it offers a unique perspective on the discipline that allows for a gestalt picture of the practice of nursing within organizations. Strauss’ definition of work extends Leininger (1991), providing understandings of work as a human phenomenon which may more fully explain the nursing experience of work. Leininger (1991) and Strauss (1993) are consistent in the following assumptions. Therefore, when used together, they will converge on the phenomenon of study, coordinating/connecting patterns in nursing work.
Both Leininger and Strauss maintain a view of man in continuous interaction with a socially constructed world thereby acknowledging the mutually interacting effects of the individual, professional, and organizational systems. In rejecting the purely positivistic explanations of phenomena, both theorists seem to incorporate wholistic approaches to knowledge development that allow for the recognition of both overt and covert components of nursing and action and the use of qualitative methodologies to examine them. Both Leininger and Strauss represent an opinion that theory can be used to direct an investigation through which more specialized concepts can be refined.

The Theory of Cultural Care Diversity and Universality

Leininger (1993) considers the three main concepts of culture, care and context as critical to nursing (p. 17). The three components allow for a “focus on what is and what could be seen in practice as central to nurses’ patterned activities and modes of thinking” (Leininger, 1991, p. 40). It is precisely the patterns of activities and modes of thinking and the meanings nurses associate with them that the present study attempts to capture. It attempts to elucidate an indirect, dimension(s) of nursing herein referred to as coordinating/connecting patterns.

Definition: Nursing as a Culture

Culture is defined by Webster (1988) as “the ideas, customs, skills, arts, etc. of a people group, that are transferred, communicated, or passed along...to succeeding generations” (p. 337). Leininger (1970), who considers nursing a subculture, adds depth
to the concept as follows:

Culture may be viewed as a blueprint for living which guides a particular group’s thoughts, actions and sentiments... The material culture is reflected in the items which man produces as a result of his creative thinking and technology... The non-material culture consists of many intangible items and abstract culture expressions, such as the ideologies or beliefs embodied in social and political institutions (p. 49).

These definitions provide a conceptual lens to view nursing knowledge and practice embedded in one entity, culture, as opposed to the theory/practice dichotomy discussed earlier. Leininger’s framework provides for both emic (local) and etic (universal) interpretations and explanations of phenomena. One of her premises states, “Folk(emic) and professional(etic) care and health values and action patterns are identifiable in a given culture” (Leininger, 1985, p. 197). The premise allows one to see how a nursing activity may be influenced by both professional and institutional values. Within Leininger’s (1991) framework, one can at least begin to think about, in a legitimate way, the possibility that nurses have both emic and etic explanations for nursing phenomena. One could then begin to look at the relationship between the two explanations in order to understand it and see how they shape each other rather than continually placing them in a dichotomous relationship which only serves to proliferate the distance between the two. Leininger seems to support such investigation in her assumptions (Cohen, 1991).

Definition: Caring

The word caring is used in nursing discourse as a philosophy, a moral imperative, a
description of behavior and an explanation of nursing action. Within Leininger’s framework, caring is the core value in nursing culture. She identifies caring as a foundational aspect of both the practice and knowledge base of nursing (Leininger, 1985; 1991). However, because the goal of this investigation is to identify and define a dimension(s) of nursing, its relationship to caring in the sense of any of its meanings, is not clear. Therefore, caring is not being used as a conceptual lens in the sense of a grand theory in order to avoid circularity and potential bias. However, the use of the word itself cannot be totally eradicated because it is so commonplace in the writing of Leininger and the conversations of practicing nurses. Therefore, selected studies are reviewed for their particular relevance to a discussion on caring within organizations.

Caring as an idea is used throughout the discourse of both nursing and women’s work and is often discussed in conjunction with the common theme of invisibility (Leininger, 1991; Jacques, 1992; Gordon, 1992). Within nursing, the concept is broad and not well differentiated. Morse, Bottorff, Neander and Solberg (1991) identify at least five different conceptualizations. They place Leininger’s theory within a category of caring as a human trait and characterize the universal nature of caring as necessary and foundational to humanity (Morse et al., 1991).

Building on Leininger’s premise of between group differences in caring patterns, Ray (1989) uses ethnographic and grounded theory methodology to develop a theory of bureaucratic caring explaining caring within organizations. Ray’s (1989) study identifies that an individual’s humanistic values, role and position within an institution influence caring and further supports the interrelationship between the individual and hospital
culture. She states that "In administration and on the clinical units, the context itself to a large extent influenced how caring was defined and practiced" (Ray, 1989, p. 35). Her data validates the idea that types of caring can occur within political, economic, legal, technological/physio-logical, educational and social categories and supports the sometimes competing influences between and among these forces on caring practices. Ray's (1989) study lends credence to the idea that although a nurse may have humanistic values, she must negotiate different forces within an organization that impacts actual practice. Little is known, however, about specifically how the nurse negotiates these practices especially when the structures are incongruent with nurse or patient values. Further study of this dimension of nursing work would lend insight to the problem and into the type of systems necessary for humanistic nursing practice.

Kahn and Steeves (1988) report a qualitative study that attempts to determine the structure of the concept of caring. The study was grounded in the assumptions that nursing is a cultural group sharing values and beliefs which affect nursing practice. Although Kahn and Steeves (1988) focused primarily on the nurse in relationship with a patient, they define the structure of caring as praxis or nursing actions influenced by the themes of ideological context, attributions for caring and liking as the basis for caring. Ideological context includes the idea that caring is related to nursing identity and values which develops by nursing's professional/educational socialization. Attributions for caring included time and environment as factors affecting the development of caring relationships. Praxis includes nursing actions such as liaison and advocacy roles. These issues imply that nursing action is influenced by the professional subsystem and the
external context. However, the issues are not emphasized in the analysis because the study is focused on the nurse/patient relationship and, consequently, the organizational/interactional implications are kept “invisible.” However, the study does raise questions about the ethical implications of caring in an environment that does not allow time for it. The moral implications of the beliefs inherent in the structure of caring as praxis were discussed, but only as they pertained directly to the nurse in relationship with a patient. The Kahn and Steeves (1988) study hints at, but does not analyze nursing actions outside of this relationship, how environmental factors affect them and their moral implications.

Benner and Wrubel (1984) also focused on the nurse in relationship in their early qualitative study on nursing expertise. They identified two out of ten dimensions of practice which are comprised of nursing actions in interaction with the system. The dimensions are called monitoring and ensuring the quality of health care practices and organizational and work-role competencies. They discuss the negative effects of system constraints such as understaffing and define competencies related to the situation. Benner and Wrubel (1984) present a good example of how nursing actions are connected to a situational context by a system problem.

Spangler (1991) reports the results of an ethnonursing study on nursing care values and caregiving practices of Anglo-American and Philippine nurses. Her study is the only study using Leininger’s framework to study nursing care practices in an American hospital. She defined cultural differences between the two groups of nurses and also reported two universal themes which support Leininger’s premise that social structure,
cultural values, language and environmental context influence care. She also states that several researchers including herself, have noted that there is overlap between generic and professional care values which influence nursing care patterns but that it is difficult to tease them apart (Spangler, 1994). The universal themes uncovered in the study identified that nursing shortages and institutional standards influence practice but did not define at a process level specifically how the nurse negotiates or works through the influences.

Lastly, Jacques (1992, 1993) in a study of knowledge workers reports serendipitous findings about the “invisible” caring/connecting work of nurses. He conceptualizes a “structural dimension of caring work” (p. 2) from his findings. The structural dimension serves as an enhancement of interpersonal theories of caring. The study included structured observations and interviews in an attempt to construct and validate a “normal” day of nursing activities. Jacques’ (1992, 1993) study lends insight into why caring work is difficult to discuss.

Using Foucaultian genealogical methods, Jacques (1992) researches theories of the employee, organization and professional and calls for theory which will allow for new representation of caring work to be articulated. He basically argues that caring/connecting work has been ignored because current theories do not allow a way for it to be represented since “social experience can assume meaning only if a representation exists by which that experience can be conveyed” (p. 91). Caring/connecting work is part of “taken for granted” activities. Consequently, caring/connecting work tends to be explained in the language of emotion, affect or common sense. Jacques’ (1992) study supports the claim that caring/connecting work is not discussed in the language of principles and science
because of its nature and social construction. His research raises a question about whether or not representations can exist that include both thinking and feeling aspects of action.

Because Jacques' (1992) study is hospital based, methodologically unique and by his own admission, limited by his perceptions as a non-nurse organizational theorist, continued investigation of an "invisible" dimension using nursing perspectives is warranted. Jacques (1992) sees nurses as representing a new type of worker and therefore, such research is important "not just to the future of nursing, but to our fundamental understanding of work, organizing, and social experience in our time" (Jacques, 1993, p. 10).

The studies listed here support and identify the need for in depth, continued investigation of a dimension of caring/connecting work with a focus on the organizational context. They provide evidence for an investigation centered on the nurse in interaction with the context of her practice environment. Since nursing work is more completely understood as actions with attending thoughts and beliefs that occur over time (or trajectory), it is logical to investigate the connecting patterns as a route to defining additional dimensions of nursing work. If and how the dimension is related to caring as a grand theory, especially in terms of its role in the creation of meaning for nursing actions, is a possible outcome of the present study.

Definition: Context

Benner states that "Only as we see the whole can we adequately appreciate the significance of the nurse's contributions to patient welfare" (Benner, 1984, p. 41).
However, wholistic perspectives require strong conceptual anchors. Leininger provides the critical components in her definition of cultural and environmental context which connects three frames of reference, the individual, group and social system. She states:

“The cultural context of behavior refers to the implicit and explicit behavior tendencies of a designated group of people who have lived and interacted together in a particular cultural setting according to certain values, practices, and life goals” (Leininger, 1970, p. 111). She defines environmental context as “The totality of an event, situation, or particular experiences that give meaning to human expressions, interpretations, and social interactions in particular physical, ecological, sociopolitical and/or cultural settings” (Leininger, 1993, p. 19). These concepts represent the nature of the relationship between a person’s thoughts, actions and the social structure as one of interconnectedness and mutual shaping. Further, Leininger’s idea of context implies that comprehensive understanding offers not merely a delineation of parts but a more in depth knowledge of how the parts fit together. The usefulness of understanding context is analogous to viewing a pointillist painting whose image does not emerge unless viewed from a distance. With an eye toward method, Leininger (1979) brings forth the idea that context is best understood through “a conscious effort...directed towards seeing and hearing through the eyes and ears of the people” (p. 112).

Definition: Cultural and Social Structure Factors and Their Relationship to Nursing

The cultural and social structure factors defined in the cultural care theory “refers to the dynamic patterns and features of interrelated structural and organizational factors of
a particular culture” (Leininger, 1991, p. 47). These include spiritual, social, political, educational, economic, technological, and ethnohistorical components which influence action. Leininger states a major theoretical premise as follows: “Features of social structure are powerful forces influencing health and care in any culture” (Leininger, 1985, p. 197). Therefore, investigations must look specifically to how the influencing takes place.

By including context and social structure factors into the theory, Leininger (1991) acknowledges the importance of the impact of sociocultural and psychophysical environments on individuals and provides a basis for considering what types of work the nurse does in the broader environmental context of the agency. Leininger postulates caring patterns include supportive, facilitative or enabling professional actions which help patients and providers adapt to differing values, beliefs and lifeways. She states further that the actions influence health “as well as general human conditions, lifeways and environmental context” (Leininger, 1991, p. 32). From her premise on culture care accommodation or negotiation, one can infer that the framework allows for a dimension(s) of “invisible” work that is directed outward between the patient and other providers and system components (p. 48). Further, there is a recognition that nurses strive to enhance beneficial interaction between patients, providers and institutions assuring that the “system” works for the patient. Perhaps by investigating such types of patterns, a dimension(s) of nursing work that refers to the nurse in interaction with organizational structures can be identified and defined. Leininger (1991) states:

...institutional cultures of nursing education and service have (not) been studied to identify and understand current practices that influence values, decision-making,
and normative practices... The Theory of Culture Care Diversity and Universality is a highly appropriate framework to study the culture of nursing and appropriate organizational structures in nursing education and clinical services for the future, especially since the theory includes the worldview, social structure factors, cultural values, environmental context, linguistic aspects, and ethnohistorical considerations. (p. 379)

**Definition: Relationship Between Actors/Interaction**

The work of nursing is influenced by and influences the culture and social structure of both nursing and the health care agency. Leininger’s framework allows the work of nursing to be viewed as interacting between and among the components. The Theory of Cultural Care Diversity (1991) depicts the components of the cultural care worldview to include political, religious, social, economic, educational, technological and cultural factors with accompanying interacting influences and relationships. The model outlines the multiplicity of interacting influences on the person which Leininger sees as essentially inseparable. These factors, in turn, also affect the professional and nursing health systems. The model allows investigations to take place at multiple levels based on the researcher’s focus (Cohen, 1991). Leininger (1985) believes it can be used to study any culture and notes that the professional health sub-system is largely unknown, a fact very relevant to the present investigation (Leininger, 1985). Specific philosophical orientations and assumptions are developed further in the section on methodology.

**Orientalational Definitions**

Leininger suggests the use of orientational definitions in qualitative research (Leininger, 1991). These definitions are used as guides to assist the researcher in
investigating the domain of inquiry. In this section, orientation definitions for the present study are listed.

1. Care (noun) refers to abstract and concrete phenomenon related to assisting, supporting, or enabling experiences or behaviors toward or for others with evident or anticipated needs to ameliorate or improve a human condition or life way (Leininger, 1991, p. 46).

2. Work refers to a universal form of action, pattern or course of action that involves effort and can be overt or covert; a type of interaction directed toward others but not necessarily in the presence of others and may be reflexive (Strauss, 1993). Work as a concept includes ongoing thinking and evaluation in a series of acts that takes place within a system of beliefs and values or culture in order to generate meaning. In other words, work includes thought, belief and action and work activities and is continually influenced by personal, organizational, and societal definitions of work. In the present study, one’s work may or may not be one’s job but is essentially tied to identity, quality of life and personal meaning.

3. Culture refers to the learned, shared, and transmitted values, beliefs, norms, and lifeways of a particular group that guide their thinking, decisions, and actions in patterned ways (Leininger, 1991, p. 47). Culture is continually operative in the human situation.

4. Cultural and social structure dimensions refers to the dynamic patterns and features of interrelated structural and organizational factors of a particular culture (subculture or society) which includes religious, kinship (social), political (and
legal), economic, educational, technologic, and cultural values, as well as ethnohistorical factors, and how these factors may be interrelated and function to influence human behavior in different environmental contexts (Leininger, 1991, p. 47).

5. Context refers to the conditions influencing action and interaction (Strauss, 1993). Multiple cultural contexts, which include but are not limited to the client, the nurse and the health care system’s culture, are operative in nurse-client interactions (DeSantis, 1994).

6. Environmental context refers to the totality of an event, situation, or particular experiences that give meaning to human expressions, interpretations, and social interaction in particular physical, ecological, sociopolitical and/or cultural settings (Leininger, 1991, p.48).

7. Cultural care preservation or maintenance refers to the assistive, supporting, facilitative, or enabling professional actions and decisions that help people of a particular culture to retain and/or preserve relevant care values so that they can maintain their well being, recover from illness, or face handicaps and/or death (Leininger, 1991, p. 48).

8. Cultural care accommodation or negotiation refers to those assistive, supporting, facilitative, or enabling creative professional actions and decisions that help people of a designated culture to adapt to, or to negotiate with, others for a beneficial or satisfying health outcome with professional care providers (Leininger, 1991, p. 48).
9. Cultural care repatternning or restructuring refers to the assistive, supporting, facilitative, or enabling professional actions and decisions that help a client(s) reorder, change, or greatly modify their lifeways for new, different, and beneficial health care pattern while respecting the client(s) cultural values and beliefs and still providing a beneficial or healthier lifeway than before the changes were coestablished with the client(s) (Leininger, 1991, p. 49).

10. Contextual care work, derived in part from 2, 7, 8, and 9, refers to a hypothesized dimension(s) of nursing work that is directed outward between the patient and other providers and system components. Contextual care work refers to directed nursing actions or patterns that mediate the various contexts within the health care system in order to create an environment for nursing services to take place; the nurse’s work in interaction with her practice environment.

**Qualitative Research Design**

The tenets of ethnomethodology are chosen as the overarching research approach to address an examination of pattern and meaning and are represented by research strategies such as ethnography, ethnoscience, grounded theory, phenomenology, and historical and ethno-life studies (Leininger, 1987, p. 17). The methodology is also the basis for Leininger’s ethnonursing approach which provides the specific data gathering and analysis techniques for the present study. Each are discussed separately in this section, along with a review of the philosophical underpinnings of the methodology.
Philosophical Assumptions

The ontologic roots of ethnomethodology can be traced to phenomenology (Bowers, 1992; Patton, 1990; Van Manen, 1978-79). The kinship (Bowers, 1992) is described by Van Manen (1978-79) who compares ethnography, ethnomethodology and phenomenology by saying:

all use participant observation and life experience material, as well as employing an ‘interpretive methodology’, and various applications of ethnomethodological inquiry ... are closely aligned to the interpretive method of phenomenological research (p. 53).

That is to say that ethnomethodology falls generally into what Patton (1990) calls the phenomenological perspective as distinguished from a specifically phenomenological study. He states his interpretation that:

one can employ a general phenomenological perspective to elucidate the importance of using methods that capture people’s experience of the world without conducting a phenomenological study that focuses on the essence of shared experience. (p. 71)

The phenomenological perspective has several definitive assumptions which undergird ethnomethodology and are refined by A. Schutz who is credited with incorporating phenomenology into sociology (Bowers, 1992; Patton, 1990). The most primary of the assumptions is the irrevocable link between the person and their environment or world. Phenomenology sees person and environment or context as one. Bowers (1992) describes “the world, its social structures, institutions and culture...is the unquestioned setting and condition of all our projects” (p. 64). This feature invalidates the notion that a phenomenon can be dissected from the conditions of its existence, the
so-called objective perspective, and validates a research approach that values knowledge gained from a person’s reflection or reconstruction of their world.

Benner and Wrubel (1989) offer additional support for the idea from a Heidiggerian phenomenological perspective. They state that “Context describes all the ways the person is connected to the world” (p. 114). Background meanings, which include culture, subculture and family, are an important part of how a person understands the world and context. Through the Heidiggerian idea of concern, a person develops a two-way exchange with what matters to them and how they attend to their context/situation. Temporality, past, present and future, continually pervades the person’s specific experience of context. Foundational to the phenomenological perspective is the idea that man, as a self-interpreting being with embodied intelligence, has both prereflective and reflective ways of knowing that are not acknowledged in traditional science.

A brief review is added here not to make a case for phenomenological research but to lend additional ontologic support for types of research that “illuminate what kind of knowing occurs when one does not stand outside of the situation, but is involved in it” (Benner & Wrubel, 1989, p. 41) and speaks to the link between phenomenology and ethnomethodology as a type of research for this purpose.

Such principles are also integral to distinguishing the present study from a study of nurse’s perception or opinion. Benner and Wrubel (1989) establish the credibility of knowledge gained by accessing subjective meaning stating that “when reflected upon, subjective meaning becomes objective and can be made explicit” (p. 46.). The present
study seeks to generate additional information about the nature of nursing work by seeking exactly these explanations through reflection.

These philosophical assumptions are especially relevant to the position taken in this research project, that nursing work can best be conceptualized as embedded in the situation or conditions of its unfolding, doing and performance. The work of nursing, interactional by essential nature, always takes place in a social context; a social world where the idea of work is essentially constructed as an economic, physical effort concept. Caring as work and especially as work that engages the social context, is rarely discussed in nursing science. The full epistemics of nursing care will not be understood until it is recognized that there are dimension(s) of nursing work also imbedded in the worldview, social structure, values, and culture of professional nursing and health care organizations that should and can be systematically studied.

Epistemology: How We Come to Know

If the essential philosophical and ontological roots of the present project lie in the person’s unquestioned interrelation with his world, then it is logical that the epistemic roots are "grounded with the people as the knowers about human care and nursing knowledge" (Leininger, 1991, p. 84). The related question about what can be studied or what is knowable is answered by Patton (1990), who in his discussion of phenomenology treats an emotion, a relationship, a job, a culture or an organization all as viable foci or phenomena for inquiry.

The third important epistemological assumption for the present study is that the
phenomena of interest is experientially based and includes the production behind the conceptualization. Bowers (1992) using an example from psychiatric nursing, express sympathy, discussed the interpretive problems in naming an interaction. She calls the conceptualization an example of an underlying pattern. Although she recognizes the fact that knowledge about social actions cannot be absolutely defined, she still supports the investigation of how such patterns are produced. In her view "concrete instances and pattern mutually elaborate each other" (p.63). Such understanding is important because in such a way we understand how phenomena are made visible (Bowers, 1992) and how each participant knows it exists even though we are not able to dissect it objectively or define it as absolute truth (as is the case with any qualitative data). Such knowledge is valid as a route to conceptualization based on experiential knowledge and in fact holds the notion of absolute truth, so-called objective knowledge, as problematic and possibly unattainable. Knowledge does not exist separate from the person. The goal of qualitative research and the present project is an understanding of the individual's experience of phenomena and a rigorous, thematic analysis for similarity and differences between and among individuals, recognizing that the interpretation of experience is clearly revisable with the evolution of personal meaning.

Ethnomethodology

Ethnomethodology, a term invented by Garfinckel (1967), refers to a research approach which focuses on the ordinary, on the routine (Patton, 1990). The methodology
attempts to uncover the taken-for-granted practices of a people. Patton states

"Ethnomethodologists elucidate what a complete stranger would have to learn to become a routinely functioning member of a group, a program, or a culture" (p. 74). The goal in a way is to make "explicit what might be called the group's tacit knowledge" (Patton, 1990, p. 75). Bowers (1992) citing Heritage, calls ethnomethodology a "social microscope." She supports a claim that ethnomethodology "in the widest sense...might be able to show how the social institution of nursing is constructed, accomplished and brought off as a methodic production by individual nurses" (p. 65). The ethnomethodological approach represents a philosophical position in the production of knowledge (Bowers, 1992) which encompasses the following assumptions consistent with research questions about "invisible" work. It is a method using naturalistic, open discovery, and largely inductive, emic modes and processes with diverse strategies, techniques, and enabling tools to document, describe, understand, and interpret the people's meanings, experiences, symbols, and other related aspects bearing on actual or potential nursing phenomena (Leininger, 1991, p. 79). Such a method acknowledges the nurse as positioned in the middle of complex dynamics between family, self and organization and allows for giving voice to her subsequent reflections. Ethnomethodology seeks "to discover the common sense categorizations used by nurses to organize and order their working lives" (Bowers, 1992, p. 66).

Leininger offers the distillation of this position to specific methods for research in nursing. The method she calls ethn nursing includes techniques for gathering emic data on a specific phenomenon. In-depth individual interviews and focused observations are
used in this study to gather emic data. Ethnonursing, developed in the early 1960's, is a qualitative approach that draws on both emic and etic data to obtain inside and outside knowledge about a phenomenon (Leininger, 1985). In Leininger’s (1985) conception, the emic dimension of knowledge refers to local or indigenous cognitions and perceptions about a particular phenomenon, such as caring and nursing care; whereas the etic dimension of knowledge refers to more universal or outside knowledge related to care phenomenon under study. (p. 38)

An emphasis on the perspective of the individual experiencing the phenomenon recognizes the research subject as the primary knower and co-participant in the discovery process. Informants offer knowledge verbally, through their interpretations and explanations of events and by their actions (Leininger, 1985). In fact, in ethnonursing the researcher is cautioned to continually “move with the people” (Leininger, 1991, p. 86) and utilize the ethnonursing design as a “rough schema (or sometimes with a very limited schema)” (Leininger, 1991, p. 86). Leininger’s philosophical position is a distinguishing feature of ethnomethods and is especially appropriate to a study of “invisible” work about which little is known. Ethnonursing is defined as “The search for the obscure, elusive or obvious phenomena of nursing...The focus and purposes are specific to document personalized, interactional, and environmental care meanings and attributes...” (Leininger, 1985, p.38).

Rationale for Choice of Method

Although Leininger (1985, 1987) suggests many indications for using ethnography
and ethnonursing methods, four are especially relevant to the present study. First, ethnonursing is especially relevant to problems within which little is known or what is known is ambiguous enabling the researcher to develop new lines of inquiry. It is used as a method to obtain firsthand information from participants about their experience and actual situation including environmental context. Leininger (1985) sees ethnonursing strategies particularly appropriate for questions about the definition and meaning of nursing.

Philosophers have written about the problems of studying phenomenon that seem so familiar to the informant that they are taken for granted or become transparent (Wittgenstein, 1953). Is contextual care work really “invisible” or is it so much a part of the nurse that it cannot be seen as a separate entity having assumed a transparency, a level of unquestioned taken-for-grantedness, a background understanding or meaning? Such background understandings are the goal of ethnomethodological research techniques (Garfinkel, 1967) and the second reason to call upon these methods for a study of “invisible” work. Patton (1990) states that “Ethnomethodology gets at the norms, understandings, and assumptions that are taken for granted by people in a setting because they are so deeply understood that people don’t even think about why they do what they do” (p. 74).

The third reason to pursue ethnomethods is because “caring is always understood in a context” (Benner & Wrubel, 1989, p. 5). Therefore, it is logical to assume that the work of nursing should also be considered in context. Leininger (1985) identifies that ethnomethodological methods “help to restore data that have been stripped of their
meanings by other methods” (p. 39). For example, nursing intensity measures isolate nursing activities by design. The present study strives to enhance such workload studies by gathering and analyzing cultural, contextual data about the work of nursing. The ethnonursing method allows for a focused but in-depth pursuit of the totality of the domain of inquiry supporting “Context discovery as interpretation” (Leininger, 1985, p. 38). The method calls for an exploration of both current and historical culture and social structure dimensions. Leininger (1991) places great importance on context by making it a part of evaluation criteria and will be discussed further in a later section.

The last reason to use ethnomethods is based on the fact that work is defined as patterned activity for the present study. Leininger (1985) states that ethnomethods are used to “identify recurrent and patterned lifeways of people” (p. 40). The analysis of phenomena as pattern is different than considering a specific aspect of work because pattern allows for a more wholistic reference and the grouping of data in a more sequential format. Work patterns incorporate thought, belief and action over time providing an alternative to the more traditional task definition of nursing work. Leininger (1985) best summarizes the idea in the following words, “Bringing ‘bits and pieces’ of related findings into larger gestalts of information in order to obtain a sequenced picture of human actions is an important new direction in nursing” (p. 40).

It is assumed that because of the lack of knowledge about “invisible” work, both the Theory of Cultural Care Diversity and Universality and the literature review direct an investigation that views it as a phenomenon embedded in worldview, social structure and cultural context. In fact, the literature review demonstrates that such perspectives are
rarely used to look at nursing work. Further the questions call for a naturalistic, inductive, open discovery method.

Data Collection

Setting

The study was conducted at an urban rehabilitation center. The facility focuses on providing comprehensive treatment for people with disabilities. The mission statement and philosophy of the facility communicate a respect for the multi-dimensionality of the person and the core values of teamwork, collaboration and continuity. These principles are valued in relation to patients, families and staff. The setting was chosen based on a pilot study which demonstrated that nurses working in the environment could reflect on and articulate aspects of the domain of inquiry and would, therefore, qualify as key and/or general informants, meeting the sampling criteria as discussed.

The facility is steeped in history. Many of the original founders and leaders in the field of rehabilitative medicine were still working here at the time of the study. I had many opportunities to hear stories about “the beginnings” from those who were actually there.

The facility itself stands as a testament to the hard work and perseverance of the early leaders who worked to establish the center and raise funds to build an architecturally advanced facility for rehabilitation medicine. The environment was intentionally developed to enhance the quality of life for the disabled with special consideration to the amount of time they would spend in closed quarters. Although the facility is located in an urban area,
outside seating areas are developed and used by patients and staff. It is not unusual to approach the facility and see family or staff strolling the city streets with family members, wheelchairs and various equipment in tow. In this way, the staff operationalized their rehabilitation philosophy by strongly encouraging and supporting “practice” forays into the real world.

The general tone of the facility initially is informal and open. Prior to a restructuring which began in August 1995, staff valued their access to administrators, often sharing opinions in the cafeteria over lunch and hall ways. There were not many administrative meetings. However, patient care conferences were always considered critical events.

Staff were flattered that their facility was chosen for the study and felt that it verified their strong professional commitment. As a whole, the community was warm and friendly with a clear value to maintain supportive staff relations. The employee group was remarkably stable. Many senior members were present when the facility opened its doors. Staff enjoyed recalling their employment interview; recounting what was said to them by various managers and telling stories about how they were mentored and by whom. Nurses, especially, valued the opportunity to work in a stable group that supported each other through various career passages. Many of the participants had come to the facility as new graduates. It is not unusual for people to leave to go to school or to expand career experience and then return to the facility. The leadership group was successful at developing a work environment for retaining clinicians, allowing them
freedom to pursue new ideas, develop projects and implement solutions. These strategies attracted creative staff who are motivated and satisfied

Study participants often referred to an indigenous nursing role called nurse therapy which requires clarification. The role is institutionally defined and developed as a way of dealing with the team model of care delivery where only one nurse was responsible for twelve plus patients per shift. The nurse therapist takes responsibility for overall planning and co-ordination of care. In recent years, the role has evolved to include discharge planning and aftercare.

Not unlike many other health care agencies across the country, the facility underwent a restructuring program midway through the data collection period. The program included an early retirement program and many senior staff were eligible. The restructuring changes were not fully implemented during the data collection period. However, several ramifications were being discussed by staff. These included the loss of senior staff who had kept the facility's history and tradition alive. Turnover at the top is a common side-effect of restructuring decisions. At this facility, the changes also represented the first major leadership transition for the facility. I was fortunate because these changes created an environment of reflection and recollection which enhanced the richness of the interviews.

At approximately the same time, the facility received a prestigious national award for quality. The award was received with a great deal of pride and satisfaction and efforts were made by the staff to share congratulatory sentiments with all members of the facility community. However, as is so often the case when restructuring begins, people began to
question why things were being changed if they weren't broken and how quality could be maintained in light of the transitions that were being made.

Field Entry

Arrangements were made through the facility's nurse researcher and nursing service administrators for me to discuss the study with the nursing research committee and the nurse managers. These meetings were friendly and informal with individuals staying afterward to share ideas and offer helpful suggestions. There was unanimous support for the study and a welcome was extended to begin. The nursing research committee generated a list of possible participants which was drawn from multiple clinical areas. The list was later reviewed with a nurse administrator to validate employment status and appropriateness for the study.

Sources of Information

The goal of data collection is to allow the information to emerge by following the suggestions of the participants. The data collection period was approximately ten months. In addition a pilot for the study had been performed at this site a year prior to the study so I was familiar with the facility and a few of the nurses. Data collection began with several visits with nursing service administrators to discuss the study and to make preparations for institutional review board approval. In the course of the study, multiple sources of information were utilized. These included non-participant observation, in-depth interviews,
meetings, informal conversation, educational films and field journals. I gathered and maintained all study information. In most cases I was led to resources such as historical documentary films, meetings, or retired staff members through informal connections. The final visits included several group meetings with staff to discuss the findings and obtain feedback.

Although the administration was very supportive of the study I was not directed to particular activities or units. I was given a facility identification badge which allowed me to roam freely and was offered the use of various offices and telephones as the need arose. Consequently, I was left to seek out experiences for data collection without being denied access to any event or material that was requested. Members of the facility were invited to help me identify sources of information that best reflected a comprehensive understanding of the facility. The staff, however, were very participative in directing me to experiences that they thought would be important to "explain" their culture. For example, I was told emphatically that I must watch the training film about what the facility stands for because "everyone must see it" to insure that they, too, will adopt the facility's priorities of care.

I introduced the study to potential participants through a personal letter and followed up each introductory visit with a phone call. The letters were hand delivered in order to meet staff members, in person. As I delivered the letters, I had opportunities to visit different parts of the facility as a non-participant observer on all three shifts. All meetings and interviews took place at the facility in a location of the participant's choosing. Additional opportunities for observation were created because the nurses
usually preferred to remain on their clinical unit. Consequently, the participant and I were never too far from patient care issues even though we were not at the actual patient’s bedside and the nurses were frequently interrupted with calls and questions.

“Waiting for the elevators” was a collective activity at the facility. Groups gathered at the elevator bank included every combination of clinical and nonclinical staff, inpatients and outpatients traveling to treatment floors, even the women’s auxiliary would occasionally be in attendance. The elevators became an ideal place for observations and informal conversations. Here, staff would greet patients’ families, students, they had not seen in a while. Often greetings and introductions would be exchanged. One key informant was actually recruited through an elevator introduction. Patients might be trying out new transport modes with willing helpers nearby, starting up conversations or directing newcomers. There were no status symbols here and everyone discussed the news of the day.

I maintained a field journal throughout the study. Documentation included informal conversation, facts and details about the facility as well as more elaborate reflections and descriptions. These were usually handwritten as soon as possible following a visit or interaction. During interviews, written notes were kept in addition to audio-tape recording to document the tone of the meeting, topics, setting and additional information. The field journal was also used to document themes and topic clusters as they arose. As I reviewed tapes and transcripts, key points were documented in the field journal.

Almost all of the thirty-two interviews conducted for the study were conducted at the
facility. Nurses were invited to choose the interview location, a decision that was made intentionally to allow the interview to take place in a location the participant found most comfortable. Most of the nurses chose to stay on patient units in temporarily vacated offices, empty patient rooms, exam rooms or anywhere else where the nurse could find a little place to sit down. One interview took place on an outdoor patio because the nurse needed a place to take a break after a long day before going back to “write notes”. However, because the nurses chose to stay in the patient care environment, I was given an additional opportunity to observe the nurse in “her world.” One interview with a retired nurse was conducted in her home. Two others were conducted in public restaurants to accommodate nurses on leave.

Interviews were often interrupted. Phone calls, overhead pages, and questions from staff about patient needs were common occurrences. Twice, nurses left the room in the middle of a conversation in order to discuss patient management problems with other team members. When offices were used, other staff members freely walked in and out, or sometimes stayed. In one case, I had an office mate sign a consent form because she became a major part of the conversation.

Flexibility in time scheduling was an absolute requirement for the conduct of this study because nurse’s time is so unpredictable. It was not unusual to have interviews canceled because of an imminent patient problem or a sudden increase in workload. Although the participants were very generous with their time, often staying after hours if necessary, I had to “wait my turn” based on unit priorities.

Interviews were audio taped with participants' permission but not required for participation. Indepth interviews were conducted using an open-ended inquiry method
recommended in ethnomethodological research (Leininger, 1985; Patton, 1990) and participants quickly related to the topic of "invisible" work. Generally the interviews began with participants describing their career development and progressed into stories and examples of their "invisible" work. Most often this occurred in relation to an event or comment that had occurred at their facility.

All tapes were transcribed. I checked all transcriptions by listening to the tapes while reading the transcript and editing. In the few cases where tape recording was not possible due to sound difficulties, I typed notes and interview reflections into an interview file for consistency. Text quotes used in the presentation of findings are taken directly form these transcripts edited only for flow.

Study Participants

The general sampling strategies for this study are defined by Patton (1990) as purposeful, and opportunistic. Sampling selection was purposeful in that information-rich cases were sought in order to uncover "issues of central importance to the purpose of the research" (p. 169). An initial list of clinicians was generated by the nursing research committee. The list was validated and expanded through further staff recommendations. Opportunistic and snowballing sampling strategies were utilized in keeping with the ethnonursing approach which calls for the unfolding of the research design in order to follow the data. Therefore, I remained open to letting the sample emerge through either self-selection or recommendation (Patton, 1990). All participants were encouraged to
comment freely on the content and process of the study and many offered helpful suggestions.

The ethnonursing method calls for the use of both key and general informants. Key informants are those thought to be most knowledgeable about the domain of inquiry (Leininger, 1991). Eight nurses participated as key informants participating in indepth interviews. These nurses represented between eight and twenty-two years of clinical nursing experience. Seven nurses had a Bachelor’s degree in nursing, of which two nurses also had a Master’s degree. Although the group represented rehabilitation nursing their breadth of experience included clinical specialties such as intensive care, pediatrics, mental health, student health, therapeutic touch, gerontology, recovery room, gynecology, spinal cord injury, oncology and arthritis management. The key informants were all currently in clinical roles but had experience in both inpatient and ambulatory settings, staff development, management, counseling and research roles.

General informants have general knowledge of the domain of inquiry (Leininger, 1991). Sixteen participants where formally enrolled as general informants but many additional conversations took place with interested members of the community when I was present at the site. The group included facility executives, department heads, researchers, one patient, several first line managers, and staff nurses. These individuals spoke to various aspects of the cultural context. The group served as an additional source of data as well as another source for confirmation or disagreement.
Ethical Considerations

Participants in the study were asked to sign a written consent form which included an explanation of the study, assurance of confidentiality and their right to withdraw from the study at any time with no negative consequences. The consent form also included permission to re-interview for validation and to publish and present findings from the study. Participation in tape recording was discussed in the consent form but a refusal did not constitute elimination from the study. However, no one refused tape recording. The research proposal was approved by the Loyola University Research Institutional Review Board for the Protection of Human Subjects and by the appropriate institutional review boards for the study site to further insure the protection of participants.

A coding system was used for recording data to avoid the use of names in any aspect of the study. I kept a register of names, addresses and phone numbers for purposes of scheduling. The register was kept separate from the field journals and computerized data.

No known risk was associated with the study other than the possible resurgence of negative emotions such as anger or depression associated with past events. The possible benefits were cited as increase in a sense of affirmation and pride regarding the value of nursing work in response to the researcher’s interest and the informant’s reflections on the topic. These sentiments were expressed by many participants. Key informants received type written copies of the interview transcript to insure accuracy. An example of the consent form in included as Figure 2. (See Figure 2 below)
You are invited to participate in a research project to consider how nurses articulate various aspects of their work. Participation is completely voluntary.

What does the study consist of?

The study consists of interviews, preferably audio taped, lasting 60 to 90 minutes. It is anticipated that at least two meetings will be necessary however additional meetings will be left to your discretion. Interviews will be conducted by the principal investigator. In addition the principal investigator will conduct meetings with various members of the community to learn more about the work environment.

Are there any risks?

It is possible, but not likely, that negative emotions may surface as a result of discussions about unpleasant work experiences. You are free to stop the discussion or change the topic at any time.

Are there any benefits?

It is possible that you may experience a sense of pride and satisfaction in your work as a result of reflecting and sharing on your contributions as a nurse.

When and where will the interviews be done?

The interviews will be scheduled at a time and place that are convenient for you.

Who will have access to the material from the interviews?

The audio taped interviews will be transcribed by the principal investigator or a trained secretary. You will be given a copy of the completed transcript to review. The principle investigator will also prepare computerized documents to assist in analysis. Any identifying information from the interviews will be removed or altered on the written transcript and the computer database. These documents will be shared with the study committee consisting of the principal investigator and three faculty members familiar with qualitative research. Tapes, transcripts and computer files will be coded anonymously with numbered codes. No individual identities will be detectable in any reports or publications resulting from the study.

What if you change your mind?

You are free to withdraw from this study or to refuse permission for the use of your interviews or transcripts at any time. You may take as much time as you wish to think this over. Before you sign this form, please ask any questions on aspects of the study that are unclear. I will attempt to answer any questions you may have prior to, during, or following the study.

Authorization: I, ____________________________________________, have read this form and have decided to participate in the research project described above. My signature indicates that I give permission for information I provide in the interviews or transcripts to be used for publication in research articles, books, and/or teaching materials, as well as for presentation at research symposia. Additionally, my signature indicates that I have received a copy of this consent form.

Signature and Date __________________ 

If you need further information, please contact the principal investigator.
Data Analysis

Data analysis generally followed Leininger's Phases of Ethnonursing Data Analysis Guide. (See Figure 3 below).

Figure 3
Leininger's Phases of Ethnonursing Analysis for Qualitative Data

Fourth Phase

Major Themes, Research Findings, Theoretical Formulations, and Recommendations
This is the highest phase of data analysis, synthesis, and interpretation. It requires synthesis of thinking, configuration analysis, interpreting findings, and creative formulation from data of the previous phases. The researcher's task is to abstract and present major themes, research findings, recommendations, and sometimes theoretical formulations.

Third Phase

Pattern and Contextual Analysis
Data are scrutinized to discover saturation ideas and recurrent patterns of similar or different meanings, expressions, structural forms, interpretations, or explanations of data related to the domain of inquiry. Data are also examined to show patterning with respect to meanings-in-context and along further credibility and confirmation of findings.

Second Phase

Identification and Categorization of Descriptors and Components
Data are coded and classified as related to the domain of inquiry and sometimes the questions under study. *Emic* or *etic* descriptors are studied within context and for similarities and differences. Recurrent components are studied for their meanings.

First Phase

Collecting, Describing, and Documenting Raw Data (Use of Field Journal and Computer)
The researcher collects, describes, records, and begins to analyze data related to the purposes, domains of inquiry, or questions under study. This phase includes: recording interview data from *key* and *general* informants; making observations, and have participatory experiences; identifying contextual meanings; making preliminary interpretations; identifying symbols; and recording data related to the phenomenon under study, mainly from an *emic* focus, but attentive to *etic* ideas. Field data from the condensed and full field journal is processed directly into the computer and coded.

Although the guide is broken down into a process with four steps, it is important to note that data gathering, coding, processing and analysis are simultaneous processes that actually took place throughout the project.

The study yielded a very large quantity of text data; yet, managing the data without losing contextual meaning was essential. All interviews were read and listened to several times after transcription. Computer coding was problematic because it was difficult to separate the text without decontextualizing it. Participants expressed their ideas about work through stories, using a colloquial conversation style. Consequently a dilemma arose in data analysis. I was tempted to capture "the idea" of the conversation as a concept. At the other extreme, any attempt to code phrases eliminated contextual meeting. I resolved this by grouping data according to the ideas nurses presented, making every effort to keep the ideas in the nurses' own words.

The data from the key informants was reviewed using a word processing program. Text could be divided in various lengths and placed in separate files named according to a coding system that emerged out of the data, sometimes using the participants words as file names. After thirty-five codes were identified the data started to consistently fit into pre-existing files and it became clear that the code list had been saturated. The coding system also allowed passages to be coded more than once. Passages were coded as many as eight times. By coding in this way, I had ample opportunity to reread, study and reflect on the text.

One file was used to capture any comments that nurses used to describe any part of nursing work in their own words. This file, alone, was over sixty pages long. Other
files averaged about 20 pages long. The "naming" file affirmed my observation that, although the texts offered much information on nursing work, the results of the study focused on definition.

Common patterns emerged early in the interviewing process. These were pursued in additional interviews and validated by study participants. A separate file was created to collect text excerpts which referenced confirmation data.

**Evaluation**

Evaluation criteria developed in the quantitative paradigm cannot be used to evaluate qualitative research since the philosophical assumptions which undergird each type of research are paradoxical. Therefore, Leininger's (1990, 1991) standards for qualitative research were utilized in this study. These criteria include credibility, confirmability, meaning-in-context, recurrent patterning, saturation, and transferability. The next section includes brief definitions of each criterion and a summary of how they were applied to this study.

Credibility is defined as the degree to which the findings are believable. It is also referred to as the truth value of the data (Leininger, 1990). Confirmability refers to the idea that "findings, interpretations, and recommendations [are] supported by data" (Lincoln & Guba, 1985, p. 318). Therefore, the ability to explicate a data trail is important to confirm findings. Leininger (1990) adds the importance of validation by participants. She states that "Mutual agreement by the researcher and the researched establishes confirmability" (p. 43). Further, data is confirmed when ideas re-occur in
different data sources. Meaning-in-context refers to how well the data provides complete descriptions about the informant's actions, thoughts, beliefs and interpretations as relevant to a particular situation. This criterion emphasizes "the importance of describing and detailing diverse factors impinging on the meanings of human care..." (Leininger, 1991, p. 88). Recurrent patterning requires that there is repetition in the data to document and validate the presence and significance of an event over time. "Repeated experiences, expressions, events, or activities that reflect identifiable, sequenced patterns of behavior over time are used to substantiate this criterion" (Leininger, 1991, p. 113).

The concept of saturation refers to the idea that a phenomena is fully explored when comments and themes become repetitious. The adequacy of the sample is met when additional interviews do not yield new data. Redundancy (Leininger, 1990) from informants or contextual data is an indicator that saturation has been achieved. The criterion of recurrent patterning and saturation seem to relate to more traditional notions of reliability.

The last criteria, transferability, refers to the application of qualitative findings in other settings (Leininger, 1990). Lincoln and Guba (1985) state that "transferability inferences cannot be made by an investigator who knows only the sending context" (p. 297). Even though qualitative studies do not aspire to be generalizable, the researcher is required to present sufficient information within the study so others can determine application to other contexts. Thick description is considered substantiation of this criterion. In order to insure trustworthiness of the study, these criteria were met through the following strategies:
1. All audiotapes were copied and archived. Transcriptions were checked against the audiotapes for accuracy.

2. Topics from initial interviews were often validated or expanded in later discussions to insure thorough treatment. Complete transcriptions were checked by key informants who were asked to correct as needed.

3. Raw data was maintained in the coding files and identified by subject and text location.

4. Several nurses and committee members read original interview texts and interpretations providing outside validation that the conclusions were supported by the data.

5. Upon hearing the findings nurses frequently comment that the texts and interpretations capture what they do. Such comments have come from both facility staff and outside observers. The findings were presented several times. Nurses from diverse backgrounds who participated in these presentations affirmed that the data resonated with their own experience in nursing.

6. Credibility was established through prolonged engagement and persistent observation at the study site and with the data (Lincoln and Guba, 1985). Findings were cross checked between and among key and general informant interviews and field journal observations. The findings gathered around topical areas that were consistently discussed by all participants.

7. In order to maintain the meaning as intended by the informant, data is presented within the story as told by the participant.
8. The reflexive journal was utilized as an additional aide in meeting many of these evaluation criteria (Lincoln & Guba, 1985). The journal enabled me to reflect on the research experience as well as the actual interviews. It became my conversation with myself and served to remind me of the individual nuances of both the setting and the individuals. Maintaining the journal helped me prepare for future interviews and served to make me aware of the directions the study was taking.

After interviews were completed, I listened to each audiotape individually. Significant ideas and reflections were handwritten in the journal, creating the basis for later analysis.

In closing, K7, a key informant, offers a fitting example on the integrity of her interviews and her experience with the research process. After reading the transcript of the first interview, she says:

I think I incorporated pretty well what I do. I mean you found me today in the middle of exactly what I told you about, how these little things get thrown in the path and you have to deal with them one at a time in order to get to the end of the process...and you know, to get the person home as safely as you can with what knowledge you can give them, what knowledge they can receive and what knowledge they've had before that may or may not be accurate, you know... I know that I was somewhat surprised [at the length of the transcript]... I guess I didn't realize how passionate I am about what I do but I am and I'm glad! I admire myself a little bit after reading that, you don't take time to do that, you know ... I'd like to send a copy to my friends and family.(K7,pp.5-6,#2).

Conclusion

What is presented here as study design should not be misconstrued as a rigid signposts directing the inquiry. Rather "design in the naturalistic sense...means planning for certain broad contingencies without, however, indicating exactly what will be done in
relation to each” (Lincoln & Guba, 1985, p.226). In this regard, the plan for study format should be viewed as an evolving design so that the research, in part, is in designing the map that leads to uncovering “invisible” work. As Patton (1990) states “A qualitative design needs to remain sufficiently open and flexible to permit exploration of whatever the phenomena under study offers for inquiry” (p.196).
CHAPTER IV
PRESENTATIONS OF FINDINGS

Introduction: Metaphorically Speaking

The journey through the world of nursing work proceeds to a location where nurses are gathered to discuss their work experience. Finally, after searching and thinking our way through the complexities that bear on our understanding of nursing work we can add the nurses’ words to our reflections. Therefore, the metaphor enlarges to include a sense of hearing. In fact, music provides the venue for the analysis and interpretation of the spoken word.

Too often, when we listen to music, we focus only on the melody, ignoring the lower, bass tones which provide foundation to the piece. In fact, C. Scotellero (Personal communication, 1997) states that it is the bass arrangements from which the melody springs forth. So too, when we attempt to measure the work of nursing simply by looking at the tasks, we are in fact looking at the melody and missing a major part of the composition which connects thought, value and action. Another word from the world of music, contrapuntal, best describes the ongoing challenge of trying to understand undefined aspects of nursing work. Contrapuntal in music composition means “presenting a contrast of or interweaving of component elements; according to the rules of
counterpoint.” This requires the “combination of two or more related but independent melodies into a single harmonic texture in which each retains its linear or horizontal character” (Gove, 1981).

The results of the present research are best understood as contrapuntal melodies. One melody presents the actual words nurses use to articulate their notions of “invisible” work. This comes directly from the text. The other melody, while also text based, comes from not what the nurses said but how they said it. This melody becomes meaningful when placed in contrast to the well-worn intonations about how we build definitions in language. Chapter IV attempts to tract each of the contrapuntal melodies. It is crucial to remember, however, that the melodies are equal, independent and critical to the whole.

Words are defined in meaningful ways, according to the social representations we have come to understand that they represent. According to Jacques (1992) “social experience can assume meaning only if a representation exists by which that experience can be conveyed” (p. 91). The present study is essentially an attempt to capture a phenomenon that has hitherto remained “invisible” because it does not fit well into current representations of work. The findings presented in Chapter IV, provide us with evidence to demonstrate that “invisible” work does in fact exist. The chapter’s goal is to look at the ways nurses represent the “invisible” work, in terms of both what they say and how they say it. In addition, to begin to appreciate the breadth and scope of “invisible” work as an important part of nursing work.
The Problem of Definition

In a lengthy treatise written in 1950, R. Robinson attempts to answer the question “What is the definition of ‘definition’?” He reminds us that “the word ‘definition’ is more often used by the general public than any other peculiarly logical term except the word ‘logic’ itself” (p. 1). He claims that “definition” has been more widely accepted a any other part of Aristotelian logic (p. 1). Yet, after reviewing the opinions of the world’s greatest thinkers, from Plato to Carnap, he lists as many as eighteen various “species” of definition (Robinson, 1950, p.18). Robinson’s (1950) writing suggests that various types of definition have developed alongside of the development of Western logic and science. The issue of definition has grown up in the shadow of the great realist/nominalist debates in history and how we define seems to be intimately fused to our world view. In fact, Robinson(1950) states that “Our list of definitions shows that, while some good writers have used the word ‘definition’ to refer to a process dealing with words (Locke, Mill) other good writers have used it to refer to a process dealing with things (Aristotle, Milton) and others to a process dealing with concepts (Kant)” (pp.9-10).

Word definitions, then, are used in situations when the goal of communication is to define X as “In this case, X is represented by TAG A, or a stipulative definition.” In this example, definitions are tags assigned to symbols, useful especially in empirical studies and when representing the nominalist view. Another instance of word definitions would be when one states that the common usage of X is Tag B, a lexical definition.

The goal of word definitions is for an understanding of the essence of a thing. Often in nursing, the realist view is represented by the philosophical question “What is
Definitions dealing with concepts allow for discussions of abstract ideas. Consequently, the process of definition allows one to ask the question "What is the meaning of excitement?" While each type of defining may seem to lend itself to different types of research, each offers a different contribution to knowledge.

Robinson's (1950) work demonstrates how the process of defining has changed and grown throughout history and philosophy of science to offer more varied tools for the enhancement of knowledge development. Obviously, confirmatory research would not be possible without stipulative definitions and qualitative investigation is based on an epistemology which allows for an appreciation of essence and meaning.

Nursing has wisely explored and used many types of definition in its science. However, the profession's self-examination tends to reflect theoretical, operational definitions and lexical definitions, based on what nurses have always done. The point of the above discussion is not that we try to clarify what "definition" means to nursing, but rather that we approach definition with an open set of possibilities, realizing that the act of defining itself can be evolving, creative and used to our own purposes.

Definitions of nursing do not have to fit into a particular stereotypical category, but the "types" and styles of definitions may be implicit in nursing. What types of definitions can accurately portray nursing are still to be discovered. The findings presented in the next section sit in sharp contrast to any formulaic rules regarding how to define and are presented as findings also in order to examine the style nurses themselves use in describing their work.
Findings: The First Melody—How Nurses Define

The findings of the present study offer a view of how nurses articulate their thoughts about nursing and the conversational forms nurses use to talk about their work. This melodic theme builds on how nurses move toward defining. Text examples document some of the common definitional issues that came up as the participants tried to describe their work. The issues are described under the following categories: filling in gap work; the use of understatement; the struggle for words; images and stories; and not exactly X definitions. Underlying all the examples throughout the study is the presupposition that as the nurse talks about a particular nursing act, i.e. patient education, she is describing a process of blending knowledge of the patient, team and family members and experience to determine an action plan. Through the process, the nurse displays how she combines the specific act with a thoughtfulness that is much deeper and mindful.

Defining “Fill in the Gap” Work

How would one define work that only occurs when a void exists? The nature of this “filling in the gap” work is such that it embodies invisibility. It hides in a potential state. Several nurses offer descriptions and situations. When K7 realizes that the discharge wheelchair is coming in pieces, and no one is taking care of this problem, she jumps in. Her work is “putting it together”. She realizes how her work is missed if it is absent but not recognized when present.

So by the time they came to pick him up it was together, but had I not, I'm telling you, had I been off that day, he would have gotten all these pieces of wheelchairs,
you know, and I...that day but I worked my butt off. And those are the things that nobody will ever know...Nobody will ever know that I did that except me. And the family was appreciative of course (K7, p.7).

What is the nomenclature for reimbursement? Problem-solving; solution provider? Solution provider I would name it...I think of nurses as the “mom” of the organization. [This work is] making up for what other people are not doing (K8, p.1, #2).

But I think someone needs to give that information and ultimately, if no one else gives it, it’s up to the nurse (K2, pp.5-6,#2).

These quotes represent how nurses perform actual tasks that don’t exist unless they are a result of someone else’s omission. They are just filling in which requires that they have the knowledge to occasionally perform work usually assigned to other types of staff. Nurses will use such open definitions, simply leaving a space, saying more about the character of the nurse’s role, her flexibility and changeability, than it does about the specific work. Of course, attempts at defining are difficult because the nurse is not generally accepted as the permanent substitute for other team members.

The Understatement

Participants often seemed to downplay their work, almost disqualifying its significance. K3 gives a good example summing up her work and making these statements in a casual tone of voice and with matter of fact expressions.

So, what a nurse therapist does is just help the patient throughout their whole stay here, get ready for discharge and teach the family”(K3, p.7)...I guess I’m just managing all these different things, I’m just trying to make sure that everything is taken care of for the patients that needs to be done” (K3, p.9)

K7 adds “I kinda facilitate a little bit the conversation like for somebody going home, to
be discharged home (p.6). K2 comments "Who said patients go to the hospital because they need a nurse?...and I think it’s true. I think that nurses sort of keep the patient together, um, families" (p.11, # 2).

K1 was often called upon to work with difficult patients because of her expertise. After her description of such a situation that required extended effort to obtain staff and patient co-operation, the following was her response when asked to describe the work. Notice that she chooses words with negative connotations, learned the skill from a family member at home and, of course, it’s no big deal.

Well, I always just call it being manipulative (real quiet). I rely on skills my sister taught me when we were little...[No big deal?]. Well, yeah and it really is (K1, p.13 #1).

Struggling for Words

Definition usually enhances articulation. However, it may also block articulation, when what we mean to say cannot be spoken clearly. Words take on a life of their own often being "...the wildest, freest, most irresponsible, most unteachable of all things...They hate anything that stamps them with one meaning...for it is their nature to change" (Woolf, 1961, p.175-177). It is difficult to study a definitional problem when the words themselves cannot be trusted.

The following example from K7 demonstrates the nurse’s struggle to find adequate words to describe nurse’s work, sometimes leaving the reader to find meaning in their absence. In these examples, K7 is discussing whether the work is similar to patient education.
Yeah, I think it’s like - let me see - life’s adaptability? The ability of a person to adapt to whatever has happened or the environment that has changed, or something and it’s something very necessary for Rehab, you know, it’s - that’s it (K7, p.4).

Never thought about it. Um, maybe it’s a plan to meet the goal of patient education. Maybe it’s like a, thinking of it as sharing my experience with other patients, like, you know, whatever little bit I can share. Um, it’s like a plan so like the patient will have hope. I don’t know if I explained that O.K. but that’s what I see it as (K7, p.5).

...and I kinda look at the little things that some of the therapists don’t think of. They don’t and that’s because we do kinda have our mind set. This is occupational therapy, this is physical therapy, you know what I mean (K7, p.6).

Reality mind setting. I don’t know, I don’t know, I don’t know. Like knowing how hard it is to help some of these patients, to move them. That when I go home from work I’m tired, my body’s tired, and I can’t imagine doing it without some kind of help, without some kind of a plan (K7, p. 11).

These examples are evidence that some unexplained version of a definition exists because nurses are struggling with picking a word and enhancing it, sometimes just opening a space for thought and letting the observer try to fill in the meaning. The language does not offer the richness of the experience or the “being there” or the “doing it.”

Images and Stories

Phenomenological research has already documented that nurses are good story tellers and will resort to patient examples to make their points. This practice was validated by participants in this study. In addition, many nurses offered pictures and analogies when words failed them. For example:
Well, let’s see. I feel a little bit like a, um, a telephone wire, you know. And it’s like reaching out to all the surrounding Metropolitan towns and suburbs. And at the end of the telephone wire is, ah, it’s kind of like this big word - ”answer”, “resolution”...and I also picture myself like in a stewardess uniform and, um, I’m kind of showing people to their seats. I know that’s strange but that’s exactly how I feel. I feel a little bit like a hostess...and making sure that they’re, making sure that they’re comfortable and happy and at the same time making sure that management’s happy about them being happy. So I kinda feel like this person - I don’t know how I would draw the picture but I feel like this person would like, kinda like my head can do a full rotation and I have this big smile on my face at all times and I’m making sure that everyone’s in agreement that everyone’s fine...with things...I also feel like a big blackboard and on it, it says, “Soundings”. And, um, I have like a couple a gashes, and guns and poles and some darts that are still sticking in the board. Because, in a way you’re like a buffer between the somewhat frustrated, angry, or depressed out-patient - cause now they’re home, they’re in the world and they’re, and I would say 90% of them are very depressed and disillusioned and kind of feeling like they’re not receiving any respect or support from their care givers or environment. So, you’re the buffer between them and their doctor, them and the out-patient management. Um, kind of like this board that just stands at the door of the Clinic room and you’re just kind catching it all. And then when the Doctor walks in they vent it and they’re ready to talk about their medical needs. It seems like in out-patient the patients don’t view the nurse as someone medical as far I’m concerned. I feel almost like a sociologist...yeah, kind of a Social Worker, you know. It’s like a big board and a long telephone wire going out of this office out of this window to all the different towns (K6, pp.1-2, #2).

Another image is offered by G8:

What I would do is as the family and patient come through the door, their entire case and their history, the family, where they live and where the discharge disposition’s going to be, everything about them, the environment they come from and are going to, put all that collectively into a body - so we have a holistic sense of that person and I thought I’d never use that word holistic again because it was drummed in ad nauseam at school...But to get a whole picture where everybody’s poured in a gel where it’s, you can’t split apart the gel, it remains gelatinous into the body. A physical body and I hold that body’s hand while they’re here, between my constant communication with them on a daily basis. Either, sometimes it could be just in passing on rounds or it could be sitting down with the family that day because I saw they were upset or nervous about the transition home. Um, to guiding that body into where they’re going to go after they’re done here, what institution are they going to. And then let’s say they going to a nursing home, it doesn’t mean I don’t have to educate the family and that patient. I don’t just sluff
it off to the next people. I want to give that family as much education as I can to make sure they’re managing that patient’s Rehab issues well enough... But, it’s the image of everything about them that’s poured into one human body. [it’s more than the physical it’s] their environment, their spirituality, the relationships that’s why I say pour in the family too into that body because I want to work on the relationship. If they’re stroke patients, concentrate a lot on the return of sexuality and intimacy ... not just stroke but my other patients too. Um working on their self-esteem, ah, and trying to return them to continency as soon as possible and working on trying to get the family involved in that. If I’m looking at staffing issues being difficult and I know that they can’t get a patient to the toilet on a regimented basis to get him regulated again then I want to incorporate the family somehow into that. Some of the guise that this is their practice field, which it is in actuality but sometimes I also have to use that as a tool for problem solving and they’re complaining that the staff isn’t there for them and I say, ‘Well, you know, this is your practice field and I want you involved’ (G8, pp.12-13).

“Not Exactly X” Definitions

The next issue occurred most frequently. Through listening to nurses discuss their work, it became apparent that the conversations would include a word or concept which was commonly understood. However, the nurses would then enhance it to make it fit their thoughts and experiences. Such fitting referred to as “the new and improved” version, or the “not exactly X” definition. Initially, nurses tried to use words that are commonly used in nursing (like patient education, advocate, assessment), but then discovered in the process of talking that such words fail to communicate the full meaning the nurses are trying to convey. In fact, nurses were using common words to explain quite uncommon activities. Examples of this phenomenon are presented here. In the next section, examples get layered into complex explanations which actually cover several dimensions of nursing work, taking on an additional level of meaning when considered in their entirety.
Not Exactly Assessment

There are no boundaries between you and the patient. There's such intimacy - many times more intimacy between a patient and a nurse than the patient or the nurse may even experience in their own personal relationship. They, you hear about things, you see things... seeing with your eyes, seeing with your touch, the way someone moves under your hands, your assessment is, is your doing something with that individual, just how their body feels under your touch, how you can see their body tighten up, you can read the expressions on their face, inflection in their voice that you can see so much more than the other folks who do - than everybody else can, because they have so many things between them...[It’s not seeing as observing] Seeing as far as all of your nursing assessment types of things. Using all of your five senses...Part of it is knowing, a lot of mine is gut, unfortunately, and that's one of the biggest problems of nursing...because you can't quantify it. There's some of those folks who like quantifiable data. It's a hard thing to quantify (G15, p.9).

[Sometimes my assessments differ from other nurses’] I probably keep it to myself. I know I don’t communicate that. I do report anything psychosocial that I notice, that’s always a big part of my report to the next shift (K1, pp.7-8).

Not Exactly Patient Education

K4 discusses how nurses function as extensions of the work of others. She states:

“I was thinking about the glue that is nursing, that was the other area that I thought of but didn’t say is that they can learn it in therapy but until they live it on the unit and modify it on the unit and do it over and over again under the supervision of nursing and the cuing and the helping of nursing it doesn’t really become integrated in what they do...[it’s usually put in patient education]...And that’s very much related to that cuing, or I mean that, what I was talking about that we were teaching eight hours a day...you are always doing that (K4, pp.6-7, #2).

G5 also talks about this constant type of teaching. While it currently is not captured under patient education, perhaps it could be captured under a separate category of intervention. For example, another nurse calls it “carry over” work. It is discussed further in the section on bridgework.
In the next example, K4 discusses teaching patients to direct their own care “to just simply being able to tell somebody - a total stranger, an uneducated person how to do what they need to do, to be their hands for them.” She also describes a process education that goes on through nurse-patient interactions which demonstrates how nurses intertwine teaching into other activities.

depending on whether or not you consider instructing a person or directing a person through activity, a teaching. I mean, I do, but I think that there are other people who, you know, so if someone else were standing out listening to the nurse and the patient and the nurse is saying “put your arm over here, turn this way, do this,” I’m not sure they’d consider that teaching. They’d think it was instruction to get through the activity kind of a thing. Except that there are less direct ways of showing someone how to do something in an efficient manner especially when looking at functional levels (K4, pp.3-4, #2).

[We have knowledge of what the patient is going through] because we see people who suffer a spinal cord injury and the base of knowledge is there from our own education here. But then we have the experience of seeing people and what they are able to do and we can share that with the new patient...And I just sent a patient home with Guillian-Barre...and he didn't make as much of a recovery... and I just shared with him about a patient that we had three years ago who had the same diagnosis who went home with a tracheostomy the first time and was totally dependent and was not able to move or turn himself. And then, six months later, he came back and we got rid of the tracheostomy and he was moving his arms. And then, six months later, he came back and he started walking. And I just saw him and he's back at work part-time, walking and he's O.K. You know, pretty much O.K. And so, sharing that with these patients - we've also had patients come back - people who have recovered to whatever degree- and talk to other patients...Never thought about it [as patient education]. Um, maybe it's a plan to meet the goal of patient education. Maybe it's like a, thinking of it as sharing my experience with other patients, like, you know, whatever little bit I can share. Um, its like a plan so like the patient will have hope. I don't know if I explained that O.K. but that's what I see it as (K7, pp.-5).

So this last piece of text describes work that the nurse does that may be related to patient education but is not traditional patient education and requires very different strategies and knowledge. She makes more connections, integrating knowledge of people,
disease process, personality, resources---to provide this “educational” story for this patient and to create hope.

Not Exactly Advocate

In this first example, K3 is discussing home care for ventilator-dependent patients.

[We don’t have a specific number of people], we tell them the more people who know how to do [the home care] the better. I like to teach at least two to three people before they are discharged just how to manage everything. But, just with a patient a couple of weeks ago, she only had her mother and a cousin. They were the only family available at all and they did not have insurance at all to pay for home health agency, so they’re going to be going home with this ventilator-dependent patient, just the two of them. And that worried me but I felt comfortable once we did the teaching that they were going to be reliable and responsible and that they were very good. [This includes assessing education level, personality, the relationship between the patient and support system] and with that case also the doctor wanted to discharge the patient too soon because of the insurance issues and I had to say that the teaching had not been done and we cannot discharge this patient. So it was a kind of struggle there but we had to get our head nurse involved and finally they say “OK, you’re right, we need to finish teaching”...[I would call this being an] advocate...Oh yeah, [I had to strategize] because I needed backup (K3, pp.10-12).

When looking carefully at the above description, one sees that perhaps it is not a traditional definition of “advocate” for in order to advocate, other types of nursing work are presupposed in this conversation. For example, the nurse must have evaluated each of the following areas, both individually and in relation to each other; figured out and weighed the patient and family responses; against the disease process and her knowledge of those care requirements; and the system requirements with both formal and informal operations which she put together and activated in order to get what she thought the patient needed.
Each of these aspects may be identified as a part of nursing work, in the vernacular of nursing, psychological assessment, and family assessment. But when looking only at the parts, one can miss descriptions that document that the nurse takes all these different aspects and brings them together to operationalize a full scale intervention that takes into account not just the clinical results of her many assessments but the total results of patient, family and organizational assessment in relation to one particular patient.

Such complex analysis is also present in K7's story about managing a complicated discharge and trying to prevent the patient's return for a special wheelchair. Her comments show us how she raises the questions about the discharge problems in an operational way. She asks the who, what, where, when, how questions which are important to her. Perhaps they are a part of what she calls "looking at the whole person" and seeing how they are going to manage. This is not a conceptual discharge issue (that one learns about in school under the heading "The Nurse's Role in Discharge Planning")

and I see this wheelchair coming in pieces, I was so angry and I called the therapist and I said "where's the whole wheelchair?" and she said "well they'll put it together." I said "who's going to put it together?" "Well, seating and positioning." I said, "well do they know it's coming?" "Well, they'll find out." I go, "How are they going to find out, it's being delivered to the unit?" (K7, p.7).

Not Exactly Communicating

Another common example has to do with the expression "communicating with the team". G5 offers us a concise version of who he communicates with and why. It becomes clear that this simple act of communicating goes beyond carrying messages. It becomes a decision-making process of who needs what information and how to deliver it in light of...
their individual learning needs and psychological state. In this quote, G5 lists those people he communicates with besides physicians, psychologists, occupational therapy, physical therapy, and social workers.

Well, certainly families and any other significant others that plays a role with that patient’s maybe post-discharge plans or whatever. Um, but also - and when you say that you mean all the therapists like Speech and Therapeutic Recreation and all of that, and certainly anyone else that has a, like Dietary, um. Um, really any department that has an issue with the patient really... We have the Dietitian make rounds with us once a week and she may not be part of the team and sitting in on the conferences but she’s still part of that patient’s progress and it’s still somebody to be communicated with as things come up. Ah, certainly we have a role with communicating with visitors to whatever extent that they can, you know, I mean there are visitors who are family members or who are significant others who are real integral in what’s going on with the patient that we simply communicate a lot with... all interested parties who come to visit, you know, the extent that we can and that they want to be involved. Other people that we communicate with - certainly anybody whose going to have a role post-discharge we would communicate with. [Nurses] are going to talk to Home Health, if there’s Home Health, anybody who - with equipment - other than those, I mean issues, that physical therapy sets up or supplies. And also some of the Nurse Therapists make the follow-up appointments to plug them back into their referring or family physician. Ah, kind of get them back into the network of things. Or we talk to the out-patient nurses if there’s a significant issue that they need to be appraised of, other than the written information that they get down there (G5, pp. 5-6).

G5 describes the nurse in the middle as an intermediary. So again the act of communicating has an action agenda.

This phenomenon, using common words to express uncommon activities, is not indigenous to nursing. In fact Robinson (1950) tells us

Men will always be finding themselves with a new thing to express and no word for it, and usually they will meet the problem by applying whichever old word seems nearest, and thus the old word will acquire another meaning or a stretched (italics mine) meaning. Very rarely will they do what A.E. Housman bade them to do, invent a new noise to mean the new thing. For they like to feel that they are not creating language but using an established and approved language; the
closeness of the old sense helps to make the new sense intelligible, and indeed often conceals from everybody the fact that a new sense has arisen. [This] will ensure the mutability of language. p.55

And in this case, adding once again to the “invisibility” of nursing work.

To Define or Not to Define

Two nurses in the study raised a question about the possibility that the act of defining itself would somehow undermine the special characteristic of flexibility and openendedness that nurses bring to their work. G8 states:

You know, there were a lot of times when I thought that this job needed to have more organization to it. (Laughing) More a way of being able to convey the job to the next person in line. And the more I’m in it, the more I’m realizing “no”, it shouldn’t be. It should be something that develops intrinsically and I just hope and pray that we don’t all up and walk out and leave it to people who don’t know anything about it. (Again laughing) But, um, I don’t know that it is so important that it is definable… as human beings we’re spirits and everything else we do shouldn’t be definable if our jobs are very sincere along with that as we’re embroiled with each new patient simply…Why should we be so definable and we should be able to be flexible enough not to be so definable and our tasks don’t always have to be so defined(G8, p.14).

In this section, we have looked at various ways nurses try to explain their work. Definitional problems persist to the point that the nurses do not always fully acknowledge this work and credit themselves. For example, K6 says with surprise..

Why didn’t I ever think of it? Just to come in and cut it out right there. I am the continuum caretaker sent for you and the community. I guess because I thought if they come to this clinic and they understand it’s out-patient, that they would, that they should automatically understand what I do…I just always thought that they knew that. And I would, I would be repeating myself if I did that. But obviously they don’t (K6, p.7 #3).

It has been suggested that the historical constraints and social devaluing of women’s work have played a part in nursing’s “inability” to define according to the
"rules." While this fact may be contributory, one other possibility is that we have not allowed ourselves to restructure the rules to suit the work. We have treated definition itself as a rigid process. One thing is certain. When given the opportunity, nurses in this study had much to say about defining their work. Until we can find representation for their descriptions, it will continue to go unsaid.

**Conclusion: a Constellation in the Winter Sky**

While the present study yields evidence of "invisible" dimension(s) of nursing work, it seems presumptuous at this point to claim a clear definition on the basis of this research. Perhaps more important it would clearly be illogical to offer an operational definition, with order and hierarchy, since such representations have already failed to capture this phenomenon. In fact, the very assumption that such work is performed in some type of stepwise fashion itself must be held problematic in order to understand how this work is done.

When nurses talk about their work, they often move into stories and analogies to share their ideas. By reviewing each of the nurses' stories, certain descriptions seem to group together in clusters. However, they appear like starpoints in a constellation. It should not be presumed that they have all been identified because, like constellations in the night sky, they change according to season. The starpoints identified in the current study are, at best, beginning reference points. In fact, the work of nursing is highly contextual and nurses may hold certain strategies activated but in abeyance until needed.

Therefore, the findings are presented in process form, as the story of how they
revealed themselves. The findings display themselves like starpoints in a constellation, with different starpoints together creating a vague outline of the total picture. The picture shifts position much like the night sky in seasonal rotation. In the case of nursing, however, it is very likely that the starpoints show themselves according to the nature of the interaction/context. Therefore, in reviewing the study findings it becomes important to view aspects of the work as they appear in the story. That is, in a potential state, much as nurses do when they are actually performing their tasks. At times, nursing activities appear to be identical. However, The activities are not identical because the nurse has couched them within very individualized plans and goals for a particular patient and family. The study participants’ stories have many levels of meaning. In light of these issues, portions of text are repeated throughout Chapter IV, to show how the text fills in the outline of the constellation from several vantage points.

Findings: the Second Melody- Nurses Describe the “Invisible” Work

"What I do is I create a picture of the patient for other members of the team to see."

This section begins with comments that nurses make, in their own words, which give a general sense of the tone and timbre of their conversations on “invisible” work.

Get Past the Pills

I think it’s that concept of relationships. That I”’s not just passing the pills. It’s that strong sense of “as I’m passing the pills, I’m interacting with that patient.” And, maybe it’s just a “how is the weather, how was your day” kind of thing. But still, bringing a smile to that patient’s face of listening about how terrible therapy was. Maybe making suggestions - just a simple, suggestion like “well, maybe if you were in such pain in therapy, maybe you should think about taking your pain pills right before.” The fun part is the interaction. But unless you can get past the
getting the pills out and the kind of task oriented, I think you might miss a bit. (K5, pp.10-11)

Intangibles

Yes, they’re there [the intangibles], very much and at all levels here. I enjoy my job very much but I find it all encompassing, let me tell you. I have to do little things that nobody else will ever see. Nobody else will ever see but I see them. The little extra things that I do for a patient going home who is so confused, or the family is so confused, and have absolutely no idea how this is ever going to work, how the medications are ever going to go O.K. (K7, p.6).

In the next example, K4 touches on intangible factors including how nurses contribute to developing a sense of community for patients and discusses the frustrating problem of documenting and measuring intangible issues.

I’m not sure how intangible [the experience of the staff] is, but part of the intangibles are being able to talk to your peers as they’re going through the same - at the same time. Or running into patients who are now out-patients who are coming up to say “Hi”. And striking up a conversation - having the new patients strike up a conversation to find out they’re stopping in on their lunch break from work and all of those things that I think make a big difference in the outcomes... indirectly nursing “makes this happen” because part of the reason that the patients come back is because of the ties that were build while they were in-patients and they’re stopping in to say “Hi” and maintain those relationships. Our nurses, including myself, have maintained relationships with patients for years, and years and years... it’s more spontaneous... I feel so strongly that patient’s should be here--- it’s all sort of related, it’s the spirit of the place. It’s fairly upbeat, there are young people who work here with lots of energy and optimism, ah, those kinds of things would be the intangibles... I’m certain [a measurement tool] is not getting it all. [It’s not getting] those kinds of things that I just talked about, absolutely. [Some don’t look at education] at all. Doesn’t look at patient’s ability to direct care at all. It’s all it’s designed to be - you know - it’s functional. It’s only a functional measure. [Patients ability to direct care is] their ability to just simply being able to tell somebody - a total stranger, an uneducated person how to do what they need to do, to be their hands for them (K4, pp.1-3, #2).

Then, if nurses effectively teach this skill to patients, cost savings are accomplished because unskilled caretakers can be hired by the patient in the future. However, because
this work takes place “eight hours a day,” she states it is neither being documented nor would it be considered a credible statistic. In her words:

depending on whether or not you consider instructing a person or directing a person through activity, a teaching - I mean, I do - but I think that there are other people who, you know, so if someone else were standing out listening to the nurse and the patient and the nurse is saying “put your arm over here, turn this way, do this”, I’m not sure they’d consider that teaching. They’d think it was instruction to get through the activity kind of a thing. Except that there are less direct ways of showing someone how to do something in an efficient manner especially when looking at functional levels (K4, pp.3-4, #2).

Keeping the Patient Together

who said patients go to the hospital because they need a nurse? And I think it’s true. I think that nurses sort of keep the patient together. Um, families...It’s just what you know, it’s just your ability to give yourself to patients and to see how things are going. It comes from a lot of theoretical, a lot of education. It comes from what you know about the situation and about the patient and you just give that to patients and their families. And I think that’s something that you have to learn. I see new nurses struggle with it, so - I, to my mind, and even now as I do it I’m a lot more distant so I may not be a key player anymore. But, I try to get involved in these cases in a way that it’s going to make a difference for people. (K2, p.11#2)

K4 offers a theory on why nurses are successful at keeping the patient together.

“well I think like our Nurse Therapists do it primarily through communication and it’s kinda, it’s like the nurse therapist probably does a better job or at least did, talking to physical therapy, then occupational therapy, then social work and psychology and so they had a part of all of it. And the other disciplines tend to just talk to the ones they need to, like physical therapy and occupational therapy talk a lot together or social work and psychology talk a lot together but there isn’t a lot of cross over from that. And the Nurse Therapist tends to be the only person who has the whole picture so in that way they do. The other way I mentioned is just that if we don’t have the patients in the kind of shape to withstand the therapy, then they’ll never make it. You know, with nutrition and prevention of complications and management of bowel and bladder and all of those things have to be in place in order for them to get through their Rehab... It is at least one of those things that gets taken for granted, maybe. (pp.5-6,#2)
Breaking out of the Formula

In these few words, G3 gives one of the most typical examples of how nurses use language. He says, offhandedly...

"You hand a patient a pill—you say something. You see a patient taking off a shirt in an awkward way. That's the invisible work of nursing—You'd be writing all day if you tried to document this.

The significance of this comment was that it was one of the first responses made during an early visit to the site to explain the research project. G3 had no problem understanding what I was trying to do. In defining nursing work, G3 simply tries to open up a space that he takes for granted the listener can fill in. There is more in what is left unsaid than what is said. In later sections, the simultaneous action, cumulative information gathering through communication and the assimilation of data becomes more evident as a part of this "invisible" work.

K2 explains more specifically how a nurse exercises discernment in practice:

Well, the medications are—I mean you'd need a nurse to do that. Some of the other sort of more functional things are things that everybody does. But I think those are things that we do to sort of break out of the formulas. You know there's this instruction that you'll offer the patient the pain medication every four hours. But it's sort of this human side that says "O.K. every four hours is good but at the same time there are also these intervening things so even though it's three hours and fifteen minutes I'm going to do it now...Some people can't do that. Some people would insist that the patient wait - absolutely at four hours - even though they're 20 minutes into their physical therapy and their hurting um then they have to wait because the nurse isn't going to rush up there at 1:50 with their pain medications. Um, and some people are just really open and would do that. You know, we'll work with the patient more to keep it individual, think work. (K2, p.5,#2)

K8, an otherwise articulate nurse, admits to a caseload of about three to four
hundred outpatients. Yet her definition of her work sounds so simple, “First I do this, then I do that…”

Well, I think there’s so much - my job is really full of intangibles. I have certain things that I have to do and, um, people give me some things to do and then things happen in clinic that I have to follow up with and then there’s phone calls people have to make and I have to do all those things but I really have a lot of play over when I do what. And in clinic, because we have half an hour to see people here, there’s time to actually talk to people. It doesn’t have to, it doesn’t have to be so business oriented without us falling behind. (p.5)…[In my current position] I’m like a detective in some ways and it’s very social. It’s just, I really have to think, I really, really have to think. Whereas, I think the jobs I had when I was younger, I just had to clean up other people’s messes. I really, it was like being a waitress but I delivered other things…you do it because you’re the last guy…The word that comes to mind is ‘mindfulness’ it come from a meditation class I took. It means “to be alive”; Being mindful means being in the present, being awake. But I didn’t learn mindfulness in meditation class. I was like this before. For me it was more like learning to be just in the present...(K8, pp.1-2,#2)

This mindfulness K8 mentions implies that she is there to handle whatever the patient needs as opposed to a contrast presented by K6:

Well, really, you’re sitting in the back room, that’s just not doing nursing work. It’s just not being there for the patient...And as far as nursing is concerned, I, you know, this is probably insulting to all ICU nurse’s out there, but I really believe that anyone can learn skills and anyone can start an IV line. You just need enough people to do it on and then you know where to go in, and that feel for when you get it in. And anyone can work any monitor. I mean you just need to be taught. Buttons and, and things are getting even easier now. There’s just one button now-not a dial and a button and, you know. So... I mean anyone can, can. Given the time and given a good mentor anyone can. But I think the work of nursing, where it all comes in, really is like coming outside of your own skin... And this is not from any Catholic background or whatever. But coming outside of your own skin and realizing that this is your job. First and foremost you’re there for the patient. (K6, pp.7-8)

The work of nursing is defined by what the illness means to the patient. The “invisible” work is essentially what all is involved in coming to understand what the
patient’s meaning is given that this too will change with time and experience. “Invisible” work is accomplished simultaneously with the talking, walking with and thinking with the patient and family. This claim is drawn from the strong evidence presented by nurses that they have an imperative to particularize care because “it depends on the patient.” Consequently, as long as a problem is “patient and family focused” (K3, p.16), then any task or system may be handled within the domain of the nurse.

Therefore, nursing action must build on understanding the patient in the context of his/her life. The nurse must work to tailor care delivery systems to attend to the patient in light of this context. The nurse’s knowledge of the patient becomes the gold standard against which nursing agencies, suppliers and quality of care is evaluated. Such evaluation becomes especially important in setting up discharge plans. As discussed earlier, this type of work will be considered starpoints in a constellation. The next section includes findings to support some of the starpoints disclosed in the interviews.

Starpoints in the Constellation

When the interviews were reviewed for coding, certain topics appeared consistently. However, they did not seem best represented as themes. The relationship of one topic to another would be best described as a simultaneous, because often these topics co-exist within the work or mediate the direction the nurse will take with a situation. The areas, that will be discussed as parts of the constellation are called “Creating Presence;” “It Depends on the Patient;” expressions of knowing and why it is important; “Working the
System:” knowing the system and getting what the patient needs; “Bridgework-the Art of Connecting:” knowing what the patient needs and how to get it; and “Flexibility, Responsiveness and Mutability: the Mix.”

Creating Presence

That nurses must work to create presence may be related to how “invisible” her work is. In this section, we hear stories from both inpatient and outpatient nurses. K6 is an outpatient nurse, who is relatively new to the setting and offers insight into the phenomenon of creating presence as she compares the two settings. While she herself seems clear in her role, (see Images, p. 120) attempts to put it across to patients are often constrained by physicians, the “office nurse” stereotype and the irregularities of patient flow. In contrast, K8 describes herself in a stable interdisciplinary group where she has much autonomy and the issue of presence is resolved once patients experience how she helps them. She talks about the importance of being a presence to patients and how difficult it is to do that when the system isn’t working. From the example presented by the two contrasting nursing situations, it is evident that context effects the amount of time the nurse has with patients, often overriding any individual efforts to create a presence. Control of time and a stable work group enhance the nurse’s ability to be present for patients. As we see in some of the following passages, nurses are often constrained by access to patients either through workload, job design, or physician.

Being present for patients is not a new idea in nursing. In fact, Benner (1984) identifies it in her work on nursing roles. However, nurses in this study identify
background work that is necessary in order to become a presence to patients. Although a clear definition is not available, they can identify when it is done well. For example, a respected nurse is described as “She’s just the best. She knows so many things and just brings this presence - oh, the patients feel so good when they’re with her. You see patients go like mellow” (K2, p.12, #2).

Being able to create a presence is necessary in order to develop relationships with patients. Allowing oneself to be known to patients is also prerequisite to the development of relationship. Nurses feel this is how patients learn what the nurse can do for them, since the nurse’s role is usually understood only through experiencing good nursing. Due to the “invisible” dimension(s) of various nursing roles, it seems that patients need to see “tangible” evidence of what the nurse can do and how they allow themselves to be known before patients allow themselves to be known as individuals. Consequently, creating presence is so important that, if the nurse fails, she feels useless to the patient and undefined. To K6, creating presence is:

the essence of any relationship be it professional or social. And I think in order for a nurse to be effective in this clinic or in in-patient, you have to establish some type of relationship with the patient so they will talk to you and give you information ...about themselves. Or, they will feel free to call you because they’re not gonna call me to ask me to do something for them if I come off as abrupt, cold, kind of detached. (pp.1-2#3) ...sometimes I leave here and I think, “Who did I talk to, did I help anyone, did I impact on anyone’s life in any way?” Cause often they’ll call me and they’ll say, “Oh, are you Dr. so-and-so’s nurse?” I mean, they don’t even know me. Where the patients on the fifth floor will call me and will ask for me by name and won’t talk to anyone but me. (pp.6-7)

Several nurses mention that visibility and direct care is necessary for creating presence. K6 tells a story about instructing a new nurse:
And I'd say, "Well, maybe if you're more visible, people will ask you for more things. And she didn't want any part of that. And I guess I think to myself, "what other reason are you here for if it's not for the patient. Well, really, you sitting in the back room, that's just not doing nursing work. It's just not being there for the patient." (K6, p.7)

Direct care also helps to establish the credibility necessary for a caring relationship.

According to K6:

I guess the reason I say it's important to demonstrate how competent, smart, efficient and professional you are, and then you're in good standing and you create this presence... [We work at this because] people don't know what we do. Because we're just not able to demonstrate down here [in outpatient] as we are (pause) I mean, in-patient wise you could walk into a room, you could hang four feedings, change dressings, nursing assistants are running in and out of the room asking you questions. "Can I do this" for this patient. (K6, p.6#3)

The stories about work in outpatient settings are more precarious than inpatient experiences because there is less task work for the nurse to perform. Outpatient nurses talk to a lot of people ABOUT the patient and spend a lot of time on the phone referrals.

However, K6 remarks that this is not clinical in the traditional sense because she does not feel that the patient sees her as a medical person, does not use her directly but as a way to get something else or just doesn't know who she is. She does not have a presence.

So, you have the patient calling with questions, you have Home Health Care Nurse calling with questions, you have the Home Health Care office calling with certain issues about patients. I'm calling a lot of patients. I'm calling a lot of Home Health Care Nurses, some of the community doctor's offices, yeah... [I spend] collectively I would say, two or three hours [on the phone]. Some of the conversations are clinical. But most of the time, they're calling you to get to the doctor. So they don't really ask you questions. As a matter of fact for example, on Friday I had a patient call me because he needed a re-fill on some of his medications and I said fine. And I asked him how he was doing and he said fine. And he knew he was speaking to a Registered Nurse. A half-an-hour later the secretary from the physician's office called me and said, "Mr. Smith just called me and said that he's been dizzy and sweaty and hasn't felt right. Can you handle this call?" I said, "Well, I just talked to Mr. Smith and he said he was fine and I re-
filled some of his meds”. And she said, “Well, he told me he was sick”...so he called the doctor’s secretary to tell her he was sick but didn’t talk to me about it. (K6, p.3#2)

In the nurse’s view, the failure to develop presence not only contributes to the nurse’s sense of uselessness but actually turns her work into something other than nursing.

So, as far as out-patient is concerned I really do miss [direct care which allows the patient to see her as clinical]. And I, as much time as it involves, I enjoy the patient over time, because I get to get back into that because I enjoy clinical work a lot more than hostess, slash, I don’t know, appointment lady kind of tasks but kinda hostess work. (K6, p.3)

Physician validation combined with the nurse’s ability to seize opportunities to show herself as a “medical” person are important to creating presence.

So most of the time if you handle one medical issue then [patients]...start calling you. But most of the time they usually don’t initiate and “Well, my arms still kind of numb”, or, so I ask some questions just to get them kind of going along those lines. (K6, p.3#2)...But most of the time when I’m out there with my doctor’s services I probably work-up most of my own patients, only because for me as a nurse it doesn’t make any sense not to take vitals. I mean, it just seems like nursing has gotten away from a total, a total assessment. I mean, I would like to be, and it would make sense to me as a patient, you know, “why does that nurse take my blood pressure and that nurse ask about meds.” That would be very confusing to me so I try to get in there and do the total thing so there’s a bonding there and maybe they can see that I’m a clinical person and I can answer questions...I’m still trying to figure out how [to create a presence in outpatient]. And, you know, one of the start points is when they come into the clinic waiting area. You’re the one who gets them in, you’re the one who takes vital signs and talks to them about medications, allergies. Some of the doctors really would rather have you out of the room when they’re doing their interview. So as you get to know your docs, the doctor’s you can kinda pop in and out on, you know, you then become that doctor’s nurse. And if they need dressing changes then you get to do it and you bond even more with this patient and they not only identify their doctor in this clinic but... his nurse, you know. So, as much as I can do for the patient and if they have a lot of questions and they don’t really seem to understand how to get their medical needs met in the community as far a medications, supplies, so on and so forth, then I usually give them my card. And I just say, “Call me. I can help you out”. And as they do they get to know me and then it
becomes more, you know, of a wholistic practice as opposed to, “Well, I’m Dr. Smith’s nurse. Are you allergic to anything?” (K6, pp.5-6#2)

Nurses also identify that bonding is enhanced when there is an age similarity.

I just, um, when I think of people that I’ve worked with... the other thing about it is I see it as an age, I’m sorry to be an ageist...But I see a different level of presencing with nurses who are closer in age to patients. People just bond with M. These little old Ortho ladies just adore her. And these young nurses who are young enough to be her children do too. They all do it...And people just really respect, I think people are drawn to - it’s hard to be drawn to a nurse who’s young enough to be your granddaughter. I mean it’s fun to be around those young kids because they keep reading and pushing talents, our skills and stuff but, we’re drawn to people, I think, who are similar to us...On the other hand, then they turn around and they do it with each other. Everybody wants to be with A., we had 75 people at M.’s going away party - unbelievable! We just want to be with those kind of people. (K2, p.14#2)

[Patient she has known for 12 years]...he was a young kid around my age. He was hiking in Indiana, fell off a cliff and broke his neck at C2. He had this wonderfully warm, I guess I really strongly identified with him, it was kind of like same background. (K4, pp.2-3#2)

Another nurse can talk about how she builds her bonds with patients by honoring them with her memory of them as individuals.

And I have a gift of having a great memory for people’s names and their story and so it’s a great gift, that’s wonderful and they connect with you then...[They connect with me] and they’re shocked. I had a woman call me who we’ve only seen, I’ve seen once and talked to on the phone another one or two times but haven’t talked to her for maybe eight months and she called me up and I said, “I remember that you’re 40ish, you live in Lake Forest, you’re a nurse, you have a son with a brain tumor - she was shocked. And I think that also makes people feel better that they’re not lost. (K8, p.4)

The intention to help is an important part of creating presence. K1 talks about how intentionality helps the nurse to keep personal issues separate from the patient’s, helping her to ready herself to be present.
It means if I put my hands in your aura nothing’s going happen unless I have the intention to help you and that’s intentionality ... And you don’t always [connect]... sometimes you go into a room...like with chronic pain patients with just trepidation, trying to figure out how to get out real fast. We’re not always being Florence Nightingale but if you know that you can do this (communicate intentionality) then you can go into the room with the patient with chronic pain and it won’t bother you and you’re not in a hurry to get out and you deal with whatever you want to deal with. It makes a difference ... (K1, pp.8-9#2)

Creating presence has to do with defining the nursing role or identity in a particular setting.

I just think it’s important to create- it’s so hard, as a nurse in this clinic, I think, to walk into a clinic room when the patient is here for maybe a half-hour at most, and to define your role because sure they know you’re a nurse and you’ll take vital signs and, you know, if you need a bandage you’ll run and get it for ‘em. But I don’t think that they grasp the, the whole nursing role thing. They could talk to me about all the information about their, um, medication and allergy and pain and problems they have within the last month, so on and so forth, as well as they can talk to the doctor. Because I feel sometimes you walk in a room and you sit down and I usually introduce myself and kind of break the ice with like “cold outside?”, “boy that’s a pretty dress”, or something like that. But then I’ll start asking them questions and they’ll start giving me one word answers - yes, no, yeah. And then a doctor will walk in and they’ll open up about all these things that I, I could have gotten. So I think it’s real important to create a presence in order to define your role. I mean, who, who are you? (K6, p.2#3)

Being present with consistency and tangible purpose affects the nurse’s being known.

I really believe the only way you’re able to connect with anybody on any level is to create some sort - you know, I’m here and I’m here to do this and this is who I am and this is my demeanor or whatever, you know. So, I think in-patient wise it’s easy to do that because it’s part and parcel of just being there. You walking in at AM and waking the patient up, bathing them and dressing them and giving them meds. It’s like the nurse is very much there. And you’re there every day or three days a week. (K6, P.2, #3)

Later, K6 discusses how she creates presence:

I introduce myself, I tell them...I’m working with Dr. so-and-so and I’d like to ask a couple of questions, I’d like to run through your current medications and then, depending on the doctor, some of them are really weird about you being there,
when they're, when they're in the room doing their history and physical, but if they're O.K. with it I just walk in the room and I stay with em. And as much as I try (pause) I try to dialog with the doctor with the patient so I'm part of their conversation and unfortunately...more often than not, and I say unfortunately because I should be able to do it by myself, but unfortunately being a nurse, that validates who you are. If the doctor's asking you a question he says, you know, like acknowledging your presence to the patient. More often than not that validates who I am, in this trio, in this relationship. (K6, p.2# 3)

During a discussion about trust, K5 adds the external actions that she contributes to creating presence. Later in this same interview, K5 highlights how she is actually monitoring many things at the same time, asking simple questions but does this with total engagement to be present.

And you know, therapeutic use of self comes in really strongly in building a trust relationship. Your sense of humor, your sense to set them at ease. It's your being right there, answering their light promptly. Letting them know, "hey, I can support you, we'll do this together. I'm going to be engaged and involved in your process here." So, it all kind of meshes together...And also as you're interacting you are also, that other favorite nursing word, you are assessing. So, as I'm talking I'm also eye balling, how does he look today, is there anything that seems amiss? My gut telling me about how he's doing? So, it's not just asking how their day went...it's other stuff at the same time. Well it's also, [pause] well, it's also attuned to, while I'm here I can check the incision so I might as well get that done then I don't have to do that later...What else can I get done at once? It's also organizational kinds of things but you do have to organize... I don't know if I always pull it out [of my head] but that's what I'm doing...Your engaged, your totally engaged in what you're doing. And I know I'm engaging that person in conversation and I'm working toward a conversation, not always a heavy conversation, (Like K3 asking about life trivia, photos, etc.)but a conversation that's going to communicate with the person that I'm concerned about them, that I care about them and I'm here to make their evening better. So, things go on in multiple levels. (K5, pp.10-14)

Sometimes creating presence has to do with being quiet, patient, letting it unfold.

I really believe what people want is to be cared for and to talk to somebody, especially the older people we see. They come in and they don't even talk about their arthritis for the first ten, fifteen or twenty minutes. They just tell me about their lives or what's been going on with them. And so I don't interrupt, I just
listen 'cause I think that's what they want. We should give them what they want -
and what they need...it helps people in their life to feel that there's somebody,
maybe in an authoritative position that they can talk to or trust and validate them.
But you see it over and over that people just wanna be connected to other people
and we're safe. Maybe that's it. (K8, p.4)

Successful interactions defined as “being able to solve a person’s problems,”
cements the nurse’s presence.

For the most part, [I’m the first line of communication for the practice]. I think
when people get to know me, I mean the doctors give their business cards and so
then if they might get through to me, somehow, but once people know me they call
me first because they know that I’ll follow through in a timely manner. (K8, p.7)

So usually at the end of my clinic appointments though I cap it off with “here’s my
card, here’s my phone number. If you need anything or if you need to talk to the
doctor, please call me first. I would be the way that you would do that type thing.
And then they start a phone relationship with me for medical supplies, nursing
issues, what not. And then I become, I guess, a presence. Or, I become part of
the team then. Then I am, confirm that I am part of the team because Mrs. Smith
called me. (K6, p.3#3)

Although creating presence takes work, K6 states that outpatient is harder because
it’s more elusive. The physical care, which is more tangible, is absent.

Inpatient, you can, you can kind of skip through. Because you have what you
have developed and you can just kinda visit each one, each person, each
relationship. But here it’s like you got one shot at em. So you have to be there.
You have to be present, you know and if you’re not then they don’t know who
you are when they come in the next time they don’t really identify you and then
you’re lost to nothing. So, you really have to be aware of being here at all times as
opposed to in-patient. You’re tired, you’re having a bad day, you had a tiff with
one of your co-workers, the dog ate your best shoes, you know, something like
that you kinda just get to work and just get through because you know you have
the next day to kind of undercoat things. (K6, pp.6-7#2)

Interestingly enough, working hard to creating presence may be related to how
nursing has been defined historically and the social construction of women’s work. For example, other disciplines have acquired the attributes of power, offices, appointments, which say their work is important in our culture even though their roles may be just as nebulous.

Yeah. And I hate that [Nurse’s are real dependent on how others treat them] because any other business, any other professional up there kind of niches out their role...I don’t think [social workers] have to work this hard [to create a presence]. The physical therapist, occupational therapist see the patient one on one and they are, I mean that’s it, man. And they don’t have to work. “I’m meeting Anne at ten o’clock for my splints - I’m meeting so-and-so for this.” You know I never did think of it this way. God, I don’t know. Is it because, it’s probably a myriad of things dating back to Florence Nightingale and kinda what we were defined, ...you know, this caring angel of mercy - I’ll set aside my own needs to take care of yours type picture of a nurse. The less professional kinda picture - the hat with the stripe of the school you went to, um. I don’t think people look at nurses as independent professional women who are truly a part of the team, truly a part of the decision making. Even on a social level, if I meet people and they ask me what I do and I tell em, they say, “That’s so nice - how nice...I could never do what you do. So giving.” (K6, p.5#3)

In clinical settings where nurses have a tangible, physical presence on the patient care team there is less of a need for the nurse to work at “creating presence.” Throughout the interview, K6 cites examples from her experience. However, she also is genuinely surprised at the idea that she could assertively discuss her less tangible responsibilities in home care and make them more visible to the patient. So the work K6 has to do to create presence may be related to the lack of clear definition. She mentions in this interview that she never thinks to tell patients that she is involved in aftercare issues. Perhaps nurses participate in creating their own “invisibility.”

Yeah. And it’s like the nurse is expected to respond on an emotional level with the patient’s needs and the doctor walks in and says, “Uhum. Uhum. O.K. This is
what we’re going to do.” I guess the reason I say it’s important to demonstrate how competent, smart, efficient and professional you are, and then you’re in good standing and you create this presence... Because when I worked, I worked on neonatal ICU for four years and I want to tell you, you don’t work hard there as far as creating a presence because you’re so revered by parents, residents, Med students and Attendings because you’re given so much responsibility and you’re with your one to two babies all shift. And you’re the one that sees the changes, and you’re the one who intervenes when they start to crash first. And you’re the one who calls the code - the whole bit. Well, the unit I worked on was so open that the parents were just right there and saw everything. So you mentally didn’t have to do a whole lot of work, a lot of juxting for position. You were just there and just by the nature of your procedures and your tasks brought you that respect and that connection with your team. And you were clearly part of the team...there were...a handful of parents I remember, unfortunately. Their babies, I mean these were two babies that I was actually with when they coded so I called the code and started to run the code. And so in their eyes I was this incredibly great nurse then...But prior to that, “she’s good,” “she, um, she, she brought us back the pillows and blankets that we needed so we could sleep next to the crib.”...Why didn’t I ever think of it [explaining the outpatient role]? Just to come in and cut it out right there. I am the continuum of caretaker sent for you and the community. I guess because I thought if they come to this clinic and they understand it’s outpatient, that they would, that they should automatically understand what I do. (K6, pp.6-7,#3)

These conversations leave us to reflect on how and why it is necessary to explain to patients what nurses do. Nurses need adequate articulations of all dimensions of their work and the courage to announce them.

“It Depends on the Patient:” Expressions of Knowing and Why it Is Important

Knowing the patient is an important and satisfying aspect of nursing. Knowing the patient is vital because when disability (or any illness) changes a life, then the nurse must come to know the patient’s life well enough in order to be of help. In K2's words:

We put patients at the center ...because disability is life changing. And you’re going to live your life differently because you have this knee replacement now. I
hope you’re going to be a lot better than you were, I hope you’re going to be a lot more functional that you were. You may not, disability is life changing, it can be catastrophic. We had a young man recently who was an actor who had a bleed from an ADM, forty years old. He may never work again [or work] in a very different way than you had worked before. You’re not going to sing and dance on cruise ships any more, I can tell you that. But we put patients first because the nature of disability means that we all have to get involved in this. (K2, p.9)

K6, reflecting on getting to know a new practice area, comments on her value for getting involved with people. Several nurses echo this value.

[In the outpatient area] you don’t really get a chance to get intertwined in their lives and their family and friends. Whereas in-patient, as a nurse therapist, you were everything. And you talked to parents and you talked to friends and you got to know their wives and you got to know their fathers and mothers and brothers and sisters and you got involved in their lives. I mean you just couldn’t help but get involved. And, if things weren’t going well for that person I would - and I know that we’re taught not to - I would, you know, feel that. Or I would be with them in spirit or, you know, however you want to term it. But, you know, it’s not as draining on an emotional level, I think. And in that way I don’t like it as much ...isn’t that funny. (K6, p.6)

We all really know the patient. (K8, p.2)

but you hope these are people you get to know well, you establish relationships. You do a lot of teaching, their families, this and that and you usually feel a lot closer to your nurse therapy patients than other patients. (K1, p.12)

In discussing working with case managers, nurses express frustration because “somehow something always gets lost there because the case manager doesn’t understand exactly what the patient needs” (K3 p.8). In having to work with additional go-betweens for supplies, etc., control of the care shifts to others and “they haven’t even met the patient” (K3, p.14). This goes very much against K3’s value of particularizing to the individual and she finds herself also having to educate the case manager as part of her negotiations.
Knowing the patient is highly valued whatever the nurse’s responsibilities are. K8 responds to patient’s because she thinks people want to be “known”. She reports that her large caseload includes many individuals which she shares with another nurse. They keep each other informed for the patient’s good but not with checklists. In fact, K8 works hard to maintain a very personal style; by listening and remembering their stories in their own words:

I would say 300, 400 regulars and then maybe another few hundred that are in and out and [most of those people] I’ve seen once or had phone calls from. And I have a gift of having a great memory for people’s names and their story and it’s a great gift... and they’re shocked. I had a woman call me who I’ve seen once and talked to on the phone another one or two times but haven’t talked to her for maybe eight months and she called me up and I said, “I remember that you’re 40ish, you live in Lake Forest, you’re a nurse, you have a son with a brain tumor-” she was shocked. And I think that also makes people feel better that they’re not lost...’cause I really believe what people want is to be cared for and to talk to somebody, especially the older people we see. They come in and they don’t even talk about their arthritis for the first ten, fifteen or twenty minutes. They just tell me about their lives or what’s been going on with them. And so I don’t interrupt, I just listen cause I think that’s what they want. We should give them what they want - and what they need and it’s nice I’m in a position to do that. I think that in our world we are raised to believe that people who provide health care have, I don’t know, a certain knowledge or that they’re just somebody you can trust and connect with and bounce things off of. I don’t know how to articulate it except for - it helps people in their life to feel that there’s somebody, maybe in an authoritative position that they can talk to or trust and validate them - I don’t know. But you see it over and over that people just wanna, I think people wanna be connected to other people and we’re safe. (K8, pp.3-4)

K8 doesn’t just know about arthritis. She tries to understand how the person experiences it. In this way, knowing the patient becomes part of the treatment because the patient feels understood and valued. This knowledge directs the development of the care plan.
You don’t know how to treat somebody unless you know their life. I mean there’s just no way. You need to know if they’re alone or if they have support or what they want to do with their life. It’s a totally different thing if you have little kids at home or if you’re working or if you’re retired. So, I was talking to someone a few weeks ago and she was shocked. She said nobody ever asked her that before, and I couldn’t believe it. I couldn’t believe it cause it’s such a big part of who she is and the life she leads. (K8, p.4)

The idea is also supported by K7’s comments. They demonstrate that she feels a responsibility for not only the illness but also how the illness affects every aspect of daily functioning and the ongoing interaction between the two. Recognizing how her work is different from that of other care providers, K7 adds that her “mind set” tunes her into that patient’s simple everyday activities as her realm of attention “...and I kinda look at the little things that some of the therapists don’t think of. (K7, pp.6-7)

Physical care is an important link for the nurse in coming to know the patient. These nurses report a commitment to providing direct care even though it may not be “politically correct.”

[I feel I have to apologize for being interested in doing the physical care]...Because to the extent that you do that you can’t get your professional nursing responsibilities done. So in a sense, I think I told N, I would have been better, at a better equilibrium and more happy, if I’d just been a supertech. But a supertech doesn’t get paid near what a nurse does...[an ideal nursing role would include physical care]...Oh absolutely, because I think it’s all integrated and I think the fear here, and I agree with it, is that if you remove yourself entirely from the physical care giving I think you become less human and less humane and you’re not aware of the holistic needs of the patient and the nurse had been the bridge between the “in the trenches”, gut kinds of care giving on the one hand and the physician, who’s much more detached and works from a much more detached role. The nurse is much more in-between because she or he is a professional who really spans that whole gap. We have to be as smart as doctors, often as knowledgeable. As good at assessment, often better. Able to make decisions like a doctor. Yet we have to be as nurturing and intuitive and caring as a grandmother, a grandfather, an aide, an assistant, a tech. I think, I guess everyone thinks their job is the greatest, the noblest, most important. But I do see nurses as spanning a very wide gap. They’ve got to do it all and I think that’s good. I
think if you want to know what’s going on with a patient don’t go to a doctor, go to a nurse. The doctor has such a large case load, they’re only seeing every patient for a few minutes. The nurse is really there, informed. So I would want it to stay that way. I don’t know...It [knowing the patient] wouldn’t be the same if I weren’t giving those patient’s showers and bowel programs and medications and feeding them and rearranging the stuff on their table cause they can’t find things. Yeah, I would not want to loose that...I like to know people. I like to see what makes them tick and I’ve taken it as a personal mission, vocation to bring out the best in each person that I encounter... But I think when you see their not so glamorous side, you get to see the real person. Actually I think when a person is a patient, everything’s exposed. They have no privacy. It’s all hanging out--their fears, their hopes, their frustrations, and it’s a chance to really see them. They really can’t help (pause) but you know you’re emotionally vulnerable and exposed as a patient and that’s the time when you can really interact with somebody in a way to get to know them, and I think, bring out the best, let them know that you care. I didn’t want to walk into a room acting like “I’ve got something that I can give you. I’ve got something that I can do for you. You’re helpless and I’m in some way gonna make you better.” I always wanted to walk in with the attitude “Hi, we’re two human beings. We have a chance to interact. As you say, a win-win, and hopefully bring out the best in each other.” The best ones [care givers] who really care, know what makes a patient nurtured, feel comforted. When a patient’s having a really rotten day, the good medical personnel know what to do, whether it’s a certain way of brushing the hair, of brushing the teeth, or singing their favorite song. But you can bring out the best in them that day. And I think that is, first of all, I like that for its own end. I think it’s also the means to the end of the most effective healing. ...Boy am I really going on ---You got me going now. (G16, pp.22-23)

Sometimes the most mundane physical care provides an elegant route to knowing the patient, incorporating touch as a way of connecting. K2 also apologizes for mentioning this.

(embarrassed)That’s terrible...it’s [foot soaks] such a light example. I was a P.M. nurse before I went back to school...The very first patient that we cared for was a fellow who was a hit victim who was found on the street and was a John Doe. And through the course of his acute stay was identified and was the descendent of some famous family in Chicago. I can’t remember now what is was. And as a result of having been on the street had terrible, awful dry skin and this place is dry all the year round because of the way it’s heated and the way it’s cooled. And doing foot soaks using cooking oil is a long, long tradition here because it’s so thick. We do it with corn oil because it’s so thick, bath oil doesn’t work. And it’s just the way that we teach each other to do it that that really is a held tradition where - what we do instead of putting people’s feet in a basin is, for a lot of people who come here that can’t sit right away,...you oil up their feet and wrap them in
hot, wet towels and then wrap the hot, wet towels in something plastic that holds the heat in. And it's utterly practical and we've seen it work but it's something that so, almost trite, that we take it for granted. We order foot soaks on everybody that has even marginally dry skin because we don't want their feet to be cracked and bleeding because we have to move them. But to my mind those are the kinds of things - now, when our patients are called a month after they go home, "This is the Program Evaluation Department calling. I want to know how your stay was." Those are the things they remember... They really get a sort of whole patient approach when they come in. When we admit patients we look at their heels - we check all their potential skin areas. I think it's one of the last things we do really--- it's a touch thing... But there are not a lot of reasons for us simply to touch people. And especially with older people I do it a lot. The other thing that I do when I talk to patients in wheelchairs is I'll kneel, I'll sit on the floor or whatever. It helps me to be at their level so if I'm talking to a patient in a wheelchair I'm going to put my hand on her back, I'm going to put my arm on the other hand grip so she's in contact with me. And foot soaks is one that is done almost exclusively to help people feel better. If your feet are dry that's gotta be painful. And if your heels are cracked, they're going to bleed, they're going to breakdown, you can't wear shoes, you're gonna feel worse and you're gunna miss out on therapy. It's done really to be soothing. One thing about foot soaks... that first night when we had this guy. It almost has a spiritual feel for me. There's this Biblical idea about Christ and the disciples feet. We don't impose our beliefs on patients. But for me that's something that has a very spiritual feel to it. And if your going to take care of the whole patient, then you're going to have to pay attention to just how they're doing anatomically, the whole patient. Just for all those reasons. (K2, pp.10-14)

This research verifies the work of Zane Wolf (1988). It is clear that direct ministrations give nurses a special and powerful entree into the life of the patient and this role will not be set aside lightly. Perhaps the importance of this intimate contact is another reason why nurses resist delegating physical care.

Nurses often talked about reflecting on a personal experience as a way of coming to know and understand the patient. K7 see's her own illness as a disability and a chronic illness and draws a connection between her experience and the patient's.

When I was a Junior in college I had developed X disease. And I felt that it was a kind of a barrier - kind of a disability because there were a lot of people... one of
my instructors said "don’t even tell anybody." And you know, I found it to be very odd but, you know, I listened to a lot of people and took a lot of things. [In choosing a place to work, I wanted to be where I could see people growing from, I don’t know what the word is, growing from chaos? ‘Cause I probably felt that my life was a little that way, with my health. (K7, p.3)

She sometimes uses this part of her history to share with patients. She experienced it as an adjustment to disability and felt separated out because of it. The idea of sharing experience is related to the nursing commitment to education but is based in experiential knowledge.

I do sometimes [share my experience with patients]. Not always...I don’t tell them unless it’s something that happens, and I have had a reaction or something like that and they’re like “Oh, you are?”... sometimes if they’re discouraged something I try to help encourage them or maybe work a little differently about their diet and that kind of thing...Yeah, that comes into play. (K7, p.4)

Further, nurses report trying to get as close as possible to the patient’s experience. The study participants often gave evidence of knowing patients and families extremely well and for long periods of time, often maintaining relationships for years after discharge.

I put myself in someone else’s shoes going home, thinking “what will it be like if I’m this patient and I’m at home by myself, can I do it” (K7, p.6)

Yes, twelve years [is my longest relationship with a patient]. He was our first ventilator- dependent, he was on a phrenic nerve stimulator. He was here 12, maybe 13 years now cause I was only here for a few years when he came in. And, he comes back every now and then - he lives in Indiana and we probably talk to one another every three or four months, send each other cards and letters at holidays...part of the reason that the patients come back is because of the ties that were built while they were in-patients and they’re stopping in to say “Hi” and maintain those relationships. Our nurses, including myself, have maintained relationships with patients for years, and years and years. I have a separate list, a Christmas list you know, you know I always get letters from patients and I always send - I mean there must be, I don’t know, 70 people on it over the years. (K4, pp.1-3#2)
Getting to know people in the patient’s world is included in this requirement to know the patient. In this way, the nurse learns about pre-trauma lifestyle and adjustment responses.

So your focus is on Johnny’s physical needs, of course, first. But your second, even I think equally important, is for the parents or the friends or the spouses, too. You know, they have to heal too. They’ve been through a trauma. So you could be a big, big, big part of that. You could be a part of letting them vent. And then when they’re done with that kind of chaotic kind of anger phase, you could be there to answer lots of questions. You can be there to show them that other people have made it in the same circumstance. So, you know, you, if you really want to get invested and you really want to be there, you can have a big part of helping them heal. (K6, p.9)

It is important to see each family member as an individual and get to know them separately because of different reactions to illness and educational needs. K7 follows and talks about “the process.” Families and patients talk about the outcome. This is a judgment she makes about family adjustment. She feels she must address this to get them to engage in the process. She is diligent about seeing each patient and family member as an individual and to come up with approaches that individually connect with them.

and people will tell me, "well, no, but I don’t need to do that because they’re going to walk". And I go, and you say "yes, but its going to be a process"...And they don’t hear it all the time and maybe that’s good, a little bit of it’s good. But for the person being responsible for doing the care it’s not good. (K7, p.12)

Knowing patient and family is also putting together a set of facts about people and situations. Often this information is gotten in very simple ways... small talk, if you will.

K7 offers examples:

When I’m talking to the family I ask them questions like, “well, do you have any stairs, how is she going to get to the bathroom, where’s the bedroom” because I want to know, you know the therapist doesn’t always think to order a commode or
things like that, you know. And if the person doesn’t have a bathroom on the first floor they’re practicing the stairs again but how many stairs is it going to be and can they make it, [how many times a day] and is there urgency. (K 7, p.10)

The following passage reflects the depth of knowledge the nurse brings to this situation in which only the patient, who is the head of the household, speaks English. She strategizes to gain information and transforms her cultural awareness and knowledge of day-to-day needs to work on an action plan.

Now the man that I just sent home with the virus who’s a quadriplegic basically, he’s bowel and bladder continent but in order to go to the bathroom his wife has to lift him and put him in a commode chair. And she’s this little woman and she has four children under fifteen. And I sat down with him for a half hour and I’ve been working with him for three months. And I said - they have no family here. They’re from Mexico, and her family, their family’s all in Mexico. And for three months I’ve been saying “You need the help of friends.” They don’t have many friends. They have a few people in their building that they know and he had to go up two flights of stairs so she got neighbors to come and help her carry him up two flights of stairs for a day pass. (K7, p.12)

She becomes aware of a complicated communication problem. The wife can speak only to a Spanish speaking nurse who then talks to K7 about her fears, all the while telling her husband that she is fine. K7 takes risk and confronts the husband. So her work includes communicating with a whole network around this family, being culturally aware of dynamics in Spanish families. K7 “puts herself in the wife’s shoes” and extends herself to understand the family situation.

She’s got a four year old, a ten year old and fifteen year old and I think she’s got an 8 year old and a dependent husband at this time, who she loves very much...And she looks wonderful but she only speaks Spanish so that everything I did was translated from him to her. So what happened was she was calling our one nurse who speaks Spanish and being totally frustrated and saying like “the letter didn’t get to the work and they’re not going to pay the bills.” And she was like three times in one week ...Well, the other nurse told me eventually and I’m like O.K. So
I sat them down. I said, “you know what, your wife is telling you she’s OK, she can do it and she’s not.” And I told him, I said he wasn’t wealthy but I think he could hire somebody like two hours a day a couple of days a week. I said, “you really need to hire somebody.” And his benefits don’t include like a Home Health Aide for dressing or bathing so she’s going to do everything with these four other kids. And I said, “you have four children, whose taking care of them”? “Well, they can help.” So he kept telling me this for three months. I kept going over and this last day I sat down and I said, “You know what? Your wife is telling me she’s gonna do it.” And I said, “Uh,uh,” I said, “You have to make the decision. You have to tell your wife “No, I’m going to hire somebody.”” And he still goes “no, no, no she tells me she’s O.K.” I go “she will tell you she is O.K. She’s never going to say to you she can’t take care of you because she loves you and she wants to take care of you and she’s not going to make it if you don’t get her some help.” And he just kept looking at me and I said “Nope, you are going to have to be the one to make the decision. You are going to have to say “Wife, I need to get you a little bit of help.”” And I don’t know if he’s going to - not for sure...(K7, pp.12-13)

How Do Nurses Get to Know Patients?

The study participants offered surprising insights to this question. Nurses talk often about using small talk, multi-tasking, layering information and a style of knowing, which nurses call “seeing” but not with their eyes. These ideas provides a fascinating perspective on what may be a nurse’s arsenal of investigative skills that are limited by the word “assessment.”

Study participants describe their work as requiring them to understand people, really know them from more than just a psychological standpoint. Yet, nurses describe seemingly simple approaches to accomplish this goal.

[ “Invisible” work is] not just the interaction. I think part of the interaction, yes, the interaction with the person. And also as you’re interacting you are also, that other favorite nursing word, you are assessing. So, as I’m talking I’m also eye balling, how does he look today? Is there anything that seems amiss? My gut telling me about how he’s doing? So, it’s not just asking how their day went...
other stuff at the same time... Well, it’s also attuned to, while I’m here I can check the incision so I might as well get that done, then I don’t have to do that later... What else can I get done at once. It’s also organizational kinds of things but you do have to organize. I don’t know if I always pull it out but that’s what I’m doing... You’re engaged, you’re totally engaged in what you’re doing. I’m lucky...[I can do several things at once]... I think some of it is from years of experience, I do it automatically, so I don’t always stop and think "gee, this person’s color is this, this, and this,... but I know I’m doing it. And I know I’m engaging that person in conversation and I’m working toward a conversation, not always a heavy conversation, but a conversation that’s going to communicate with the person that I’m concerned about them, that I care about them and I’m here to make their evening better. So, things go on in multiple levels. And so in the middle of all that someone comes up to you and you say “Hello Mr. X, how are you?” and then you have a third thing going on... and then [a fourth, ...a sixth]... And that’s part of the challenge of it.[trying to gather and sort information over time]. That’s part of what I was getting at - the richer role. But, you do build on what you’ve seen and you do love the consistency with the same patients... That’s one of the things I like about Rehab patients. they’re here long. It’s not two-three days, then they’re gone.[You can’t do that in two days]... Not the same way, not building on that same data collection, as you put it. But it’s that recognition that you are doing some data collection each time you’re with a patient. And there again, I think that’s something that sets the experienced nurse apart from the new nurse that doesn’t always have the larger picture so her interactions are not going to take her there and, you know the one interaction, hence the boredom factor might set in quicker then because she doesn’t have the perspective... I love working with the little ladies and one of the reasons I love working with them is that they’re hard to establish trust with. They come in so anxious, so dubious about everything and fearful that it’s always a challenge to build up that trust relationship with them. And, so I always kind of relish getting that patient in. Now, I don’t always think about it but it’s, I’m going to accomplish it. Huh. And it’s one of those that occurs after multiple interactions with them... And you know, therapeutic use of self comes in really strongly in building a trust relationship. Your sense of humor, your sense to set them at ease. It’s your being right there, answering their light promptly. Letting them know, “hey, I can support you, we’ll do this together. I’m going to be engaged and involved in your process here.” So, it all kind of meshes together. (K5, pp.10-14)

The same almost simplistic approach is described by K2 when she discusses following up the work of occupational therapy and physical therapy.

Yeah, it was something that I never really thought about that I was specifically doing. Sometimes you just listen... You just talk to people and see how it went.
You look at what they have now that they didn’t have yesterday in terms of equipment. And I always ask people, that’s something that I learned right after I started down there, if you need information, ask the patient. Those kind of things but there are a lot of ways to find out from patients what they’re doing... Ideally, on a good day, it will go through on report, too, some assessment of how the patient is doing functionally or, in most cases, it’s what they’re not doing. So it comes from nurse to nurse. There are a lot of ways. It’s something that I think as nurses learn over time, as you continue to work with patients, you learn what they’re capable of. And you know, we used to teach it in orientation, you know, “what to expect from right-hemiplegics and left-hemiplegics.” Some of it is theoretical and some of it is just experience... You’d have some sense about the continuum of care... And you pick that up from looking at the patient, from looking at the chart. For a while, we had all manner of signs plastered above the bed of every patient on the unit. Just a lot of different ways of swapping information. (K2, pp.8-9#2)

I asked K8 about “seeing” as a theme in the work of nursing. Before I could finish, she shook her head in agreement and said “Nurses don’t ‘just see’, they know someone -- the patient is in the state of being seen." (K8, p.1#2). She adds:

[Associates with “seeing”]. The word that comes to mind is “mindfulness” it come from a meditation class I took. It means “to be alive.” Being mindful means being in the present, being awake.... For me it was more like learning to be just in the present... K8, pp.1-2#2

Seeing is presented almost as an alternative or adjunctive assessment style in the next three examples.

I do think what the nurse does, ah, a lot of times is that she brings a more complete perspective of the patient and the family than anyone else on the team seems to get. Um, we see the patient twenty-four hours a day and we see what they’re like. At their optimum and at their lowest points. And we also see the family members, you know, at various points and at various stages of their coming to grips with things and learning about their family members disability. And all that’s a good thing. You know, I think, um, you know other than the advocacy that we do for the patient and family and the education and the support that we do for the patient-family, we also I think have probably the most complete picture of them. (G5, pp.2-3)
There are no boundaries between you and the patient. There's such intimacy - many times more intimacy between a patient and a nurse than the patient or the nurse may even experience in their own personal relationship. They, you hear about things, you see things ...seeing with your eyes, seeing with your touch, the way someone moves under your hands, your assessment is, is your doing something with that individual - just how their body feels under your touch, how you can see their body tighten up, you can read the expressions on their face, inflection in their voice that you can see so much more than the other folks who do - than everybody else can - because they have so many things between them...[I mean] seeing as far as all of your nursing assessment types of things. Using all of your five senses...part of it is knowing, a lot of mine is gut, unfortunately, and that's one of the biggest problems of nursing... Knowing and gut, because you can't quantify it. There's some of those folks who like quantifiable data. It's a hard thing to quantify. (G15, p.8)

K1 talks about different types of knowledge:

I think that it all comes from the right side of the brain... but maybe each has its own little area and I don't know what I do. I don't understand it yet but I think whatever understanding I come to will come from energy fields...I probably keep it [seeing things differently] to myself. I know I don't communicate that. I do report anything psychosocial that I notice, that's always a big part of my report to the next shift...(K1, pp.8-9)

K3 describes how she knows "how to deal with [patients]," "dealing with"

referring to creating this highly individualized recipe of care, by saying:

I don't know. It's just something I learned somehow by dealing with the younger male patients. I think I'm the type of person, I grew up with a younger brother who I very much, I mean I babied him terribly, so even if he was kind of selfish, or whatever I just would deal with him. You know, that's my brother and that's the way it is, so I think it's that kind of relationship. If a patient is really moody, if they're in a bad mood, that's O.K. I'll just deal with it and we'll keep on doing what we have to do to get him to therapy and get on with what needs to be done. And so, I know a lot of nurses can't deal with the moodiness or somebody who has just been really mean, they get really upset and they just can't handle it but I say that's OK, let's just go on. (K3, p.6)
These participants demonstrate that they have reflected on the range of reactions to injury and can conceptualize them as such.

Some people become so depressed that they don’t even think about the future; they try to deny that there is anything wrong and that they’ll be fine in a few months. And then other people are just really motivated and they work really, really hard in their therapy and it just seems that nothing is going to get them down, they’re going to get back to what they were doing before. (K3, p.5)

Notice how K3 moves in her work from the concept of depression, to the action she will take to intervene. In the process she performs thinking work that requires both intellectual and intuitive acumen and the ability to apply what she knows about people, the individual patient in particular and necessary treatment and system strategies, to a real life situation.

So you have to, it depends on the person how you deal with them. If someone is really down, you have to make them focus on their therapy and just push them a little bit. You have to learn how much to push too, because sometimes if you push too far then they’ll become angry and they won’t do anything. (K3, p.5)

In a later interview, she expands on this “knowing” and describes the informal ways she has developed to accomplish this. Note the relationship between increase in time spent, knowing the patient and flexibility.

If I hadn’t been involved with that patient before and I kinda need to back-track and see what has been done [time with insurance companies would go way up]. It’s very important. I mean if I don’t know the patient I just feel like I have to wing it [a surprise discharge] and I don’t know what they need ... what kind of things they need before they leave...How do I know their needs...I just go and bug em!...Well, and I also just go in there and I do, I like to do care for them. You know, like I’ll just be in there, you know, and if they need help with a transfer I’ll start talking to them, you know, and I’ll look at their stuff that they haven’t even learned and just ask them about pictures or different things, a lot of times you get that [person’s pre-morbid personality] from families, too. You know, families will say, “Well, you know, he’s been lazy even before this so that’s why he won’t get
out.” So, yeah, you kinda try and find that out, after you’ve gotten to know them a little bit. (K3, pp.8-9,#2)

With the words “it depends on the patient” this nurse reflects a process type of thinking. She doesn’t say “if you have a patient with depression” which denotes a diagnosis. She says “If someone is really down”; almost assuming that “being down” is a part of the process, a step along the way. K3 must then do thinking work to figure out how to continue the recovery with this particular contingency in place. The nursing work is not static. It is a delicate business finding again the special recipe of intervention, time and amount; always monitoring, modifying, the plan; grounded always in the basic rule “it depends on the patient.”(p.5) How she knows the patient as a person becomes the basic rationale for any particular action. This is why she talks about how difficult it is to help someone get ready for discharge when she does not know the patient as a person.

If a nurse makes intervention decisions based on “it depends on the patient” then there is a presupposition that she holds, unsaid, that she must invest work time in getting to know the patient. Nurses talk formally about assessing the patient, developing the therapeutic relationship. These are more formalized constructs that define sets of actions that nurses perform in their work. It seems that, in K3’s definition of nursing, knowing the patient may have more to do with how the nurse picks up information about the patient and the families, a myriad of detail, comments, interactions over days, scanning, if you will, for information. Next the nurse puts it together in a picture that contains her knowledge of the person, which is never finished because people are always “in process” especially as they proceed through a traumatic injury recovery.
Boundaries

How well nurses know patients raises the issue of creating boundaries. These two nurses incorporate learning from experience and appreciate how much more effective they are when they establish clear boundaries.

Well, I went from the emotional, jumped into the spiritual part. One way that I use it is that it helps me to see behaviors in patients... whether its health behaviors, their attitudes or actions toward health or just the behaviors that are difficult for us to deal with and understand. It helps me separate that and get a different perspective on it and then you can deal, it’s easier to take but you can deal with people on different levels. (K1, pp.7-8, #2)

in the beginning I think I became too involved with the patients by doing too much for them. So I’ve learned a lot from that too and I can distance myself a little bit better knowing that helps the patient a little bit more. (K3, p.4)...a lot of patients do call. This was a problem originally when I was younger. I would have them call me at home ‘cause I wanted to know how they were doing. You know, I would worry about them and I would give them my home phone number and then I learned that that’s just not good. And so I tell them just to call here if they’re having any problems. (K3, p.13)

K3 calls the process learning to “distance herself” but this does not really mean to create a distance between the nurse and the patient, but to find “the right” amount of space for this more mutual relationship to establish itself, where the nurse is not drained, the patient is not smothered, the relationship empowers both. I think it takes skill in assessment and knowledge of the patient in the fullest sense of the word to allow such a relationship to be established. It also requires that the nurse monitor the relationship for a change in patient needs, modifying it over time. Perhaps we can appreciate how much change the study participants experience in their work with patients and the possibility that it is not possible to maintain a level of caring while dealing with an unstable work environment.
K7 spoke of several nurse-patient/family relationships. The comment which follows is from the patient that she confronted about the need for household help for his wife. According to K7, when patients are in a state of being “known” the outcome is positive:

And when he left yesterday he told me, it was cool, he told, he said, “thank you for being supportive to me and for really listening and helping me.” And I felt just for that one line it was very nice...That’s where you get your little bits of pats on the back. (laugh) Besides patting yourself on the back (laugh). (K7, p.13)

Knowing the patient in the aggregate sense makes nurses valuable resources for program design. Really understanding special needs and then responding to them with sensitive services acknowledges that the staff takes knowing the patients as an important responsibility.

And we have a special [gyne exam] chair here for the disabled...It’s not a platform table that you have to climb up on. It’s an actual chair that folds up and out. So all they really have to do is simply get out of their wheelchair or crutches or walker and just sit down in a chair. And then the chair itself does the rest of the work. Yeah, it’s real nice. And I think it also, for the disabled women I’ve seen so far, they’re much more comfortable in this setting as opposed to going to someone’s office. Because usually the waiting rooms are too small, the halls are too small getting into the rooms. It’s real, it’s difficult for them and has become real embarrassing because office staff don’t know what to do as far as getting them onto the table or trying to help them to get on to the table and so forth... It really helps out with care. [Women return even when their rehab needs are decreased] I find women that are a lot more functional than being in a wheelchair, I find that if they’re just using a cane or one crutch, I find that they come back because they’re not only comfortable because they know our desk staff and nursing staff but they also bonded with the doctor real well...And the doctor put some extra effort into bladder, bowel things that maybe, uh, I don’t want to say a normal Gynecologist but, an office - an outside office Gynecologist may not encounter these difficulties. Ah, if someone comes in with a rash well they might want to culture them up and all that and the first thing we ask is, “How often are you incontinent, do you leak, what level is your cord injury?” Cause it could be a simple rash from just leaking and not, you know, cleaning up enough. So I think that they come back because they just bond so well with us. And our office visits are a little longer. They’re
usually like an hour, a hour and a half. So the three of us in that room in that time period get to know each other pretty well. So I think they do come back. They just like it here. (K6, p.2)

K6 gives an example of how important "being known", is to patients.

We do it all. As a matter of fact we currently have our first pending birth, I guess. A thirty two year old with cerebral palsy - she’s having her first baby. She’s married to an able-bodied man and she came to us and she was six weeks pregnant when she came to us. And instead of choosing to be seen at Prentiss and be followed next door, she’s chosen to stay here with us. So it’ll be, it’ll be really nice to see how that all, how that all pans out. (K6, p.2)

Several participants mentioned the down side of knowing the patient. They sometimes find themselves in conflict with the rest of the team because their understanding of the patient’s problems actually differs from the other members of the interdisciplinary team. Also, study participants were very troubled by how much time and environment interfere with the nurses’ time with patients. Nurses mentioned division of labor, paperwork and system breakdown as the most obvious interferences. As K8 sees it,

Well, I think it’s kind of an ideal nursing position [her current position] because I think this is what nurses want to do and nurses go into nursing because they want to care for people. But, I believe that the system that we have, the health care system, does not promote that. But I’ve been able to find a place where that’s what I can do. I mean I think that your average nurse wants to do it most of the time but they can’t because they have to do what they have to do [which is dictated to them] ...because I’m kinda of on my own... But, the way the system is set up there is so much documentation nobody’s going to read that doesn’t help the patient and people can spend more time documenting than they can in actual patient care and I think that’s what nurses want to do. They want to be with people. (K8, p.14)

Overall, nurses seem to have knowledge learned from books and another area of knowledge that comes directly from knowing patients and their experiences. Nurses seem
to have an ability to adapt what they know from the books with what they know of the
patient. K2 agrees that this is both a remarkable and important skill.

Are you talking with A.? She’s the best at it. She knows so many things and just
brings this presence. Oh! the patients feel so good when they’re with her. You
see patients go like mellow and I think that’s something that you get better at as
you practice. (K2, p.12#2)

Once again, K5 reminds us of the definitional dilemma before us based on the
social and political opinions of work.

I mean hospitals are not going to function without nurses. Period. But the
question of valuing the nurse above and beyond her technical skills and getting the
treatments done, meds passed, the I.V.s hung - all that kind of business - that’s
more of a bigger question. If they’re valued for that relationship and those
assessment making skills and those problem-solving skills; that’s what I’m not sure
their valued for, you know. The bottom line is that patient had a better day
because that nurse has been there. I’m not sure the hospital is looking at it that
way...(Nor is the culture) I think the average person on the street would say “Yes”
nursing is important to them but it doesn’t translate into any pressure on Congress
or any political pressure to do anything about it...And in some ways when we learn
to toot our horn then, as the whole feminist movement and the impact of course
that’s had on nursing, probably we’re caught in a little catch 22 in that the whole
concept of relationships puts us back in some ways into a traditional women’s role.
And so we don’t want to (thinking) We’ve been stressing our knowledge and our
high tech capabilities and all that and so some of this talking about the out and out
essence of patient care, relationships, gets lost. (K5, pp.1-2#2)

Working the System: Knowing What the Patient Needs and How to Get it

Most nurses can relate to K8’s story about calling for trays and supplies. This is
an area of common experience, making the system work for the patient. The idea has
negative connotations because it is associated with system omission and filling in gaps in
care. However, it is quite clear that nurses seem to carry a mandate to act in these
situations because of a commitment to care for the patient. The work seems to require
knowing the workings of health care systems and being able to negotiate their culture and politics. On an interpersonal level, working the system requires a basic understanding of the role of other health care staff and persuasive communication skills to help them join in to work on a problem.

K8 offers us the best example of the dilemmas which confront her in the process of working the system and being face-to-face with the patient when the system doesn’t work. Although K8 wishes she did not have to own this work, it is both cerebral and intentional.

“I’m like a detective in some ways and it’s very social. It’s just, I really have to think, really, really have to think.” (K8, p.11)

In the next examples, K8 describes two different settings, traditional inpatient and outpatient, where she must get needed patient information. She demonstrates her ability to adapt strategies in response to how the organization works (or doesn’t work). K8’s adaptability presumes the capability to perform system assessments. She is not lacking for a different way to put herself to use therapeutically when she finds herself in another system that, in her opinion, works more efficiently. These stories demonstrate K8’s very systematic, tenacious approach if it’s important for the patient.

I just had to clean up other people’s messes...it was like being a waitress but I delivered other things [in-patient or out-patient]...Although there is more that can go wrong in-patient - I mean there’s more misery in-patient. But it was the same thing, working in a clinic and, you know, weighing people and checking their blood pressure. I remember checking somebody’s temperature once... it was 102 and the Attending asked the Resident to take it again. I mean it was so insulting, I couldn’t believe it. Or, er, I mean having these oppressive loads and then having - feeling so alone and not having administrators who help and not having transporters who come and pick up specimens or the medical records don’t come and there’s the nurse who’s face-to-face with the patient and that’s, I think that’s
bad. But what I've been able to do, I think since 1981, I mean there have, there are always those messes to clean up, nothing's perfect, but not to spend so much of my time doing that - more in relating to people and delivering what I hope is high quality health care. (K8, p.11-12)

K8 goes on to say that she would plan this differently now. K8 would make lists, look for patterns and do more strategizing. As a young nurse, she was too overwhelmed to see the “whole” situation and only saw and acted of incidents individually. K8 goes on to describe her experiences with system problems in outpatient work:

There aren’t as many messes [here] ‘cause what I used to do was I was a clinic nurse at another facility. So my job was just to get the patients ready for the Attending to see...So maybe I had to do that with 50 or 75 people a day. And so if we didn’t have their chart I’d try to get it or I’d have to try and get their blood tests. Whereas now maybe I see at the most ten people and some other - well, the systems work better here than they do at [other facilities]. So if we happen to not have their lab work I just go the computer. So it’s not a big deal. I don’t have to be on hold on the phone so the systems work better and then I don’t have to clean up as many messes... people might call in and it’s not that the system messed up it’s just that maybe the person had their lab work done somewhere else or we didn’t get a copy of it, it went to somebody else and so I have to find it...I call that um,[tracking the lab work] getting the patient health care because we don’t know how to help them until we have that information. So maybe some people would think that that wasn’t their job - that wasn’t a nurses job - but that doesn’t bother me at all because I’m delivering good health care to this person and that’s part of finding out what’s wrong with them. And I also think I can do it effectively because I’ve been doing it so long I know how to find out what’s going on and I can get things...And I can articulate it. I’ve done it so many times I can articulate exactly what I need and then take the person’s name and extension and if I don’t get it - now we have fax machines! So they send it over right away and so then I know if it happened or not that day. So those things don’t bother me. (K8, pp.11-12)

Solving Other Department’s Problems

K8 reflects on her time in inpatient which she described in her first interview with the words: “I found that when I was on the floor, I was so busy calling for trays that didn’t
come up or medicine that didn’t come up from the pharmacy, that we didn’t have towels, that we didn’t have enough blood pressure cuffs, that I spent so much time an energy doing that so I could care for people that I really didn’t do what I wanted to do.”

You do it because you’re the last guy... You can’t ignore it, who else would do it? But the problem should be fixed. I’m unsure [if nurses should] but nurses do fix them. Nursing fixes it when it impacts them and their giving of care... I’m not sure [if it is nursing work] but nurses do it and [they should be paid] if they do it... What is the nomenclature for reimbursement? Problem-solving; solution provider? Solution provider I would name it... I think of nurses as the “mom” of the organization. [This work is] making up for what other people are not doing... I don’t have to [do this now] I have everything I need. (K8, p.1,#2)

K8 expresses the dilemma many nurses find themselves in, feeling responsible to get involved in work that justifiably belongs in another department. However, nurses take such work on partly because they are highly effective at negotiating systems on behalf of the patient. Nurses will ultimately follow the imperative to insure a patient and family focus. However, they readily relinquish these concerns if they have what they “need” to deliver the care the patient deserves.

Perhaps this area would be less problematic for nurses if it was reframed as an area of expertise and valued as a nursing skill and asset, integral to the patient’s progress and health, instead of being rejected as “not nursing work.”

Work the System and Stay Put: Behind the Scenes

K7 offers a story that is cited in other parts of this chapter because it provides insight to many of the findings of this study. However, it is included in its entirety here so that the “flow” and process can be appreciated. K7 clearly portrays how a nurse will
design elegant practical solutions for a challenging patient, brings the plan to fruition against considerable odds, only to give the credit to another provider who claims the outcome.

Once again the story begins with how K7 objected to the team decision and is left to deal with the consequences. In this case, K7 felt it was more important to send a patient home with the correct wheelchair rather than have him return to the facility for it. K7 shows how her work involves a concern for the patient’s response. In this story, she wins the battle and loses the war. K7 tells how she tries to put together a hurried discharge but with the correct equipment. Bear in mind that K7 is simultaneously trying to prepare the wife and mother of the family to care for the patient in their home, two hours away from the discharging facility with less than optimal medical support. As discussed earlier (p.15), K7 demonstrates in her story complex analysis skills and the ability to operationalize solutions, referencing the comprehensive aspect of her work in getting a person and family ready for discharge:

But I had another patient who, let’s see, he needed a really specialized wheelchair and they were going to bring him back and have him fitted when he came back and they wanted to send him home with a trial which didn’t fit him at all. And I said, “you can’t send him home,” because for him - he was so dependent here - for him to come back here just to get a wheelchair I thought was totally absurd and they kind of pushed a little further at it and I’ll never forget, the day of discharge the wheelchair was delivered at different times, in different boxes, in different pieces...Now I’m the nurse doing all. I have an excessive amount of teaching to do, like he had a G tube, a J tube, a TAC, he had all this stuff, so I’m getting my supplies and final teaching with this notebook full of stuff for the family ...and I see this wheelchair coming in pieces, I was so angry and I called the therapist and I said “where’s the whole wheelchair?” and she said “well they’ll put it together.” I said “who’s going to put it together?” “Well, seating and positioning.” I said, “well do they know it’s coming?” “Well, they’ll find out.” I go, “How are they going to find out? It’s being delivered to the unit.”...So I was like the mediator.
and nobody knew that I did that, O.K...The team leader that day was like calling me - I don’t know how many times she called me - and I said “I’ll take care of it. “Because she knew absolutely nothing about it...And I said, “that’s O.K., I’ll take care of it, I know kinda what he’s supposed to get.” (K7, p.7)

While doing work for other providers, she also assures the wife and other nurses. Simultaneously, K7 searches for answers with few resources for herself. K7 takes on responsibility to just get it done. She covers for the therapist and tries to cover the gaps in the discharge work. As the story continues, K7 draws a contrast between how the therapist was in a particular location, unavailable because of a scheduled time to do therapy. This is protective of the therapist, while K7 is “all over the place.” The work configuration gives nurses more freedom to react to situations. However, there is a burdensome consequence for the nurse who essentially has less autonomy to control interferences in her scheduled day.

But, I had no idea there were so many pieces, I didn’t know. I wasn’t the therapist who ordered the chair. The therapist was busy doing her therapy at this certain hour because she has scheduled times. I’m all over the place, you don’t know, I will never forget how many times I called and the wife would call me and say. “Nurse, is the chair there?” And I’m like, “I’m putting it together” and she was so anxious ...So by the time they came to pick him up it was together, but had I not, I’m telling you, had I been off that day, he would have gotten all these pieces of wheelchairs, you know, and I...that day I worked my butt off and those are the things that nobody will ever know... Nobody will ever know that I did that except me. And the family was appreciative of course...But, I mean, the things that would get by-passed if we weren’t really looking at the whole person and how they’re going to manage. (K7, p.7)

In fact, K7 is looking at the whole in a very detailed way. Referring back to the inpatient care for this patient, she recalls his complicated “tubes.” K7’s work included communicating about these tubes so there would be no errors.
So, I had signs all over the room because we had nurses who didn’t know this patient at all, pulled from other places and if you put something in the wrong tube - so I did little signs, I did extra notes in the care plan, I did um, and I mean those are things that are necessary for the care,... making it happen, that’s exactly what it is. (K7, p.8)

She tells how she talks to the doctor raising questions about real life management, again raising the who, what, where, how questions to operationalize the patient’s care:

I kept talking. “Doctor,” I said “what if it [the tube] falls out at home, what is she going to do?” No one’s going to know how to do this, I mean this case, this was a really, a really, I mean no one has ever seen a case like this, I mean I think we, there were two people who had this swallowing disorder and that’s why you needed these tubes and there’s like one article of literature written on this, O.K. So I said, “Well what if this comes out?”...He’s like two hours away from us. He’s medically not going to be followed here except just for rehabilitation but internally, medicine not around here. And somebody from a small hospital out there knows absolutely nothing about this. (K7, p.8)

She makes her case with the doctor and, functioning with some urgency, pushes for some unique interventions. K7 is still involved in every detail and takes little credit for the creativity, for supporting the family, or for the political and interpersonal savvy necessary to pull this off. She worked hard convincing, coordinating and obtaining whatever was needed.

So, the morning he was leaving the doctor that I work with came down, we got all these sutures and we got all these things and he made a special suture and I went down to the supply house down here and I said we need sutures. “Well, we don’t have it.” I had to call Northwestern, I had to get it sent over here. They didn’t want to because it’s like this thing that we never do. Central Supply didn’t want to...So I worked a long time to get that thing coordinated, so this woman had the sutures, the needles and she knew how to do it. It was being sutured, we ended up suturing it to a cookie that we use around an ostomy bag. So it was an ostomy attachment. (K7, pp.8-9)

K7 claims that the physician “taught” the wife about this new attachment. He did the visible part. Her work is less obvious. She seems to be preparing the stage, calling up
the actors, bringing in the props, even positioning them at times. When asked about this K7 readily gives away the credit and de-emphasizes her role.

[The doctor] sutured it and he showed her how to do it so that if anything would happen she would be able to do it. So if it came out that area would have closed really fast. (K7, p.9)

We happen upon another "intangible" in the course of conversation when K7 mentions that she was talking to the wife who was at home just a week prior to the interview:

She called me - yeah, there's another one. (laugh) [another "invisible" activity]. You got it! ... You're right. This is a case. She called me because when she comes back for her outpatient re-checks they come upstairs and see how I am... she is the wife...

Now K7 reveals who the defined patient is versus who she is taking care of. K7 shows concern for the whole family and develops a strong relationship with them which continues beyond the hospital walls.

She is the care giver who has two children and this husband... The patient is the husband and she comes back and we talk about things and she's called me a couple of times because she's upset with his not being as motivated as she would like him to be or the tube fell out. (K7, p.9)

She continues to provide information and provide a bridge to the physician. The physician acknowledges her in this relationship and also connects with the patient, perhaps because he hears the nurse's concern.

That was one day so I think the Doc was off that day and I called him at home, y'know. And he was O.K. because this was a case that I just couldn't refer to somebody else. You just cannot, nobody else - and the guy who was covering for him at Rehab, I was explaining it to him, he was like "huh!" So I said [I called the doctor that I worked with]... Just to say this is what happened, what do you think
and what should she do and I told her this. And he said, “that's good. That’s what we'll do.” And then he called her anyway to make sure that she was O.K. (K7, p.9)

If a nurse is discharging patients two hours away, it is obvious that some very important knowledge must be gathered about the family's living circumstances. K7 describes the process she uses to get the necessary information, the resources she calls upon and the topics she brings up. Notice again that K7 begins with highlighting what someone else does. It is the Social Worker who is in the visible role of asking these questions. Later, she talks about how she (sort of) instigates the social worker and then goes directly after certain types of information. K7 impacts the timing of family work.

In conference the social worker will pretty much ask patients' questions [about home] and, you know, about social situations, how this is done... Yeah, it's pretty much in conference. But actually, actually I make it a point with the social worker that I work with, I used to work with one but now we're kind of all over so I used to like everyday stop in her office and say, “Here's our list of patients together, what's going on?” To find out like where she is in discharge planning and she usually contacts the people to come for teaching or I'll say, “well listen, I'm gonna call because I need to see them sooner or they need to hire a care giver because this person's not safe to be alone or they need supervision” and we discuss these things in conference, too. It's kind of a team thing pretty much. (K7, p.10)

Throughout this story, K7 allows us to see how she monitors the care process and instigates the involvement of the right mix of people and resources. In a way, she very delicately holds the reins in her hands and she never lets go. K7 insures that what happens to this patient and family will not escape her oversight.

**Brokering: Getting What the Patient Needs**

The last set of examples suggests the nurse's considerable skill at negotiating complexity when provoked by an overriding concern that the patient will suffer negative
consequences. K3 offers her perspective. She is a nurse who has invested in developing a "special recipe" for each person being asked to work with a standardized protocol. She resolves this point (with the institution's blessing) by increasing the time and energy she places into "brokering" for days with the insurance company.

And I have one patient right now who is a para and the insurance company said, "well, he's been here too long, he's a para, he should be long gone." And they want him out of here now but he's... he's an individual... 'cause he's very, very slow. But they don't see that. And so, he has too much in transition and so we luckily, we still do go on a person to person basis... and so we ended up having a fight with the insurance company. Our doctor will call the insurance company, buy a few more days, so - that's, I think that's just the way it is. Our doctors honor our team. (K3, p.3, #2)

K3 describes a strategizing function that she performs to insure that her patient's needs be met by enlisting alliances with others. She also demonstrates her understanding of power and how to access it in light of the political nature of the decision making process surrounding discharge.

I mean we can say, if we don't feel comfortable [with the discharge], we always go to the doctor. The doctor is the one who ultimately decides when they go home... if the team when we all got together we decided that no, we really don't feel comfortable with this and somehow our doctors can say they'll talk to the insurance company and then talk to each other and somehow work things out. But I mean I feel comfortable with the way our doctors decide the discharges and so...[They will support me if the patient's not ready for discharge] So that makes me feel good and I feel comfortable with that. And they know it's so frustrating, it's frustrating for them to.(K3, p.9)

Note that this function, although described in brief by K3, would naturally require considerable time in formulating, explaining and clarifying, essentially building a case in support of the patient's needs. The necessary conversations would be time consuming as well because K3 would be having to locate all the involved parties as well as present the
case formally in conference. The communication would take place formally and informally representing the important communication systems in any organization. All of this is left unsaid.

The issues raised in this section are often not seen as significant skills by nurses because they are not obviously clinical and are seen as personality based. Yet the words of K1 are reminders of how dependent the health care system and patients are on the ingenuity and interpersonal skills of nurses who keep the system working. In the next example, K1 talks about what she does to get what she needs for patient care. She tries to teach other nurses even though they don’t always accept it.

Maybe I’m more Irish than I ever thought. There was a nurse, it wasn’t today, maybe it was Monday, just recently, who’s calling pharmacy for medication that he didn’t have for his patient. And I told him the way he was most likely to get pharmacy to deliver it to the floor because they are very quick to say “Well, you have to come down and pick it up” and I know the rules. They’re unofficial rules, well sometimes they’re official. If we run out of a medication and we should have known ahead of time to order early, then they won’t deliver it except with they’re usual time. They won’t bring it up right away but if it’s a stat order then they should bring it up right away. Then there’s some things in between, there’s some gray areas and I’m pretty good at getting it. And then it was that same nurse, I think, who needed something from Central Supply and I told him how, I mean I practically tell him what to say because Central Supply is better at bringing things up when you ask for it. They’re not likely at all to say you have to come down and pick it up unless they’re real, real busy, then they’ll tell you. So I told him, actually coached him, “Ask them how soon they can bring it and if they say they’ll bring it right away, fine and if not ask them if they can chutec it and if not tell them it’s real important.” It’s just telling them how to get them to do what they’re supposed to do. So that’s what I mean by manipulation...It could be but most people are either awed by what I do. I mean they say “You are,” they’ll notice, they’ll finally catch on they’ll say “You are so-o manipulative” and I think a lot of them like I said they’re just too serious. It’s playing a game...It’s a game and it’s fun and a lot of people won’t do that and years ago, even when I studied here, nurses were more like that... They knew how to do it, it was part of their confidence. They didn’t think about it as a game, maybe or maybe they did. (K1, p.4#2)
Bridgework: the Art of Connecting

Nurses do not keep their knowledge of the patient’s needs and their knowledge of health care systems separate. For nurses, such knowledge exists to serve the patient. The section on bridgework allows us a glimpse of some of the ways that nurses in the study made connections where there previously had been none. In some cases, the nurses may have simply made a phone call or set the stage for interventions to be performed by other providers. In other cases they may actually build the bridge themselves as K7 demonstrates in her story. It is probably fair to say that there is more bridge building going on since patient situations are highly affected by rapid change in length of stay and treatment protocol. Such changes require nurses to develop new strategies to facilitate rehabilitation. The goal of “bridgework” is to create a positive outcome in contrast to some of the examples in “working the system” that are defined more in terms of system omission. The section begins with a synthesis from an interview with K3.

As a nurse therapist, K3 defines several types of work that she performs for the patient beyond the hospital boundaries in an attempt to anticipate discharge needs and set up necessary resources besides “any nursing issues that need to be done—you know, the bowel, bladder, the skin. Like if someone has a tracheostomy, we teach them how to suction and deal with the tracheostomy” (K3, p. 7). K3 is the go-between, connecting with people who can arrange equipment and supplies. After determining what’s needed based on the physical care needs (“Any nursing issues that need to be done”), K3 investigates the who and where for ordering, delivering and payment.

K3 connects with all team members and represents the patients in conference. Her
work must involve understanding the language of occupational and physical therapy, medicine and social work as well as having some knowledge of team/group behavior and how to influence others. She has a special relationship with social work because of their frequent contacts with the insurance company case manager. K3 is the main communicator for continuity of care be it with family or home care nurse. Consequently, she must have the necessary background knowledge to make sense of information she receives from all of these people. Nurses in K3's position carry a burden for accurate and complete communication with others; for the discrimination to know where it needs to be delivered and how to modify the care delivery in response to the information. All of this is summed up rather off-handedly as “So, what a nurse therapist does is just help the patient throughout their whole stay here, get ready for discharge and teach the family” (K3, p.7).

In her own words:

I’m a nurse therapist and also a staff nurse. Right now my role is changing because I’m becoming more of a nurse therapist, more of a full-time nurse therapist... so, what a nurse therapist does is just help the patient throughout their whole stay here, get ready for discharge and teach the family. Any nursing issues that need to be done, you know, the bowel, bladder, the skin. Like if someone has a tracheostomy we teach them how to suction and deal with the tracheostomy. And also we send them any supplies they need when they get home. You know, the family orders that. And we all get together as a team, occupational therapist, physical therapist and the doctor and we all get together and talk about how the patient is doing and what the patient needs and how the family teaching is going. And we get together with the social worker because they need to help us get together with the insurance company... The social worker has to call the case manager and then they’ll let us know if they need a home health agency at home. If the patient needs a nurse at home then we’ll coordinate all that and we’ll get nursing and therapy at home. (K3, pp.7-8)

K3 is somewhat ambivalent about her work in making connections with insurance
companies, case managers, and supply companies. Making connections takes up a lot of her time but she tries to justify the activity as a service to patients. K3 feels she must monitor the decisions of the connecting groups in the patient's best interest.

We order the supplies—well it depends on the case manager because sometimes the case manager will say "Just fax me over the list of what they need and I'll call the supply company." They have to shop around. They have to get prices on everything and what's the cheapest place and they have their network of supply places that they use. And you know we've used certain companies for a long time and we feel comfortable with the... they're reliable. Apparently the company we're comfortable with is a little more expensive than others so it depends on what they [the insurance company] decide, whether we can use them or not. And then there's some nursing agencies we feel comfortable with especially with ventilator-dependent patients and with one patient I was going to discharge home the, I can't remember the insurance company, what the deal was, but they wanted us to use someone else and I say, "Oh, no. I want to use this company because I know that they can handle a ventilator patient and it will be safer." They'll probably be less expensive in the long run. (K3, p.16)

K3 is never sure her new role is effective or if she has any impact on outcome.

[Prior to initiation of case manager] I was just able to make more decisions on my own. And I felt like I had more control of things and I was able to make sure the patient was able to get everything they needed. And now I'm not really sure they'll get everything they need and I don't know if they are going to get their supplies on time, if they're going to get the therapy at home they need on time when they're supposed to get it. (K3, p.8)

The change in her role is precipitated by an institutional response to changes in insurance company decision-making and the resulting decrease in length of stay. This serves as an example of how changes in the external health care environment and the institution effect the work of nursing. K3 offers the following evaluation of how her time is spent so as not to underestimate the amount of time she spends dealing with insurance companies. Note also that increments occurs in both the amount of time she does "nurse
therapy work” which is the “take care of everything” work as well as the amount of time she spends working with insurance companies.

Well, I think that [my role is changing now because] insurance companies don’t, I think they’re questioning the need for so much time in rehabilitation, that seems to be a major problem... The reason they [administration] wanted me to become more full-time (as a nurse therapist) is because patients are being turned over so fast. We are sending them home so fast we need one person who can deal with this very fast discharge... Well right now I’m doing nurse therapy work... I’d say about 80% of the time [and I’m] dealing with insurance companies... a good 60%. With the paper work we have to send them, everything’s, yeah and that’s why my role has changed to become more of nurse therapist so that I can deal with all the calls that we get. ‘Cause I’m also, I have my nurse therapy patients but then I’m also helping out the other nurses who aren’t working all the time but they still have nurse therapy patients. (K3, pp. 9-10)

This change in the nurse’s role can be attributed to a system response to the decreased length of stay. However, it does serve to make this aspect of bridgework more visible by formalizing it as nursing work in aftercare. K3 agrees that her role in this situation is to be a part of case management, monitoring the care process. (p.10#2) G5 validates the work in aftercare:

And you need to make sure that that information gets to where it needs to go, usually in the chart. And if there was something significant then we would talk to the Nurse Therapist about that cause that’s the feedback the Nurse Therapist needs. Nurse Therapist does - they not only are the sort of the Primary Nurse for that patient but they’re also responsible for the planning of care, the education of the patient and family and the discharge planning for that patient from the time they’re admitted through probably shortly after discharge. We don’t follow-up much after discharge but we usually hear from them shortly after, sometimes I should say. But we will plan for the home health or the out-patient follow-up, whatever it is. Ah, we’ll get that ball rolling, we’ll get them plugged into the appropriate places. And usually the first couple of days after discharge if they have a question they will call us, you know, before they establish a real relationship say with home health or whatever... We often do [represent the patient’s needs]. I think we do represent them, support them or advocate for them or all those things. Um, but I think again that also we can see them in a more complete ways that
often other members of the team, they just often don’t get to enjoy that much perspective. (G5, p.3)

Bridging Between the Patient and an External Specialist

In another type of bridgework, K8 identifies special anxiety in a woman and intervenes:

I had a lady who was an 84 year old lady, everybody she knows is dead... really, really anxious. So anxious she can’t think. And she’s seeing us for her back and has a lot of back pain and now she has a mass on her lung and she just doesn’t know...should she go to this doctor, what’s he going do -this pulmonologist, so I made a three way phone call with her to this pulmonologist’s office. Now that’s not my job but I know that this lady is all alone, her anxiety is affecting her arthritis and her pain. (Phone rings.) And the, you know I’m a warm, caring individual and I’d like to help her so we made a phone call to this other office and we talked on the phone and we got things straightened out. And, she ended up going to him. She couldn’t make her mind up about what she wanted to do. She just couldn’t think because she was so nervous so now we know she has T.B. instead of cancer and all that and now things are going along. And had I not made that phone call, things probably would have gotten settled eventually but this way it was a week or two sooner and it’s going to help her get better faster...I think [it is] because nursing looks at the whole person and I know I’m supported in this because I used to say to V.B., who pays me, her cost center pays me, you know, we’re not making any money from this. And she said, “Well, maybe we’re not but we’re saving health care dollars and that helps society and I don’t care if we’re bringing in money, it’s important to me that we treat people like this.” But the other way that I, I might not bring in money but I free her up. I mean, there are things she might have to do but I can do them just as well as her and then she can do other things and bring in funding that way. (K8, pp.12-13)

Bridging Between Patient and Others Who Share Illness Experience

And I just saw him [a former patient] and he’s back at work part-time, walking and he’s O.K. You know, pretty much O.K. And so sharing that with these [current] patients - we’ve also had patients come back, people who have recovered to whatever degree, and talk to other patients. (K7; pp.4-5)

In this comment K7 describes being a conduit between the recovering and the recovered. She has knowledge of recovery from both her own experience and the
experience she has observed at work. At work, K7 can serve as a “bridge” between the person’s experience and the experiences of others; bridging and connecting bits of information and people. She distinguishes this type of work from patient education by her purpose which is to create hope.

Never thought about it [as patient education]. Um, maybe it’s a plan to meet the goal of patient education. Maybe it’s like (thinking of it as) sharing my experience with other patients, like, you know, whatever little bit I can share. Um, it’s like a plan so like the patient will have hope. I don’t know if I explained that O.K. but that’s what I see it as. (K7, p.5)

Bridging Between Staff and Difficult Patient

K1 connects with people at many levels, sometimes not understanding how. She is aware of her positive effect on people and also bridges a variety of problems between patient, staff, and physician.

When I have these [difficult] patients I know that I can work with them and get things out of them other people can’t. I can get along with them. When I try to teach other staff or give them ideas about how they can work with these patients I’m trying to manipulate them...I really think it’s the best I can do because they [staff] don’t understand that person. They don’t like them. They don’t want to have anything to do with them yet they have to go work with them. So I’m trying to find ways just to make them do the things they have to do and not have it be so difficult for them that they avoid the patient. And maybe even be therapeutic with the patient to boot but it’s real hard for people here. It’s not a Psychiatric unit ‘cause a psychiatric unit would be a piece of cake. Everyone [in psychiatric work] wants to know, “How should I talk to this patient? How do you act when you’re in his room? What do you do to get him to co-operate?” But people who are here all the time don’t want anything to do with that. So I’m trying to tell them “Alright, just go in and tell them you’re going to do what you have to do” and I don’t know, its...I do that. I try and to manipulate everybody so they just get along well enough. So that they just go in and work with the patient...and I’ll get the psychologist to come in to a meeting and hopefully then there’s a psychologist who can talk on a casual level, in a casual way with staff and not be too heavy, real theoretical so yeah, we need psychologists for purposes like that. (K1, p.12)
Bridge Between Disciplines

K7 tells a story, figuratively describing how she sits in the middle of the discharge and functions as a communication hub, fielding calls from staff and family. Throughout the story she adds details about how she bridges between nursing staff, family, physician, and other departments..."the team leader that day was like calling me. I don’t know how many times she called me, and I said ‘I’ll take care of it,’ because she knew absolutely nothing about it...And I said, ‘that’s O.K., I’ll take care of it, I know kinda what he’s supposed to get.’" (K7, p.7) K7 continues to provide information and provide a bridge to the physician. The physician acknowledges her in this relationship and also connects with the patient, perhaps because he hears the nurse’s concern.

That was one day so I think the Doc was off that day and I called him at home, ya know. And he was O.K. because this was a case that I just couldn’t refer to somebody else. You just cannot, nobody else -and the guy who was covering for him at Rehab, I was explaining it to him, he was like “huh”! So I said [I called the doctor that I worked with]... Just to say this is what happened, what do you think and what should she do and I told her this. And he said, “that’s good. That’s what we’ll do.” And then he called her anyway to make sure that she was O.K... (K7, p.9)

Connecting Family Needs, Supplies

The details of K7's story, although discussed before, also have relevance here as examples of bridgework.

He’s like two hours away from here us. He’s medically not going to be followed here except just for rehabilitation but internally medicine not around here. And somebody from a small hospital out there knows absolutely nothing about this...So, the morning he was leaving the doctor that I work with came down, we got all these sutures and we got all these things and he made a special suture and I
went down to the supply house down here and I said we need sutures. “Well, we
don’t have it.” I had to call Northwestern, I had to get it sent over here. They
didn’t want to because it’s like this thing that we never do. Central Supply didn’t
want to...so I worked a long time to get that thing coordinated, so this woman
had the sutures, the needles and she knew how to do it. It was being sutured, we
ended up suturing it to a cookie that we use around an ostomy bag. So it was an
ostomy attachment. (K7, pp.7-9)

Bridging Between Reality and Family Wishes.

In the case, the nurse does the work necessary to make a difficult thing happen for
both the patient and the family.

And I had one patient who...probably could have used Hospice actually and I
could not imagine the son learning all the care; it was a son, it was his mother. He
was going to take her home. He was just married and he was going to take her
home and he said “I can do it”. But he never did anything. And I said, “No, no,
you have to come in and I want you to turn her, I want you to change her, I want
you to get her up in her wheelchair. I mean he would go to therapy and he would
do one transfer and he’d say “I can do this”...she was a very large woman and she
was getting more and more weak. She had cancer, more and more weak, and
transfers were tough...So I set up a day. I gave him a list of things to do that I
wanted, ‘cause I can’t stay with everybody, and I tell the staff that this person’s
coming in and I want him to do whatever he would have to do if he was alone.
And you can help him and you can guide ‘cause he doesn’t know how to do it but
I want you [to let him do it]. So, after two days I asked him “Do you think you’re
going to be able to do this alone?” “Well” he said, “It’s going to be really hard
but I really want to.” I said “OK”. So, I think we had a family meeting then and I
told him all the things that he’d have to do and he had experienced it and then I
said, “Well, what do you think about a hospital bed,” because he didn’t think he
needed one before. There was no way he could sit his mother up without the use
of that electrical bed. And he said O.K. And so he did. So I’m you know, it took
a lot, a little extra time because he was adamant and the therapist said “Oh, no, he
does fine with transferring.” And I’m like “Yeah, but this is going to be ten times
a day. This is not going to be once. This is going to be rolling her ten times a day
to change her diaper when she’s wet. And then we ended up putting a Foley in
...(K7, p.11)

In this case, the K7 goes beyond psychological adjustment issues. She creates an
experience so that the son can understand, on an experiential basis, what he must do. K7 uses this approach to insure that the son will make an informed decision.

Bridging Reality and Family and Patient Expectations

Study participants talk about the high expectations that families have of the facility and the staff. In addition, the slow time frames necessary for rehabilitation often run counter to the "quick fix" American culture. Consequently, nurses are often pivotal in helping patients and their families to reframe their expectations in a hopeful but realistic way.

Yeah, they don't like it [hearing about reality]. And people will tell me, "well, no, but I don't need to do that because they're going to walk." And I go, and you say "yes, but its going to be a process." People think that when they come to our facility they're going to stay here until they're walking. It doesn't work that way and that's something we have to address a lot, you know. You're going to make certain goals and then there's other things, it's sub-acute or it's home therapies or whatever. And they don't hear it all the time and maybe that's good, a little bit of it's good. But for the person being responsible for doing the care, it's not good. (K7, p.12)

An example discussed in the section, "Knowing the Patient," also has application here. K7 shows how she bridges family needs and patient expectations. Of course, this type of bridgework presupposes that the nurse has a good knowledge base and relationship with the patient and family. In this regard, the nurse must have the desire to take some risk. In the example, K7 is dealing with a bilingual Spanish family but the wife can only speak Spanish. K7 uses persistence and a steady focus on the whole family's day-to-day needs and tries to create a successful home arrangement to preserve the family's health as well as the patient's recovery.
So I sat them down. I said, "you know what, your wife is telling you she’s OK, she can do it and she’s not." And I told him, I said he wasn’t wealthy but I think he could hire somebody like two hours a day a couple of days a week. I said, "you really need to hire somebody." And his benefits don’t include like a Home Health Aide for dressing or bathing so she’s going to do everything with these four other kids. And I said, "you have four children, who’s taking care of them?" "Well, they can help." So he kept telling me this for three months. I kept going over and this last day I sat down and I said, "You know what? Your wife is telling me she’s gonna do it." And I said, "Uh,uh," I said, "You have to make the decision. You have to tell your wife “No, I’m going to hire somebody.” And he still goes “no, no, no she tells me she’s O.K.” I go “She will tell you she is O.K. She’s never going to say to you she can’t take care of you because she loves you and she wants to take care of you and she’s not going to make it if you don’t get her some help.” And he just kept looking at me and I said “Nope, you are going to have to be the one to make the decision. You are going to have to say “Wife, I need to get you a little bit of help.” And I don’t know if he’s going to - not for sure. (K7, p.12-13)

Failure to Bridge Patient/Family

In the next story, K7 gives a clear example of how the failure to connect with the family costs money, wastes time and negatively affects quality. The story includes a common dilemma that nurses face about how the change in financing is sometimes cost-focused to the point of ignoring individual situations. The dilemma highlights why the nurse’s work is necessary.

We had somebody who speaks Spanish only...Admitting said we should hire somebody or [the family] should be in. Well, the family chose not to come in. Then we didn’t have, well we weren’t going to hire somebody for $60 an hour. We can’t have that option anymore. It used to be, well maybe it was simpler before. So it took us almost five days to get somebody to come in. Which this woman with speech - we were totally, we did not know if she was aphasic or not...’Cause she would answer the simple things we could say in Spanish, you know, there’s a few staff members that helped out a little but what a waste of time. (K7, p.4, #.2)

From a discussion in which K7 explains how she would institute her “ideal” system if she could change health care we can infer her concept of bridging. In this discussion K7
outlines how she identifies significant information, who she talks to, and where a nurse needs to be present. She describes junctures in a web she travels, picking up, building and delivering impressions of the patient and his care. Notice, K7 mentions care in the hospital and afterward; she bridges the hospital boundaries. She calls it “looking at how the patient is doing here in order to get the patient home.” (K7, p.1 #2)

...But a nurse on a unit, say following a doctor [different than following him to attend to him], which is pretty much what we do a little bit of, and that nurse would be in charge of discharge planning but also kind of managing the care on the units; like looking through the reports and going to the conferences, going to the team meetings, going to family meetings and that’s pretty - that’s kinda what I do now except it would be more focused on taking the staff nurse and bringing her more in to the daily teaching of rehabilitation where activities of life are done more with physical therapy, occupational therapy and the nurse on the unit...with this other nurse who’s looking at how is the patient doing here in order to get the patient home, so that would be a different goal, ya know, but you have to meet the same short-term goals in order to get to the long term goals which is home, independence or some sort of sub-acute [facility]...(K7, p.1#2)

K7 is aware of how decreased length of stay is affecting the discharge process. To compensate she tries to fill in the gaps with more teaching and by writing more extensive discharge plans but this is an area critical to a successful discharge. K7 implies that there are judgement decisions that she cannot pass on easily and she is not entirely satisfied with the arrangement. She suggests an alternative that effectively provides a bridge for continuity. In the following example, K7’s reflections give evidence that she is aware of system impact, both positive and negative. Her thoughtfulness demonstrates that she can accommodate to system constraints.

[we could] have a system maybe where we had a nursing agency that worked more with us for discharge, like a nursing agency that employed nurses who knew rehabilitation well, who knew bowel and bladder, like the neurogenic bowel and bladder, that kind of thing, who specialize in it more, because people are leaving
sooner and it takes, it takes three weeks to regulate a bowel program. Ya know, they can do that, people are going to go home ... People are going home with drugs that we used to taper here but now they’re going home. People are going home on IV’s. But I think that would be good. And then to have the Visiting Nurse be able to report right back to the doctor who sent the person because they’re our place, you know, and they know rehabilitation. I also, I think like a rehabilitation doctor who would go off to homes once in a while and check things. (K7, p. 2)

A lot of bridgework takes place over the phone. In fact, the telephone wire was the image used by K6 to symbolize her work. This example describes how she is used as a bridge to home health and aftercare.

[I call] patients, home health care. For some reason, the Home Health Care Nurse, it’s like they usually can’t resolve a lot of issues. There’s very few who can. So the Home Health Care Nurse uses us, the Out-patient Nurse, as, like a resource and a referral and all this stuff. So, you have the patient calling with questions, you have Home Health Care Nurse calling with questions, you have the Home Health Care office calling with certain issues about patients, so, you’re, yeah, I’m calling, I’m calling a lot of patients, I’m calling a lot of Home Health Care Nurses, some of the community doctor’s offices, um, yeah, there’s a lot of ... Collectively I would say, two or three hours [a day on the phone]. Some of [the calls are clinical] but most of the time they’re calling you to get to the doctor. (K6, p.2#2)

The nurse’s responsiveness and flexibility are counted on to provide this service.

Telephone communication is common for the inpatient nurse also because patients are more likely to call them with questions until they are comfortable with outpatient providers. K8, an outpatient nurse, talks about how she reworked her schedule so patient calls where not waiting on her desk when she was off. She now takes calls at home because she doesn’t think people should have to wait and it prevents problem escalation.

In this example, K8 describes phone calls and bridgework.

This summer was tougher [than past 1-2 years]... I think there were fewer phone calls for a while. I think people went on vacation but some of the time I might have twelve phone calls a day. If they’re medicine refills it’s easy. But if people have problems then it’s kind of hard ‘cause then I have to call around and then I
have to get this person and wait for them to call me back, blah, blah, blah. So there’s a lot of things, there’s a lot of things?...[I’m the first line of communication for the practice] for the most part. I think when people get to know me, I mean the doctors give their business cards and so then if they might get through to me, somehow, but once people know me they call me first because they know that I’ll follow through in a timely manner. (K8, p.6-7)

Carry-Over Work

One of the most subtle areas where nurses provide vital connecting work occurs in the practice opportunities they provide for patients. The opportunities are follow-up to the work done in treatment sessions by other disciplines. K4 agrees that nurses function as extensions of the work of others. She states:

I was thinking about the glue that is nursing, that was the other area that I thought of but didn’t say, is that they [the patients] can learn it in therapy but until they live it on the unit and modify it on the unit and do it over and over again under the supervision of nursing and the cuing and the helping of nursing it doesn’t really become integrated in what they do.

Interestingly K4 classifies this as patient education and says “and that’s very much related to that cuing...what I was talking about that we were teaching eight hours a day. You are always doing that,” (K4, pp.6-7#2) Nurses actually extend the work of others in this way but, of course, the other disciplines get credit for the outcome.

Although many participants discuss this, K2 provides us the exemplar which she calls “carry-over work.” The work includes four parts: following through with the teaching of others; knowing what is going on with the patient in order to communicate it to other staff; the return loop, seeing how the patient is doing with new learning; and, helping the patient incorporate new procedures, process and equipment into his life.
K2 quickly recognizes the description of what she calls “carry-over work” meaning carry over of the things that the rest of the team is doing. The patient goes to occupational therapy and learns how to use a splint and sits through one meal. At the next meal, it is the nurse who supervises additional practice. The nurse provides a similar function for physical therapy and speech therapy. In some cases the patient meets one-on-one with providers for counseling. Unpredictably, some time later, the emotional impact of his situation registers. Of course, the nurse provides follows up for counseling as well offering emotional support. “Carry-over work” is an example of the simultaneous, integrated work that nurses perform.

It’s different when everybody leaves at 5:00 on Friday and the week-end nurse is left to put all those pieces together...physical therapy leaves, occupational therapy leaves, can’t find the patient’s leg brace...Or the patient knows, “I’m sure I have my built up silverware handles. I’m sure they’re in my backpack. My occupational therapist gave them to me, you have to find them.” Yeah, I see that as a real turf of nursing and in what I’m doing now in terms of rehabilitation, that follow through ability...I see it as a skill of nursing, I think it’s really important. Another piece of that that gets left behind is that physical therapy, occupational therapy never find out about how the patient’s doing on the floor unless the primary nurse is in and she’s really astute. For people like B. and M. B. and some of the other people who have been around a long time and doing the full-time nurse therapy role where there’s a lot of interface between the nurse and the rest of the team, it works wonderfully. And those therapists always know how the patient is doing when they’re not around. [The nurse will communicate] this is where they are, to bring that back [to the staff]. Otherwise the occupational therapist sees a different picture. And the nurse’s role is to be sure the patient is carrying over what they learned. If physical therapy is teaching the patient how to transfer with a sliding and we’re using a Hoyer Lift on the unit, we have a big learning problem. We’re losing a big opportunity for the patient to learn the skill and maybe for the family, too. ‘Cause if they only come in from six to eight at night when physical therapy is gone then it’s up to the patient and us to make sure that they [the family] know how to do the transfer or they know how to do the skill that maybe the therapist has talked to the patient but somebody’s got to give it to the family as well - hugely important role of nursing. (K2, pp.6-8#2)
To call the carry-over function simply communication would be an understatement. In fact, K2 identifies that in order to do the carry-over function, the nurse must have theoretical knowledge, experiential knowledge and a more subtle knowledge which she describes as “part of it is learning to interact with patients.” You go around to the patients and ask them how their day was. I used to ask patients how yesterday went cause I’d leave at 4:30 and they wouldn’t be back yet.” (K2, p.8#2)

What K2 describes is a complex data gathering system that includes patient reports, staff comments, knowledge of how the disease process behaves in general, balanced against how this particular patient is experiencing it, as well as having a fairly in depth knowledge of what other treatments would be standard for the patient at this time. The nurse must have a knowledge of the overall continuum of care. She pieces all this data together to get a picture of the patient thus forming a backdrop for her interventions with a particular patient. K2 concurs that the nurse moves through the environment with the patient on a particular shift and collects information as she goes along, then she has to do some kind of analysis. Simply stated in her own words:

And you pick that up from looking at the patient, from looking at the chart. For a while we had all manner of signs plastered above the bed of every patient on the unit. Just a lot of different ways of swapping information...You get information from report, you get information from your own assessments, from what the nursing assistants and technicians give you, from everybody else on the team. There are a lot of sources of information coming in and it’s up to you to do with them what you need to do. (K2, pp.8-9#2)

The art of creating these bridges is best produced by nurses who take on this mantle of information and understand how to do with it what they need to do.
Flexibility, Responsiveness, Mutability: "the Mix"

The participants in this study definitely had a unique view of their world. In the previous sections, we discussed examples that illustrated and clustered around particular aspects of work. These were presented as separate but intertwined melodies created by nurses describing how they work. In this section, we will look at three aspects of the nurses worldview that seem to enable them to accomplish the types of work they describe. Perhaps these aspects act as the sound synthesizer, modulating and balancing the melodies until harmony results.

These aspects are neither philosophical nor cognitive but they definitely represent a particular "mind set" that nurses often refer to which informs and directs their attention. The mindset seems to be characterized by the nurse's ability to translate the patient's situation into day-to-day terms; to consider the repetitiveness of activities of daily living in care planning and to continually look at the whole person and family but to do it in a detailed way. It is this kind of unique thinking that the nurse uses to synthesize information about the patient to "make it all come out right." Nurses discuss this mindset by saying things like "But, I mean, the things that would get by-passed if we weren't really looking at the whole person and how they're going to manage" (K7, p.7) and "looking at how the patient is doing here in order to get the patient home" (K7, p.1#2). In the previous section on bridgework, K7 offers many examples that hint at the realities of how she does discharge planning, a process which reflects making specific stepwise plans that deal with the who, what, where, and how of everyday life.
Responsiveness

Responsiveness is another aspect of “invisible” work. Responsiveness is different from psychological support although that might be the resulting intervention. The purposes achieved by the nurses’ responsiveness are "value added." In this case, the nurse listens to the patient verbalize, clearing a path so that the patient’s time with the physician is optimized. Again, the nurse does the preparation but the outcome is credited to the physician.

Because, in a way you’re like a buffer between the somewhat frustrated, angry, or depressed out-patient, ‘cause now they’re home, they’re in the world and they’re, and I would say 90% of them are very depressed and disillusioned and kind of feeling like they’re not receiving any respect or support from their care givers or environment. So, you’re the buffer between them and their doctor; them and the out-patient management. Um, kind of like this board that just stands at the door of the Clinic room and you’re just kind of catching it all. And then when the doctor walks in, they vent it and they’re ready to talk about their medical needs. (K6, p.1,#2)

Several nurses talk about how nurses must be a “jack of all trades” (K4) and “solution providers” (K8) and wear many hats:

We have a Social Worker...one for the whole floor. So, she may be busy or she may be out. Occupational therapy and physical therapy is a little more difficult because you can call up there and, you know, they’re just not right there for you. So you just have to assume all of these roles if it’s really, really needed...You have to wear, I think, more hats as far as the team’s concerned. (K6, p.6)

The nurse’s capacity to be flexible and responsive is implicit in these labels. Nurses, in fact, change their work according to the situation at hand. There is also some evidence that they approach their work with the merest skeletal outline of what to do and, like a hermit crab, grow into it having arrived with their total set of skills and selves.
The issue of flexibility is a sacred one. Two nurses in the study (p.16) were concerned that the act of defining would endanger the nurse’s ability to be flexible because definition might artificially structure nursing work (see p.16). However, the following examples give evidence that this quality is quite integral to the daily life of the nurse and her openness to allowing the work to be defined by the situation.

Fitting and Refitting

In this excerpt, G8 cannot name his work but describes it and thinks he does it 3-4 times a day. In fact, G8 validates that he is doing patient, nurse and system/environment assessment continually and using himself to mediate the three levels of processing. As a nurse therapist, his work is pre-determined but he tries to adjust what he’s doing to what the staff nurses’ workload is like. G8 admits that both he and the staff nurse could have similar skill sets. They both are competent to do clinical work but, because their workload varies, they tradeoff by responding to different patient needs. G8 takes the temperature of the environment when he comes to work and processes a lot of variables.

Sure, I mean, for example, I start off every day, I sit at home and I have my cup of coffee and I write my notes for the day and what I’m going to do. And I might wind up having to cross out that whole thing, well, that’s got to move to tomorrow because some other clinical issues came up that morning that I wanted to be involved with because it involved the family...I re-write my list three, four times a day sometimes. I’ve got to change it around...it really depends on the changes that are occurring out there [in the patient care area]. Even though we’re rehabilitation and it’s not the anxiety of an acute hospital, we’ve got discharges that can happen (click finger) on the drop of a - I mean I could walk back here with a chart thinking, “O.K., I’m going to catch up on some early paperwork,” and I think, [this] comes across with Ortho more than any of us where [the Orthopedics nurse ] “O.K., we’re going to get ahead on our paperwork.” She can go out there and pick her papers that come out of the computer and find out that
the whole thing changed. "Sorry, this patient wants to go home now," drop everything you’re doing, do the teaching, set him up with the home health referral, everything else. That’s a worse case scenario but it happens more readily than we like. So yeah, it sometimes, every time we walk out on the floor we might find that something is different and we have to change our day around. Re-organize…it’s constant. (G8, p.5)

Throughout the present study, the flexibility and mutability of the participants is noted as they review the changes that are taking place in their care delivery programs. K3 talks about how the changes in length of stay affect the work she does. At the same time, she is outlining what really matters in her work but is primarily not seen. For example, it takes time to develop an accepting relationship. She feels frustrated by the length of stay and describes how it impacts her work. K3 also talks about how the insurance company dictates time decisions. She questions the appropriateness of the actions she feels forced to take which in effect are the “timing” of her interventions. Timing is now dictated more by necessity than any artful interpretation of patient’s readiness. K3 persists, however, in trying to mold herself to the situation.

it’s amazing. You know quads used to stay in the hospital three, four months...even longer. And now the insurance companies are saying you have to get them out of there--why do they need to be in the hospital. You have to teach the family how to take care of a completely dependent person and it takes a long time and they just don’t seem to understand it...(very emphatic, gentle). Now it’s, sometimes, it’s as close as a week after their injury. Sometimes if they’re more complicated, three weeks or so. We get them right after surgery sometimes. You know, they’re still in pain. That’s very hard. We’re making them go to therapy when they’re just coming out of surgery and it’s hard. It’s hard for us making them do this, you know. (K3, pp.6-7)

K3 suffers with having to enforce the “timing” decisions which are dissonant with the way she thinks interventions should be carried out. Her words reflect an appreciation
of the adjustments that the patient and family must go through in order to deal with both
the traumatic event and the subsequent recuperative and rehabilitative period. By choice,
K3 would tend to the adjustments as well, as part of her work. In other words, K3 has a
standard for her actions that includes timing interventions in sync with the process of
adjusting to the illness in addition to carrying out the tasks and education necessary for
rehabilitation. Yet, in discussing how her practice has changed and the amount of change
she lives with, she continues to define herself in an open-ended way. K3 defines her work
according to patient needs with the presupposition that she can determine those needs out
by combining her knowledge of the individual, the illness, and the realities of the situation.

In the next example, K3’s comments are typical of how vulnerable and adaptable
nurses are to change. In fact, K3 like the others, accepts the fact that she is expected to
move in and out of different role functions. K3 describes handling discharges for her own
patients and those of other nurses in their absence but:

whenever [the clinical director] needs me on the floor I’ll still help out on the floor
and do whatever is needed. The reason they wanted me to become more full-time
is because patients are being turned over so fast. We are sending them home so
fast we need one person who can deal with this very fast discharge...I guess I’m
just managing all these different things, I’m just trying it make sure that everything
is taken care of for the patients that needs to be done. (K3, p.9)

Throughout conversations nurses share values reflected from the larger culture and
context of the organization. K3 tells how “they have to be real flexible” (K3, p.10) even
to the point of developing different care models on different units, based on the needs of
different patients. The expectation of nurse flexibility is consistently portrayed by the
different styles that have developed around the nurse therapy role. In turn, K3
incorporates the value for flexibility in the actual day-to-day operation of her role.

Flexibility is a guiding principle for determining “who” or what role K3 holds on a daily basis.

Nurses often talk about seeing the whole person. In fact, the study participants see the whole person while being tuned in to the details of daily living. They take it on themselves to reality check situations even though they complain about not being heard. Even though reality vigilance makes nurses rather unpopular, they take it seriously and important to the patient’s best interest. K7 provides us with the exemplar for this idea.

I had one patient...and I reiterated one time that the patient was going home alone and that he had to climb ten stairs, two flights and there was a landing in between each. And the therapist said something like, “well, the patient can go up four stairs independently.” And I said, “O.K. but he’s discharged today.” And she said “we could discharge him today.” And I said, “wait a minute, he’s got thirteen stairs and two flights” - and I said it was actually four stairs with supervision, not hand’s on supervision but with supervision. She was walking behind him up the four stairs. So, she wanted to discharge him because she believed he was O.K. And I said, “no, uh uh, I don’t think so.” Well, they didn’t listen to me so they sent him home...and he started climbing the stairs with the people from the Medicar that had brought him home and, he went down on a knee like after about six stairs, and the men were behind him. And, it was a building where there was a Social Worker in the building so they kinda supervise indirectly but not - you know, he had no family or anything to live with. So, she called us and she wanted us to bring him back...And I said, you know, you guys didn’t listen to me and it was a big humdrum. I said, “I’m really glad...” I feel funny saying this stuff, but I said “I’m really glad that he was O.K. and he didn’t get hurt and that the guys were standing behind him.” (K6, p.6)

K7 thinks that her work brought the team new learning about being more specific in their understanding of the patient’s ability and how it relates to the patient’s life at home, but she continues her vigilance on this front.

And therapy’s thinking they will watch somebody cook a meal, O.K. and I’ll say
“well, will they really be able to do that by themselves, don’t they need supervision?” What about are they safe at the stove, a lot of our patients are impulsive and in order to do my job well I kinda draw back. (K7, p.6)

K7 feels a responsibility for not just the illness but also how the illness affects every aspect of daily functioning and how one thing relates to the other. She adds that her “mind set” distinguishes her work from other care providers.

and I kinda look at the little things that some of the therapists don’t think of. They don’t. And that’s because we do kinda have our mind set...I look at it because I’m doing the teaching for going home and to maintain your health. And that just doesn’t mean taking your medicines at the right time or making sure you do your bandage change. (K7, pp.6-7)

In earlier sections on bridgework and knowing the patient, K7 gives examples which describe nurses attention to detail which enables them to anticipate system problems. K7’s story about objecting to a team discharge decision and then working diligently to enable a successful outcome for the patient and family is also a story about nurses’ flexibility and responsiveness and is repeated here for the reader’s convenience.

and I see this wheelchair coming in pieces, I was so angry and I called the therapist and I said “where’s the whole wheelchair?” and she said “well they’ll put it together.” I said “who’s going to put it together?” “Well, seating and positioning.” I said, “well do they know it’s coming?” “Well, they’ll find out.” I go, “How are they going to find out, it’s being delivered to the unit?” The team leader that day was like calling me - I don’t know how many times she called me - and I said “I’ll take care of it” because she knew absolutely nothing about it...And I said, “that’s O.K., I’ll take care of it, I know kinda what he’s supposed to get." ...I will never forget how many times I called and the wife would call me and say, “X. is the chair there?” And I’m like, “I’m putting it together” and she was so anxious. But, I had no idea there were so many pieces [for the wheelchair]. I didn’t know. I wasn’t the therapist who ordered the chair. The therapist was busy doing her therapy at this certain hour because she has a scheduled times. I’m all over the place...So by the time they came to pick him up it was together, but had I not, I’m telling you, had I been off that day, he would have gotten all these pieces of wheelchairs, you know, and I...that day but I worked my butt off and those are
the things that nobody will ever know...Nobody will ever know that I did that except me. And the family was appreciative of course. (K7, p.7)

K7's work is "putting it together." She realizes how her work is missed if it is absent but not recognized when present.

Nursing work also involves being responsive to the information needs of the interdisciplinary team. By sharing the details of their knowledge of patient progress, nurses enable team members to plan future interventions and insure consistency in patient care. K7 offers an example:

if I forget to put something in the plan after we've had conference, like today after conference, I go back and look at the care plans and what the therapist has said, "a patient is able to dress laying down in bed, that's the only way he can get his pants on." He can't do it sitting up in the chair. He can put his shirt on sitting up in the chair so I'm going to go upstairs and type "patient to be supine putting slacks on to make him independent" and then he can do it himself. But if I forget to do that, no one will do that because they won't know because I was in conference so I, that's part of my job. I'm not saying that's an intricate thing but...(K7, p.8)

Try, Try Again: Making It Happen

The last example presents the versatility and perseverance of an ambulatory care nurse. K6 gives an exemplar to demonstrate her ability to continue to develop a plan (actually three plans) in response to new information she learns about the patient.

And I checked him out and I thought to myself, "Oh my gosh, you know, you have this huge sore." So I started talking to him and he had these glasses about that thick. And the way he responded it seemed like he could at least see me or my shadow or whatever. And so I said, (1st plan) "Well, Mr. So and So, this is what I'm going to do. I'm going to clean this up and this is the type of dressing we're going to start doing and you need to change this twice a day. Just get a mirror and put it here." And I went through, and he just sat there. And I went through the
whole session of how to put the wet to dry on, how to tape it, to be sterile or as clean as you can be. I was going to send out for gauze and, um, point nine and all that. And then I got done with that and he said, “Well, I can’t see beyond my nose.” So, then I asked him where he lived and I called Home Health Care. (2nd Plan) And he lived on the West side and the nurse refused to go to his home because it was, it was just dangerous. I mean she wasn’t going to risk her life and I really don’t blame her. (3rd Plan) So, um, I had to arrange then for this gentleman to come in every other day on the Medicar. So his dressing was only changed every other day. I mean these are challenges that you don’t ever face in in-patient because they’re there and they’re in room so and so and this is what they need and you have a work sheet and you just go do it...This is a whole different challenge. (K6, p.5)

Summary

The participants in the present study offer evidence that there is an “invisible” dimension(s) of nursing work. Our understanding of this work is dependent on how clearly nurses can communicate and how skilled we can be in listening to their descriptions. Like two contrapuntal melodies, styles of defining and the content of nurses’ stories continue to intertwine and make delineation of nursing work frustrating and exciting. At least, we are able to hear the song. How the melodies work together is not clear. We are not able to completely isolate each melody and re-tape them as outside observers. But nurses seem to do it without difficulty. In fact, the study findings suggest, that the nurse, during her work, is continually scanning her environment and accumulating information. So, at the actual point of intervention, she combs through the data, sifting and shifting until she collects the knowledge and resources she feels appropriate to the situation, in a way creating the art as she moves along. She is able to create a scrim through which to see and know the patient and then from this, to create a strong but inviting chant with which to draw her patient towards recovery.
CHAPTER V
DISCUSSION

The purpose of Chapter V is to review the findings of the present study as they relate to nursing practice, administration, education and research. The metaphor of the contrapuntal melodies was used in the study to acknowledge how traditional methods of defining nursing work prevented the articulation of the “invisible” dimension and continue to influence what is known about “invisible” work. The contrapuntal melodies described in Chapter IV, the descriptions of nursing work and how nurses define, again provide the major divisions for the discussion. Implications for practice, administration and education are based on descriptions of nursing work as they were presented by study participants. Each of the areas have, in themselves, implications for future research. The discussion of research methodology is based on findings of how nurses define and reflections on the actual research process.

Descriptions of Nursing Work: Implications for Practice

Two myths plague explanations of nursing work. The first myth is that nursing work is the physical care of the sick. The findings from the present study stand is sharp contrast to the first myth. Words like wholistic care or total patient care are commonly used to try to label nurses’ unique contribution. But these words pale in relation to the
power of the stories that nurses tell to describe their work. Nurses in this study tell stories of working on the fringes of health care; taking risks to enhance a patient's quality of life, being both cheerleader and bad news messenger to patients and their families; stretching the limits of their knowledge and creativity to get to know their patients; allowing individuals who come into their care to be known in a nonjudgmental way that transcends the social, psychological and physical self. Most people in our fast-paced, mechanized society rarely have the opportunity to be so accepted and honored. Consequently, it is difficult to imagine that a nurse would be willing to extend herself for another in, of all places, her work environment. But the stories in the current study cannot be ignored. They relay, with clarity, the imperative with which nurses attempt to be truly present and available for those in need. All of the patient’s "being" is present in the mind and heart of the nurse at work.

The second myth is nursing work as task. Parse (1995) states that "The myth that nursing is rank-ordered tasks is one that must be refuted" (p.143). This study adds to a growing body of literature that refutes this myth by providing evidence about nursing's "invisible" work (Jacques, 1992; McCloskey & Bulechek, 1992; McCloskey, Bulechek, Moorhead & Daly, 1996; Wolf, 1988,1989). By examining the actual text of the participants' conversations, we learn of a type of "invisible" work that may involve any and every aspect of the health care delivery process if it is blocking or delaying the patient's progress.

This research points to the centrality of the nurse-person relationship. It suggests that it is because of and through this relationship that the nurse's "invisible" work is both
accomplished and justified. From the nurse’s perspective, it is through the successful development of a relationship with the patient, that the nurse receives the mandate and permission to intervene in any aspect of care. If an organization acknowledges this mandate and the nurse is successful at developing relationships with other members of the hospital staff and the interdisciplinary team, the nurse’s effectiveness increases, insuring her ability to get the work done. Additional research would lead to a better understanding of what conditions are necessary for such a relationship to be developed and maintained.

Barriers to Recovery

Within the confines of the nurse-person relationship and through knowledge gained herein, the nurses in the present study identify barriers to patients’ recovery. This often takes place before the patient, his family or other staff members can see them. G15 gives an example:

Part of it is knowing - a lot of mine is gut, unfortunately, and that’s one of the biggest problems of nursing... Knowing and gut because you can't quantify it. There's some of those folks who like quantifiable data. It's a hard thing to quantify... it's something I'm interested in. It would really take away a lot of the stupid looks. [From] everybody else on the team... the people outside of nursing... There was a patient we had who... and I don't remember the particular type of personality thing this patient had but I remember within, I think it was the first or second time we conferenced this man, he was maybe there a week and a half, two weeks, and I said to ...the team in the conference, ‘We have a problem, this is what's going on’. It was totally dismissed. Dr. moved on - psychologist didn't bring that up, you know, everyone else ... Nobody heard it... Nobody spoke about it. It was a psychological situation... They all kinda looked at me like, no he's not. The psychologist, psychiatrist didn't pick up on this Four or five weeks later we're back in the same case conference. It comes up, the same, exact topic, presented by the therapist saying, ‘You know, I'm really having a problem with him in his physical therapy’. The psychologist type says, ‘Oh, it's because of’ such and such... I said, 'I told you this five weeks ago!’ I just kept my mouth shut because
I'm like, I was just flabbergasted that within a week and a half, two weeks period of time tops, I was looking at this guy and seeing this happen and, because it wasn’t interfering with physical therapy and occupational therapy at the time, it wasn't an issue. I feel strongly that in-patient-wise, a patient only gets extended because the physical therapist or occupational therapy had goals. It didn't matter if the patient didn't know his medication. It didn't matter if the patient couldn't perform the catheterizations or the bowel program - or problem solve the bowel program - that wasn't a reason to extend a patient's stay. But, if they were working on these goals as far as walk a couple of steps further or using this type of equipment that they need more time for that, then the patient would get extended. Nursing was so secondary, so back seat to things that - again they can see these measurable goals, he can go five steps or the patient is able to stretch their upper extremities or lower extremities - with maximal assist on admission and I think if he stayed another five days we could get him to minimal assist. You know, it's that type of stuff whereas the things that are - the frustrating part is that if the patient can't manage their personal care procedures, bladder, bowel, respiratory problems - it doesn't really matter if, if they can dress themselves... I think he was passive-aggressive or some sort of, um, the kind of personality that goes with drug and alcohol addiction...[I saw it early because] it's just doing really... - that intimate care. Being with the patient and watching their interactions, hearing their interactions, seeing how they do or don't look at their body parts that were affected - he's a para - um, you know, in just that short period of time saying we have problems...(pp.8-9).

Once the barriers are identified, the nurse works toward action plans which will aim the patient toward future possibilities. The ability to "foresee" problems in this way arises from the nurse's intimate connection to the patient. Yet, often, nurses describe situations where they weren't heard or team members thought they were "wrong" not trusting their knowledge. Disclosing this type of work leads to an understanding of how allocating time for the development of relationships with patients and families could lead to increased efficiency in treatment and recovery. In other words, when nurses are allowed to really know patients, they are able to anticipate and prevent problems. In another example. K5 states:
...you do build on what you've seen and you do love the consistency with the same patients... That's one of the things I like about Rehab patients - they're here long. It's not two-three days then their gone. [You couldn't do that in two days] not the same way, not building on that same data collection as you put it. But it's that recognition that you are doing some data collection each time you're with a patient and there again, I think that's something that sets the experienced nurse apart from the new nurse that doesn't always have the larger picture so her interactions are not going to take her there... I love working with the little ladies and one of the reasons I love working with them is that they're hard to establish trust with. They come in so anxious, so dubious about everything and fearful that it's always a challenge to build up that trust relationship with them... so I always kind of relish getting that patient in. Now, I don't always think about it but it's, I'm going to accomplish it and its one of those that occurs after multiple interactions with them. (pp.10-14)

The Significance of Physical Care

At different times and in different ways, nurses in this study talked about the importance of human touch in care delivery. Nurses felt this was significant to their ability to get to know the patient. An outpatient nurse struggles with how to regain this connection; an inpatient nurse whispers his regrets that he can no longer do it as much; another nurse talks about how she tries to touch people in wheelchairs while grieving the loss of back rubs and foot soaks; many nurses talked about the "small talk" they carry on between and around the washing and the comforting which serves as a vehicle for increasing familiarity about home and family. The elegance with which G15 (see Chapter 4, p.47 ) describes the use of her hands to see the patient speaks as a testimony to the power that nurses literally hold in their hands through touch. Yet, it is exactly these tasks that are being re-engineered out of the professional nursing role.

In history, the "laying on of hands" represents a rich, symbolic tradition of healing,
blessing and connection. In nursing, there is a small but growing body of literature which supports the idea that the ability to directly care for patients is critical to the nurse-person relationship. Fagin and Diers (1983) were among the first to bring attention to the intimate nature of the nurse's role as a result of her license to trespass normal rules of privacy. Lawler (1993) and Wolf (1988) closely examined nursing work in a medical-surgical setting. Both studies support the seriousness with which nurses treat their physical caretaking activities. Wolf (1988) calls it a "sacred" part of nursing work. Recently Gordon (1997) called nurses "the secret sharers" (p. 88) again affirming the intimacy which nurses attain by being allowed to enter the patient's private world.

In light of current health care system changes, doomsayers are predicting an end to nursing. Yet nurses have progressed in their ability to exert power through political influence. Perhaps it would be timely to also reclaim the power that is located in our connection to our patients. Nursing would benefit from disregarding stereotypes about work; that professional work must be intellectual and physical work is menial. The re-engineering of nursing could be useful to forging a new design for the healer-professional that incorporates both aspects of work. At least, we should be cautious about giving this aspect of our work up without more study and consideration.

This particular study certainly decries defining nursing by tasks alone, but unfortunately the physical aspects of care are often counted simply as tasks. Participants in this study recast such notion. They count the provision of direct care to patients as an important component of their success in getting to know the patient in the fullest sense
because it is the point where the task and the intellectual process of nursing are intertwined.

**Nurses Focus on the “Work” of Recovery**

Nurses in this study talked about an overriding commitment to “developing the best in others. G16 gives an example:

I like to know people. I like to see what makes them tick and I’ve taken it as a personal mission, vocation to bring out the best in each person that I encounter... When a patient’s having a really rotten day, the good medical personnel know what to do, whether it’s a certain way of brushing the hair, of brushing the teeth, or singing their favorite song. But you can bring out the best in them that day and I think that is, first of all, I like that for its own end. I think it’s also the means to the end of the most effective healing. (pp. 23-24)

With the establishment of a relationship, the nurse is able to move onto other issues of health management. Learning takes place when individuals incorporate new knowledge and skills into the day-to-day living and, further, make changes based on this knowledge. One of the important aspects of “invisible” work discussed in this study is the role nurses take in insuring that the “work” of recovery continues outside the treatment area, in the day-to-day living. Nurses reflect this in their thinking about the evaluation of discharge issues and in the kinds of data they gather and bring to the team. They discuss it as “carry over work” and by participating in the reinforcement of new learning, find ways to present a realistically hopeful future to the patient. Their concern about loosing time for this work and how they try to create opportunities within very controlled conditions is evidence once again of nursing’s “resourcefulness” and commitment to “provide answers.”
Implications For Nursing Administration

The findings of this study suggest that nurses define their work by what “the illness” means to the patient. The “invisible” work is essentially the specific work effort the nurse invests to understand the full impact and ramifications of the illness event from the patient and family perspective. By bringing an understanding of the patient and family’s perspective to care decisions, the nurse has a relevant foundation to customize care planning.

Parse (1995) states that “Tasks and procedures are not the core of nursing practice; the core lies in the knowledge that guides the nurse-person process” (p.143). All the major constructs discussed in this research relate to the core knowledge. The ideas put forth by these participants help to unveil specifics about how nurses come to understand what the illness means to their patients and then how they can best help each patient to learn to live with the new challenge. Although this “invisible” work is highly directed to the core of nursing, it is highly dependent on two additional factors, time and environment. These issues are critical to the practice of nursing service administration.

Time

Getting to know patients and their families and acknowledging this as an important commitment of nursing resources, unfortunately, is intimately impacted by two factors that the nursing profession has little control over. Many nurses in this study discussed the “luxury of time” and “what we used to do versus what we do now,” referring to programs have been altered since length of stay has been decreased. Although the impact of
decreased time with patient was not the focus of the study, it was an ever present threat in
terms of the nurses' fear of loosing their opportunities to perform their important work.
In the course of their conversations, nurses would talk about "the luxury of time"
especially referring to how, in the past they had more time to teach and talk to patients
and families.

The nurses' freedom to control their own time was another common topic.
Bartering for time, increasing patient days for example or plea bargaining with other
departments for time to do nursing treatment with patients, was a surprising discussion.
Also how their time with patients was allotted, if it was consistent, did they take care of
the same patients for four days, or were they scattered also is an important aspect of the
time factor. Lastly, the nurses sense of time, one that includes more of a day-to day reality
base perspective of the patient's life at home frequently determined the kinds of problems
and issues the nurse involved herself in to the point that "nursing time frames" were
clearly evident.

Autonomy is often discussed in nursing in terms of decision-making freedom. But
in contrasting the various roles, control of one's time, or the patient's time, is critical to
how autonomous a nurse can be----yet, nurses do not have much control over their time.
Instead, nurses must fit their work in between time for occupational therapy or physical
therapy, or be powerful enough to have the other providers work in their nursing time.
They had time with patients but that has been deeply impacted by length of stay. They are
essentially trying to do one month's worth of work in 19 days without discerning which
work is cut. It is an approach where nurses are simply trying to work harder and faster.
Yet, over and over nurses talk about how their most important and satisfying work comes from being in relationship with patients. Their dissatisfaction focuses on their involvement with other departments’ problems, work that is dictated by others, or with the ever increasing change in length of stay and resultant system change about which they have little or no input. K8 says it best. “Nurses go into nursing because they want to care for people. But, I believe that the system that we have - the health care system - does not promote that... I mean I think that your average nurse wants to do it most of the time but they can’t because they have to do what they have to do. (K8, p.17)

Yet, this research repeatedly highlights the strong mandate nurses carry to know their patients and the benefits this relationship serves. This is often communicated as a value to individualize care. Currently health care changes are not permitting nurses to carry out this individualization. Although nurses are trying to do it anyway, they often report finding themselves in a fairly high-pressured situations with, to their way of thinking, moral implications. G15 says it best:

... there's some things that just don't go together... and health care is saying that everybody is the exactly the same and you have this X period of time. It's not looking at the person as an individual in a unique situation. They're trying to say ‘All of you, this is what's going to happen and you get this and there is no more and for you who has this, you have this and nothing more.’ Um, isn't that kind of incompatible and, unfortunately, there's a lot of folks out there who are now being brought up in the higher ranks of making health care a business with market share and stakeholders, etc. and I feel real bad. There's a lot of people who are going to die, get hurt or not have as high quality or quantity of their life because of trying to lump everyone together... that's frustrating as a nurse, not being able to... these are things nurses are taught; non-judgmental, take care of this unique individual - you'll get all aspects of their life. So this puts limits on everything. Creates a real inner conflict. (p.7)
Environment/Organizational Culture

The institutional environment at this facility, including organizational culture, role expectations and model of care delivery, support the professional role of the nurse. This was expected since the site was chosen because of its commitment both in philosophy and practice to a distinct professional nursing presence. The nurses' stories clarify the organizational benefits gained from the nurse as liaison. The stories describe how the nurse is the last and final connection between the facility, the patient and family. Nurses function as arbiters for the health care system, but these benefits are not obvious and "invisible" to the organization.

The rehabilitation facility in the current study truly valued the importance of caring relationships for patients and respectful interdisciplinary relationships among the care giving team. Due to the reorganization that began three quarters of the way through this study, it is unclear how this will affect nursing work in the future but nurses were very anxious that the "new organization" would change their practice. Nurses assumed that the fabric of nursing work was vulnerable to organizational change. Examples in the present study of how nurses have had to change their practice are further evidence that external environment directly impacts nursing. This is most clear in terms of discharge teaching and family preparation. Also, nurse participants report how their roles have had to change in order to accommodate decreased length of stay and increased time devoted to brokering with insurance companies and suppliers. Interestingly enough, no one talked about increased time going to family preparation since patients were being discharged earlier in their treatment protocols.
Change

Alterations in the health care system brought on by changes in reimbursement models drastically impacted the nurse’s time, including her time to provide direct care, as well as her practice environment. This research suggests that time and environment are important determinants of the presence or absence of „invisible” nursing work. Yet, little is known about how these factors actually affect work performance. Nursing leaders are being asked to redesign work roles without understanding the consequences of their changes. Until further research is done to explore the relationships, nursing will continue to have little control over either variable.

This research supports nursing administration’s hesitancy to redesign nursing roles without careful consideration to how nursing time will be redistributed and the hesitancy of clinical nurses to relinquish some tasks to other types of providers. However, no one will miss the „invisible” work until nursing services administrators begin to bring it to the table as a legitimate issue in the provision of quality nursing care. Nursing administrators must continue to reflect on how organizational structure can best support this caring work and how to develop programs which acknowledge the value of such work and facilitate the development of the work relationships nurses require to do their jobs with efficiency.

Nursing administration must be vocal about the need for research to evaluate role re-design and the measurement of nursing work because, as leaders, they are severely hampered in discussions until further research is conducted. Nursing leaders are in a pivotal position to call for the inclusion of the „invisible” dimension(s) in the current effort to design and complete nursing outcome studies.
Implications for Nurse Educators

University-based nursing educators and providers of continuing education must respond in creative ways to address the needs of learners to help them see and understand the performance of "invisible" work. Until further research is done to fully conceptualize nursing work, it will be difficult to incorporate it into formal curriculum. However, educators can raise awareness of its existence and give permission to discuss the ramifications of its continued invisibility, thereby drawing the future nursing population into a discussion about nursing work.

Creative teaching strategies are needed to educate nurses about the concrete instances of "invisible" work such as bridgework, telephone work, and directing and facilitating teamwork. These are just a few examples of instances that expert nurses identify as intangibles and they suggest that they were learned by a type of osmosis or immersion over time in the health care milieu. As the work setting transforms from a collective inpatient nursing unit to a more autonomous work unit, nurses will need other, more efficient ways to acquire the interpersonal skills and organizational understanding necessary to participate in these activities.

Limitations

To educate nursing students, they must be taught the language to discuss our science and practice. In the practice arena created by nurse administrators, nurses learn how work is valued based on the allocation of nursing time and resources. Nursing
leaders in both administration and education are in powerful positions to encourage the continuation of this discourse about "invisible" dimensions of nursing work. They must give permission to legitimate conversations, programs and research about "invisible" work otherwise it will be lost.

Because of the difficulties languaging the concept of "invisible" work, nurses are not listened to or have gotten the message that such work is not valid. They communicate this when they disqualify their own descriptions. Yet, the present research demonstrates that nurses are willing and able to participate in projects on that attempt to hone in on the dimension(s). By developing management styles that support this discourse and by admitting these practices into conversations in education, we can encourage the struggle to find "the words to say it" (Cardinale, 1983).

This research provides beginning evidence that an "invisible" dimension of nursing work exists and clusters around certain topical areas. However, because the starpoints identified in the study arose naturally from conversations with clinicians in both inpatient and ambulatory rehabilitation settings, it cannot be assumed that the topics are exhaustive or related.

Our understanding of the "invisible" dimension is further complicated by the fact that nurses perform their work as part of an ongoing process. Activities and interventions are rarely performed in isolation. In fact, it is more common that nurses perform multiple activities simultaneously, sometimes while interacting with more than one person. Recall K5's description:
And also as you’re interacting you are also, that other favorite nursing word, you are assessing. So, as I’m talking I’m also eye balling, how does he look today is there anything that seems amiss? My gut telling me about how he’s doing? So, it’s not just asking how their day went... it’s other stuff at the same time. Well it’s also attuned to, while I’m here I can check the incision so I might as well get that done then I don’t have to do that later... What else can I get done at once. It’s also organizational kinds of things but you do have to organize. I don’t know if I always pull it out [of my head at the same time] but that’s what I’m doing... You’re engaged, you’re totally engaged in what you’re doing and I know I’m engaging that person in conversation and I’m working toward a conversation, not always a heavy conversation, but a conversation that’s going to communicate with the person that I’m concerned about them, that I care about them and I’m here to make their evening better. So, things go on in multiple levels and so in the middle of all that someone comes up to you and you say ‘Hello Mr. X, how are you?’ and then you have a third thing going on... and [and so on]. And that’s part of the challenge of it. That’s part of what I was getting at... the richer role. But, you do build on what you’ve seen and you do love the consistency with the same patients... That’s one of the things I like about Rehab patients (pause) They’re here long. It’s not two-three days then their gone. [You can’t do it in two days] the same way, not building on that same data collection as you put it. But its that recognition that you are doing some data collection each time you’re with a patient. And there again, I think that’s something that sets the experienced nurse apart from the new nurse that doesn’t always have the larger picture so her interactions are not going to take her there... I love working with the little ladies and one of the reasons I love working with them is that they’re hard to establish trust with. And it’s one of those things that occurs after multiple interactions with them. (pp.10-14)

Nonetheless, the grouping of activities is not simply organizational but represents a nesting phenomena. Certain activities can stand alone or be integral to processes such as assessment and evaluation. They nest within them. This phenomenon is also seen in the Nursing Intervention Classification developed by McCloskey and Bulechek (1996).

Nurses are very facile at customizing the activity sets. For example, the nurse who developed a plan for the son to help him decide if he could take his dying mother home. So an activity will appear in multiple sets each time representing different nursing intentions. Since nursing activities do no fall neatly into one and only one discrete
situations, it is difficult to determine if the descriptions offered here comprise one or more dimensions of "invisible" work. These issues further confound our understanding of "invisible" work making it difficult to ascertain if the starpoints, for example, from the present study, are constitutive of one or more dimensions in the definition of nursing work.

Despite the fact that the nurses spoke from a variety of experiential backgrounds, it is necessary to conduct similar research in various health care settings and specialties in order to more fully explicate the structure and complexity of the "invisible" dimension. Until this phenomenon is more fully understood in various health care settings, allocating time either in education for teaching it or in patient care for its performance will not be easily justified.

**How Nurses Define: Implications for Methodology and Future Research**

From the beginning of the literature review and conceptualization for the project, it became apparent that research methods would be required that would utilize different perspectives in order for findings to emerge. The difficulty in developing the methodology was related to the important role that definitions play in research. We are dependent on definition to give order and meaning to our lives. Most commonly, we define by asking "What is X" or we stipulate definitions for a particular study to hold the meaning constant. Phenomenological research asks for the meaning or understanding of an experience. The literature review did not yield enough information to develop a trustworthy, stipulative definition of "invisible" nursing work. The "invisible" dimension of nursing work would
not be addressed by answering any of these questions, primarily because the prevailing methods did not clearly highlight the contextual nature of nursing work.

The Theory of Cultural Care Diversity and Universality

The theory of cultural care diversity and universality (Leininger, 1991) was chosen to provide the theoretical anchors for the study for a variety of reasons. Leininger's theory of nursing is often used to study caring practices and, in fact, one study included American nurses in the sample (Spangler, 1994). Therefore, it seemed a logical place to position a study of nursing work. Further, the concepts of environment and context are important core concepts in the theory. Therefore, the framework would provide the necessary acknowledgment that nurses could have patient-focused involvements far beyond the primary patient care relationship.

Leininger's (1991) theory of nursing supports qualitative methodology, which seemed appropriate to a process of discovery rather than confirmation. Further Leininger's (1991) philosophical assumptions were consistent with a philosophy of science where theory was to be used as a guideline. The project was framed within her conceptualizations and the term "contextual care work" was developed as a tentative theoretical conceptualization in order to frame the research questions within the ethnonursing method.

As the story of the data collection developed, it became evident that it would be necessary to be more true to the method in concept rather than specific technique. The process of data collection was allowed to grow out of the interviews and the researcher
worked hard to allow the nurses to reflect aloud in conversation rather than cover specific topical areas. Consequently, the key informants were not asked to respond to specific questions about culture, history, or technology, for example, which might be common in a more ethnographic Leininger study. Rather, information describing the organizational context was gathered as it appeared and primarily from general informants, several of whom were retiring and more than willing to share reminiscences.

In like manner, rather than asking the participants to describe "contextual care work," questions developed out of more common expressions used at the institution to talk about nurses. For example, a physician from the institution spoke at a gathering and said "Nurse's are the backbone...they make everything work for us." When posed as an inquiry, participants were quick to describe what this statement meant to them. Nurses quickly related to the use of the words like "intangible" or "invisible" work. In fact, these words were a part of their experience and they were excited to share their meanings. As in other studies (Benner & Wrubel, 1989; Street, 1992), this strategy allowed nurses to resort to a familiar form of explanation through patient stories. In fact, the project provides further validation that stories are useful as an approach to understanding nursing work in context.

In this regard, the study was true to ethnonursing method despite the fact that it did not focus primarily on culture and caring. As Leininger (1991) states,

An ethnonursing research design could be used as a rough schema (or sometimes a very limited schema) to guide the research process. But whatever design or guide was used, it had to accommodate or move with the people or local informants' lifeways and their patterns of knowing and sharing ideas bearing on human caring within their local environmental context. (p. 86)
By following Leininger’s suggestion and letting the study evolve, it seemed that the theory gently held the findings in such a way as to encourage a type of inductive reflection more reminiscent of grounded theory approaches. As a result of such reflection, one of the more significant findings related to the problem of definition emerged as the study was in progress. This finding is the understanding that the work of nursing is defined according to the meaning the illness has for the patient. Therefore, the “invisible” work is what the nurse does to understand and tend to the patient’s meaning in care planning. This finding arose directly from the frequent emphasis on nurse’s comments that decisions “depended on” the patient.

This statement obviously resonates nursing’s commitment to individualize care. In addition, it provides new insight for the type of designs that must be developed in order to study “invisible” work by providing a refinement of the research question. In other words, future research building on this study could focus on the question of how nurses come to understand what the illness phenomena means to the patients. Such research would complement current phenomenological research which is building a knowledge base for understanding the person’s experience. The difference being that one approach leads to an understanding of personal meaning and the other highlights the nurse’s strategies for understanding the experience of a patient in a particular context.
Summary

The struggle with methodology for this study was continual. From the beginning it was clear that the process of defining according to Western tradition would have to be held problematic. But since research usually starts with definitions, what procedures would be needed to study a problem that searched for a definition? Utilizing Strauss' (1993) definition of work with its accompanying assumptions proved to be a viable way to reframe the idea of nursing work. Strauss' (1993) definition acknowledges that work can be covert, overt, reflexive and interactional. Factors such as feeling, thought, action and temporality could be admissible in a definition of nursing work. Therefore, the possibility exists that definitions of nursing work could be constructed including the subtleties often present in the “invisible” dimension(s) of nursing work.

This research essentially serves as a critique of the way we define and how definitional processes can bias toward a certain type of product or research outcome and one can only wonder how this affects the everyday conversations about nursing.

Perhaps nurses remain silent because they find themselves on the horns of a dilemma because common words do not capture their experience of doing their work. They say, “You have to watch, I can’t explain it.” In the book “The Words to Say It” (Cardinale, 1983) a woman recounts her struggle to heal herself from the ravages of psychosis. By working with an analyst, she comes to see her treatment as a process of finding a way to articulate her suffering. The profession of nursing should at least consider the possibility that nursing’s unique contribution will not be adequately
articulated in public and political arenas, and that clinicians will not feel integrated into the profession, until we collectively have found "the words to say it."

Conclusion

The original research questions for the study called for a complete explication of the concept of contextual care work. As the research unfolded, it became clear that the data centered on one essential question: What evidence, if any, exists for an "invisible" dimension(s) of nursing work?. While Leininger's framework was helpful in providing the general guide for the investigation, the language and definitions grew directly from the emic views presented by the participants. By analyzing the conversations nurses shared about their "invisible" work, several areas or starpoints were identified. These were defined as: creating presence; knowing the patient; knowing the system; bridgework; and synthesizing the mix. The relationship between the starpoints is one where each aspect of the dimension is held in potential for use rather than in a stepwise, procedural or hierarchical fashion. Therefore, the analogy of a constellation viewed from several different vantage points best explained how the descriptions presented themselves. The study results begin to lay out the breadth and scope of the "invisible" dimension(s) in broad strokes. In addition, the results of the study validate characteristics of this dimension, which were synthesized from both the literature and the pilot study data, by giving specific examples to demonstrate how nurses perform this work. The "invisible" dimension of nursing work is characterized as:
1. Knowing the patient as an individual and through communication mechanisms;

2. Primarily indirect interventions which radiate from, but are not focused only on a one-to-one client relationship;

3. A type of knowledge work, embedded in task, context-driven, dynamic, responsive, reactive and discretionary which contributes to the patterns of nursing decision/making;

4. A set of structural practices (Jacques, 1993) such as effort that links patient need with other services and providers in an organization, and encounters which are based in the nurse’s ability to adapt, coordinate and accommodate the needs of the organization and other providers - making connections;

5. A process of maintaining a “continual presence at the interface between patient and service delivery --- i.e. where the service interchange occurs” (Curtin, 1994, p.8);

6. Both immediate and long-term thinking for the patient and other service providers, temporality; and

7. Focusing of attention on management of the environment.

The research begins to flesh out a conceptual definition of “invisible” nursing work. Summary descriptions for the concept where offered from three different perspectives. A theoretician, Madeline Leininger (personal communication, 1994) called it “contextual care work.” An administrator/nurse practitioner/educator conceptualized it as “Being active in developing a system [or pattern] of care that will benefit the client at the personal level” (C. Hutelmyer, personal communication, April, 1994). A nurse in the pilot project called it “Creating a picture of the patient for other members of the team to
see.” While the concept does not lend itself to simple labeling, it does resonate with the individuals who mark its significance. Performing this work within the nursing role is demonstrated through patterns, defined as thinking, valuing and acting, directed toward maintaining a presence within a specific health care network that seems to co-ordinate service in the best interest of one or more patients.

By analyzing the difficulties nurses had in clearly articulating this dimension of their work and considering an honored practice component, nursing’s mandate to individualize patient care, the study revealed insights about how better to frame research questions for further investigation. Future research may shed more light on the “invisible” work of nursing by focusing specifically on how nurses come to know and allow their practice to be directed according to what the illness and health means to the patient.

Nurses have always carefully guarded their close relationships with patients. Nursing has been generous in “weaving a tapestry of care” (Gordon, 1997, p.88) in a society that “too easily forgets the value of things that are beyond price” (Gordon, 1997, p.88). Their success has been in part related to their ability to perform quietly, confidentially and in the background, thereby allowing the patient to forget their vulnerability upon recovery (Diers & Fagin, 1983). When people are sick, nurses will continue to want to be there not just to tend their physical needs but to help deal with the “day-to-day, minute-by-minute, attack on the soul. They know that for the patient not only a sick or infirm body but also a life, a family, a community, a society, needs to heal” (Gordon, 1997, p.86). Nurses, through a clear articulation of their contributions, must
find a way to protect the importance of this service by honoring their patients' privacy without sacrificing the service to secrecy.
REFERENCES


The author, Frances Rita Vlasses, was born in Philadelphia, Pennsylvania. In September, 1969, Mrs. Vlasses entered Villanova University, receiving a BSN in 1973. In 1974, she received an MSN in Community Mental Health Nursing from The Ohio State University. In 1990, Mrs. Vlasses received an assistantship from Loyola University Chicago, enabling her to continue her studies toward a Ph.D. in Nursing. Mrs. Vlasses has held positions as a Clinical Nurse Specialist, Nursing Administrator and Educator where she participated in the “invisible” work of nursing. The idea for this research crystallized when she was working as a project manager for a bedside computer documentation system.
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The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Ph.D.

4/7/97
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