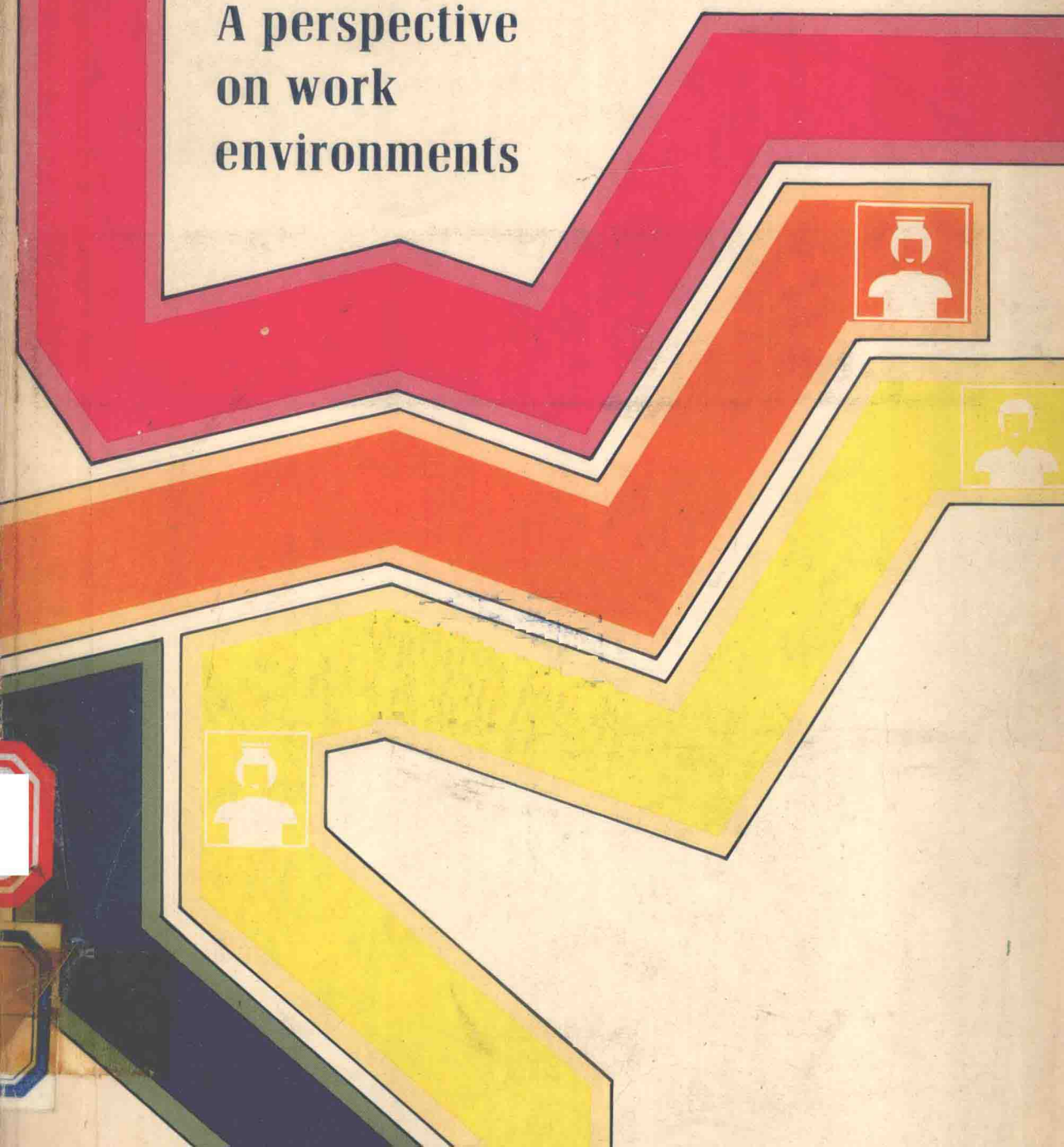
Nurses in practice

A perspective on work environments

Edited by
MARCELLA Z. DAVIS
MARLENE KRAMER
ANSELM L. STRAUSS



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Preface

This book, for students and teachers of nursing, is about the work of nurses in a variety of settings. A recurrent theme throughout is that work behavior—professional ideology notwithstanding—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. On the whole, the performance of all professionals is influenced by elements in the work environment and by developments in society in general. However, because of a variety of structural features characteristic of the profession of nursing itself, the work performance of the nurse would seem to be highly vulnerable to the influence of external elements.

One feature to consider is the relative lack of autonomy in some spheres of practice within the profession. Nowhere is this more evident than in the situation of the practitioner of nursing. Whatever autonomy the practitioner of nursing has is delegated through informal arrangements made among those with whom she works (for example, the physician) and not by way of any formal institutional fiat. A second feature is that the profession is comprised mainly of women; consequently, whatever attitudes about the role of women exist in society at large apply to nurses as well. A third feature is that a key value of the profession is the care of the whole patient rather than one segment. Today the practice of nursing, however, reflects less the care component of that value and more the coordination of the care components offered by a wide variety of other health professionals. The material throughout the book illustrates these and other features as they influence and in turn are influenced by a wide range of elements in the work environments of nurses.

The reader should be cautioned here that this material is not intended as a moral lesson on how nursing ought to be done or *not* to be done. Rather, since nurses occupy a primary position as providers of health care and the education of nurses is seen as a significant route to the improvement of that care, this material provides a point of departure for examining both. Thus, by looking at the

performance of the nurse in work environments, we can begin to extract realistic guidelines for alterations in the education of nurses that would redound to the improvement in health care for patients.

Major portions of the material presented here are observations of nurses at work in such places as the intensive care unit, the pediatric ward, the emergency room, and the patient's home and neighborhood. These observations were made in the main by nurses who, while in the roles of participant-observer and nurse-researcher, observed other nurses at work. The observations appear in two forms: (1) as raw data; that is, they are presented here just as they were originally written up as field notes; and (2) as analyzed data; that is, the observations (raw data) have been analyzed and organized according to some conceptual scheme and written into a completed piece, as we see in the chapters on public health nursing and on chronic illness. Most of the field observations were part of larger ongoing research studies, such as research grants or doctoral dissertation, and only those parts relevant to this book were used.

Short of being in the actual environment, field notes provide a vivid picture of the situation under study. Therefore, we have purposely used raw data, first for their rich context and second to give the reader some idea of how fieldwork itself is carried out. Fieldwork involves not only observing and recording what people do and say; equally important, it is discovering who the people in the situation are, how they fit into the ongoing action and setting, and what meanings the observed persons themselves give to their behavior.

The field notes of the pediatric unit offer a good example of how the observer notes to himself what he sees, how he identifies who the observed persons are, and how he comes to learn what meanings to attach to what he observed. These pediatric unit field notes tell us that the researcher observed two nurses in "deep conversation." The identity of one nurse is easily established by the tag on her uniform reading "Head Nurse." The researcher inferred the identity of the second nurse from a variety of cues: for example, about her appearance, "She looked very tired, harried, and harassed"; the time of day, "It was 8:15 AM." Since this observer already knew that the night nurse was supposed to be off duty at 7:30 AM, she assumed (and checked out later) not only that this was the night nurse but that her late departure signaled that something was amiss. Further in the field notes we learn that during the night a child had died. The emergence of that piece of information begins to explain the observed tense interaction between the two nurses and the night nurse's late departure.

This vignette, as commonplace as it may appear, contains those elements that distinguish fieldwork as a research method from other methods of investigation. The fieldworker makes observations of behavior in its natural settings as opposed to observing behavior in artificially established settings. Since the fieldwork situation provides many more cues to what the observed action means, the opportunities for correction and refinement of observations are maximized. This method is in contrast to other research methods where meaning must be inferred from a single item of

behavior, such as the answer to a questionnaire item or the response to an interviewer's questions.

Both the natural and social sciences—anthropology, zoology, geology, and so on—use the fieldwork method of research. These sciences take as their basic premise the idea that since there are constant transactions between the object and its setting, making each comprehensible only in the context of the other, the study must be conducted in the subject's natural surroundings. The tools used in the act of fieldwork are observation, participation, and written (field notes) and spoken (tapes) recordings. Through the use of these tools, the researcher attempts to provide as representative, comprehensive, and accurate a rendition of the situation under study as possible.

The aspect of fieldwork that requires observations to be made in the environment where the action normally occurs makes it most suitable for the study of nursing practice wherever it is performed. If one accepts the premise that behavior is influenced by environmental and cultural factors, it is obvious that to study the performance of a worker, one would need to observe him where the work is done. For example, the clinical situation as a locale of work is a highly complex environment, the study of which cannot be reduced to simple question and answer items on a questionnaire or interview form. Nor for that matter would setting up small group laboratory experiments get at the complexities of the ongoing transactions. A brief look at one aspect of this environment might illustrate the point. In the clinical situation multiple relationships are formed among persons of differing levels of authority, expertise, and status that constantly influence and play back on each other. For instance, the relationship between nurse and patient can easily affect the one between nurse and doctor; in turn, the doctor-family interaction is bound to play back on the nurse-patient relationship, and so on.

These relationships, complex as they may be, are but one dimension in the work context. Other factors, some widely discrepant, influence the interactions and in turn the work performance. The field notes on the intensive care unit vividly illustrate how the nurse's work is influenced by widely variant factors. At the one end may be the physician's order for minimal care of patients for whom the medical staff no longer hold any hope. At the other end—and having nothing in common other than their mutual influence on the work of the nurse—may be the inconveniently timed rotational schedules of residents and interns.

The nature of the patient's illness is an important dimension whose impact cuts across all work environments. Its significance for nurses derives less from a specific diagnosis but more from problems that confront patients, their families, and significant others when illness is prolonged indefinitely as opposed to when illness is successfully treated and of short duration. The material in the "outside" section is about these issues. They reflect in particular the low priority that the social and psychological problems of the chronically ill and other groups marginal to the mainstream of medical care have been assigned, not only by the nurses but by health professionals in general. Given the devalued status of this patient population,

it should not be surprising to see in the material evidence of gaps in care and the socially isolating and psychologically demoralizing effects of no care.

Through the use of a variety of materials, this book provides a perspective for looking at and talking about the practice of nursing in the context of work environments. So that students might critically examine this material, questions are provided at the end of each entry; some are addressed to them and others to teachers. At the beginning of each chapter, an introductory passage discusses the material to follow and provides the reader with some immediate anchoring foci.

In the book's concern for the actual work of the nurse is the implicit conviction that the concepts of nursing practice must be empirically based. Only in this way can the realities and ideals of nursing be brought into a continuing and fruitful dialogue with each other. We sincerely trust that the book (but more so, what the students shall bring from it) will further this end.

Marcella Z. Davis
Marlene Kramer
Anselm L. Strauss

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part I
Inside the hospital

Many factors impinge upon what work is done and how work can be done—in fact, they determine the very nature of the work. In nursing, one of these primary factors is whether the patient or client is an inpatient or an outpatient. An inpatient necessitates and sets into motion a whole array of tasks that at worst become a substitute for the work of nursing and that at best often prevent or vie with nursing work for dominance. It is useful to think of the tasks required when a patient is housed within an institutional setting for protracted periods of time as hotel maintenance tasks. The patient not only must be "doctored" or "nursed," but because he must also be housed while undergoing these ministrations, he must have certain kinds of hotel functions available to him around the clock, such as restaurant, maid, telephone, newspaper, laundry, and mail service.

To accomplish these hotel-type functions as efficiently as possible, departments are created to fulfill specific tasks. For example, in a given patient area the maintenance department is responsible for seeing that the building is heated properly, the plumbing is working, and so on; the housekeeping department is responsible for keeping the unit clean; messenger service might be responsible for the delivery of supplies and pickup of outgoing mail. While each department has its specific tasks and functions, someone must coordinate these various services and functions and maintain the system in operation. This person must notify the housekeeping department, for example that a patient's bathroom needs to be cleaned, since maintenance was there to fix the plumbing.

To summarize, there are two sets of tasks that have implications for the nurses' work in an inpatient setting—in addition to the activities that are called "nursing." There are hotel-like functions, and there are system maintenance functions. Historically, these have all been included in the work of the nurse, due in large measure to what Hans Mauksch refers to as "continuity of time and space." The nurse is the only person who is there around the clock—24 hours a day, 7 days a

week. To her quite naturally falls the additional tasks of providing hotel-type functions and keeping the organization running. In many instances, these tasks have been so numerous and overwhelming that they have completely replaced or obliterated the work of nursing.

Currently there is much discussion about these two sets of tasks. It is generally recognized that both of them interfere with nursing. Ward manager systems, unit clerks, and stewardship programs represent but a few of the attempts being made to provide the hotel functions and to maintain the organization without the nurse having to do these tasks. The extent to which they are effective is still to be determined.

In the series of papers presented in this part, the reader will note that some of these hotel and system maintenance tasks are still being done by nurses. In some instances, the work appears to be willingly done and perceived as an inherent part of the nurse's function; in other instances, such as shown in Strauss's description of the nurses at PPI, a private hospital in Chicago, the managerial functions are a major source of role conflict for the nurse. Kramer's field notes on the head nurse at work on a medical unit of a large city hospital, and Fleshman's field notes on emergency ward nurses at work provide an opportunity to compare and contrast the nature of the nurse's work resulting from the patient's constant need for hotel-type services (medical unit setting) or intermittent need for these tasks (emergency room setting).

Closely related to this theme of the type of tasks demanded by the hospital organization is the opposite side of the coin—the primary function of the nurse as perceived by herself and others and as exemplified in her behavior. Is the nurse's primary function the coordination of hotel, maintenance, and care functions, or is her primary function that of "care-giver"? The first paper in this section, describing the head nurse at work, and the series of papers detailing the operation and functioning of nurses in the emergency ward provide an opportunity for the reader to assess the coordinative aspects of the nurse's work. Particularly revealing, and a provocative contrast study with respect to the care and cure functions of the nurse's role as perceived by nurses, are the papers describing the nurses at PPI and the nurses in intensive care unit and pediatric settings.

Another major determinant in understanding and analyzing the nature of the nurse's work stems from variables due to types of patient illnesses and the corresponding expectations of health professionals toward patients with these kinds of illnesses or health problems. There are at least three dimensions of importance in the type of patient illness. One has to do with the expected outcome of the illness—recovery or death or some state in-between. A second is concerned with the expected rapidity of change in the patient's state of health and the potential for controlling these changes, such as the degree to which the nurse can prevent the death of a patient who is in a highly labile state. The third dimension is concerned with the degree of social loss that the death or long-term disability of the patient represents to the health professional and to society at large. (A child, for example,

generally represents a much greater social loss than an aged individual.) These dimensions in the type of patient illness and their effect in determining the nature of the nurse's work can be clearly seen by comparing and contrasting the descriptions of the nurse's work in settings such as the intensive care unit (ICU), pediatrics, and the emergency room; it can be seen most particularly in Quint's essay on the dying patient, Glaser and Strauss's excerpt on the perennial problem of caring for patients in pain, and in Fagerhaugh's description of potentially conflicting illnesses (tuberculosis and mental illness).

The type of illness and problem presented leads to a corresponding expectation of patient behavior. Previous experiences with patients having certain kinds of illnesses and presenting certain kinds of problems lead health professionals to expect specific kinds of behavior from the patient and to anticipate predictable kinds of patterns or trajectories of events. These subcultural expectations in large measure provide coping mechanisms for the nurse and other health professionals in dealing with the impact of high-stress situations. When patients, such as Mrs. Abel, the patient described in Strauss's analysis of the problem of pain, do not conform to these expectations, a series of subtle accommodating mechanisms can be perceived as nurses and doctors attempt to alter work or attitudinal patterns in order to bring about a greater degree of consonance. In addition to the Strauss excerpt on pain, this same kind of interplay can be noted in Fagerhaugh's description of the conflict in the care and treatment of phychiatric and tuberculosis patients.

Cultural differences between health care personnel and patients are evident in numerous instances in the articles in this section, particularly in the field notes on the head nurse on the medical unit and in the field notes on the nurses in the emergency ward. A difference in the way in which nurses handle these cultural differences is also noted. Is this because of differences in the backgrounds, training, personalities and life experiences of the nurses? Or is it possible that cultural differences are handled on a more individual basis in a more resident population than in a transient one? Is this a possible variable influencing the nature of the nurse's work in respect to this very important area of individual patient differences?

Values and attitudes associated with cultural and subcultural differences are learned—both prior to professional education and within the professional socialization process itself. If nurses and doctors behave as described by Fleshman, where do they learn this behavior? The conference notes of Benner seem to indicate that these are not the attitudes and values being taught to nurses in school. Benner describes an incident occurring with two students who were having clinical laboratory experience in the same emergency ward described in Fleshman's field notes. The students apparently were blocking the acquisition of the dominant values of the work setting—but at what price? And for how long would they be able to continue doing this after graduation, without the support of an empathic instructor?

One last theme that is prevalent throughout many of the papers presented in this section is the aspect of degree of professional autonomy and interprofessional control and collaboration. As previously noted, there are many structural deterrents to nurse autonomy. Other factors, such as intern-resident rotation schedules and rapidity of crises situations, appear to foster opportunity for nurse autonomy. The articles and field observations on the premature infant, the head nurse, and the ICU nurses particularly illustrate these points. Closely coupled with autonomy is the degree of interprofessional control and collaboration and the factors that inhibit or promote this aspect of the nurse's work. That this is one of the major deficits for nurse faculty when nurses are perceived and perceive themselves as "guests in the house" is clearly seen in Glass's description. The interaction between professional groups and the potential affect of these interactions on patient care is also demonstrated in the articles describing the work of psychiatric nurses in PPI, the care of patients with both tuberculosis and psychiatric problems, and the care of patients in pain.