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How Caring for Each Other Influences

Clinical Learning of Intensive Care Nurses

by

Karin Reese

THESIS

Submitted in partial satisfaction of the requirements for the degree of

MASTER OF SCIENCE

in

In Nursing

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GRADUATE DIVISION

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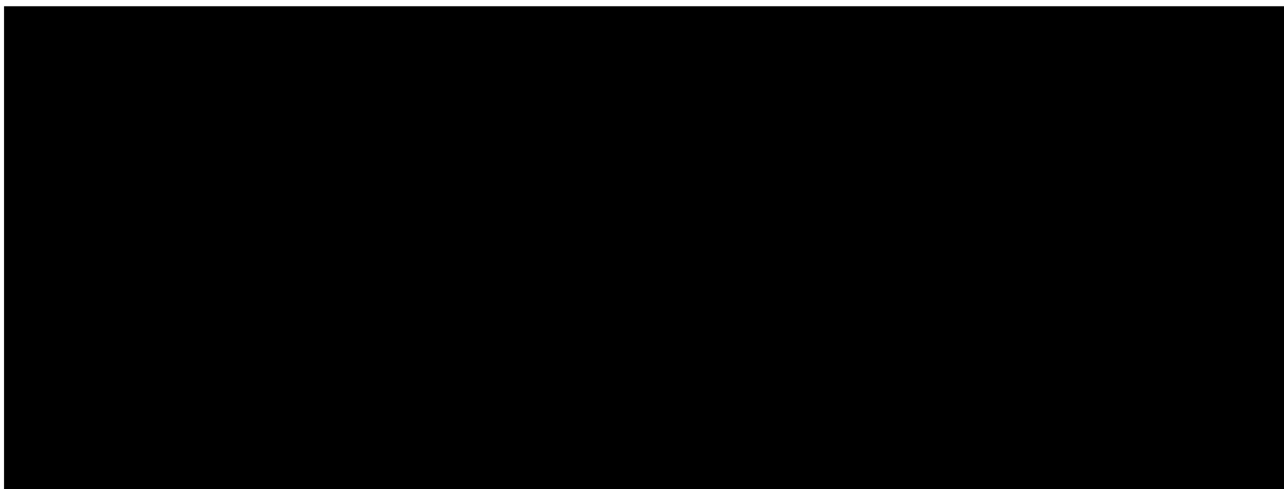

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ABSTRACT

How Caring for Each Other Influences Clinical Learning of Intensive Care Nurses

Nursing is generally acknowledged to be a stressful profession. Technological expansion in the intensive care unit over the last decade has increased the demands on the critical care nursing staff. The purpose of this qualitative study is to look at how practicing intensive care nurses communicate with each other. Can communication between nurses be a form of caring, and if so, how is it manifested? The theoretical framework for this study was guided by the larger study (Benner, Tanner & Chesla, 1992), which used the Dreyfus Model of Skill Acquisition in the practice of nursing, as well as Lewin's Field Theory (Lewin, 1984) looking at group interaction. The sample for this planned analysis was 106 intensive care nurses (ICU), practicing in eight different hospitals. Use of the computer program Ethnograph generated specific data for this study. Several emergent themes arose, including how ICU nurses cope with the reality of their practice in facing death and suffering, the responsibility of life and death situations and being a resource for knowledge. Clinical learning needed to gain practical knowledge, for beginning nurses, require support and role modeling by more experienced ICU nurses in order for them to be able to learn. Teamwork and social integration into a group is important for nurses to practice safely, and to gain knowledge and expertise, thereby achieving the responsibility of becoming a patient advocate. There is evidence that scapegoating and horizontal violence between nurses exists.

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CHAPTER I: INTRODUCTION TO THE PROBLEM

The entry into this study was guided by my experience on an oncology unit. During a months time period one nurse was found to be addicted to IV narcotics and another nurse attempted suicide. Nursing is known to be stressful but what is happening to nurses? The importance of caring for patients, and how this contributes to their health and well-being has been well documented in our nursing literature. Do nurses include caring for each other as part of the caring practices of nursing? If so, do nurses care for one another? If nurses cared about each other, would the above nurses still have been driven to such extremes to numb the pain and stress they were experiencing as nurses? How much was brought with them from their pre-nursing life, and how much can be attributed to the confrontation with suffering? What caused this tremendous pain, and did they feel "cared about" by the nurses working with them.

The nurse addicted to IV narcotics vanished from the unit without comment, and the nurse who attempted suicide was in counseling for two weeks before returning to the floor. No further discussion was welcomed or fostered by nursing management about these incidents. And none of their nurse colleagues questioned management's handling of these incidents. Why not? Did no one feel that they could stand up to management and question them, or did no one care enough about these nurses? How much do we care about each

other as nurses? Is part of the stress nurses feel in their practice coming from their colleagues?

Purpose:

The purpose of this thesis is to examine at how practicing intensive care nurses communicate with each other. What is the nature of this communication? Can communication between nurses be a form of caring and if so, how is it manifested?

Significance:

Nurses work together on units or in outpatient settings. For the most part (the exception being community health nurses), nurses work together in groups, and at times appear to be cohesive. Yet our nursing profession overall does not appear cohesive as manifested by issues such as entry level degree disagreements and lack of political power to just name a few. It is time to step back and look at how we are treating each other, while practicing, because maybe this is influencing how we see ourselves overall as a profession. How can nurses become a more cohesive political force?

Assumptions:

1. Caring for our patients is an integral part of being a nurse, yet we do not see the value of caring for each other. Caring for each other would enrich our

experiences as nurses, because it would work to buffer the stresses within our practice.

2. If nurses felt good about themselves and their practice, the quality of patient care and satisfaction for all would increase.
3. In a health care environment that is and will be undergoing major transformations, we must begin to look toward one another for support and strength.

Lines of Inquiry:

1. What are common areas and issues that cause communication breakdown and conflicts?
2. What are common resources and aids for team building?
3. Describe the nature of caring practice between nurses.
4. Where are the breakdowns in caring practice between nurses?
5. How are newcomers (new graduates, travelers, and float nurses) viewed by established nurses on the unit?

Definition of Terms:

Caring as it is used in this paper means that "persons, events, projects, and things matter to people. Caring is essential if the person is to live in a differentiated world where some things really matter, while others are less important or not important at all. "Caring" as a word for being connected and having things matter works well because

if fuses thought, action, knowing and being" (Benner & Wrubel, 1989).

For the purpose of this paper, nurses will be referred to in the feminine form because 95% of nurses are women.

CHAPTER II: LITERATURE REVIEW

Nursing is generally acknowledged to be a stressful profession. Since as early as 1960, stress and burnout have been cited in nursing literature as critical deterrents to the well-being of nurses, and consequently to the quality of their practice. Menzies, a psychoanalyst, in 1959 analyzed the nursing service of a 500 bed General Hospital in London through interviews with nurses individually and in small groups, observation of operational units and informal contacts. Her research pointed to a high level of tension, distress and anxiety within the nursing service. She found it hard to understand how nurses could tolerate so much anxiety. Certain facts seemed to indicate that they could not, for example the withdrawal before graduation from nursing school of one third of the students, the frequent changing of positions by the graduate nurses, and the high sickness rates for minor illnesses (Menzies, 1959).

Technological expansion in the Intensive Care Unit over the last decade has increased the demands on the critical care nursing staff. The high level of knowledge of patients' problems required and the clinical expertise needed to use sophisticated monitoring equipment, combined with life threatening crisis situations, critical decision-making responsibilities, and an often overstimulating environment, place critical care nurses in a high risk

category for experiencing both emotional and physical stress (Watkinson, 1992).

Nurse-Identified Stress

A procedure for a computer-aided self-observation method in stressful situations was developed by several researchers (Malacrida, et al, 1991). Sixteen intensive care nurses in a Swiss hospital recorded their experiences on a computer placed in the ICU, immediately after having experienced a stressful event. The computer asked for stored psychologically relevant information about cognitive affective and behavioral aspects. Results from the 192 recorded episodes indicated the areas of highest stressors were lack of support, conflict with other nurses, and death and dying issues.

A study examining stresses in intensive care nursing (Anderson, et al., 1988) found interpersonal relationships were sources of stress. The study was a cross-sectional survey of 544 critical care and medical surgical nurses in six acute care hospitals. Using the Nursing Stress Project Questionnaire and the Stress Audit, the study measured work setting, work stressors, and social support variables. Ranked in order from most stressful to the least stressful include, 1) interpersonal relationships; 2) patient care; 3) management of unit; and 4) role instability. In the area of interpersonal relations the items most often mentioned by

the critical care nurses involved conflict with physicians, and to a lesser degree, conflict with other staff members on the unit.

Watkinson (1992) studied 100 intensive care nurses at two Naval Hospitals to determine whether high levels of stress existed amongst nurses on these units. A questionnaire was constructed following a literature search. No name was given to this questionnaire, although a copy was available in the study. The four top stressors identified were, first, working alongside inexperienced peers, which the author cited was due to the high turnover of staff during the time of the study, making team building and maintaining morale very difficult. Frequent negative feedback was the second highest stressor, and reasons for this varied from heavy workload to unrealistic expectations in the use of sophisticated equipment. Fear of making mistakes ranked third, and fourth was lack of communication. The author states that the question regarding communication should have been structured to be more specific, thereby enabling a more precise evaluation.

Are nurses having problems communicating with each other? A Melvyl/Medline search located no literature addressing how nurses communicate with each other. Likewise, no literature was found about nurses caring for or about each other. In a study by Forrest (1989), seventeen

registered nurses were asked "as a nurse, what is caring for you?" The results found that the capacity to be caring is sustained through the comfort and support found in one's immediate co-workers, and in the collective spirit that arises from teamwork. Results indicated that as the nurse feels cared for her capacity to be caring with patients increases.

Issues in Retention

A major problem in the intensive care unit today is the recruitment and retention of critical care nurses (Doering, 1990; Huttner, 1990; Bagg, et al, 1992; Chiribogu et al., 1988). These studies cite as a key concept in the recruitment and retention of critical care nurses is finding a way to increase a nurse's self-esteem and self-actualization, and you will have a greater chance of retaining that nurse. In the recruitment of new critical care nurses, assimilation into the unit is normally accomplished through precepting (Werkema, 1990). Decentralization of the nursing unit is often mentioned as a means of retaining skilled critical care nurses. Doering (1990) implemented the concept of decentralization as a way to increase nurses' ability to participate in decision-making at the unit level. This promotes a work environment in which the nurse at the bedside has an opportunity to have a meaningful voice in administrative and clinical decisions

that affect patient care, and to be recognized for her contribution. It appears that power, or lack of power, is a problem for these practicing intensive care nurses.

Moral Stances and Power Imbalances

Currently, the majority of nurses still work within patriarchal systems, where there is an imbalance of power between practitioners. This power imbalance is not only between physicians and nurses, and administrators and nurses, but also between physicians and patients. Nurses are seen, at times, as extensions of patients because there is lesser power imbalance between them in relationship to physicians. A common theme in nursing curricula is that a key nursing role is to be a patient advocate. Unfortunately, advocacy for patients brings home the inequality of power between nurses and physicians. How are nurses able to be patient advocates in light of this power imbalance? This influences communication, not only with physicians, but with other nurses as well.

The traditions of "our" patriarchal past have been of major significance in perpetuating the gendered social structures and practices that have resulted in continuing and serious injustice for women. Theories of justice that depend on traditions or on shared meanings - even if their intent is to be critical, cannot deal adequately with the problem of domination (Carse, 1991). When Carol Gilligan

published *In a Different Voice* in 1982, she claimed to hear a "distinct moral voice" in the reflections of the women subjects she interviewed for her research on moral development. Gilligan dubbed this voice the "voice of care" and contrasted it with the "voice of justice." According to Gilligan, there are two distinct voices or orientations: justice orientation and situation or care orientation. The justice orientation construes the moral point of view as an impartial point of view, understands particular moral judgements as derived from abstract and universal principles, sees moral judgement as essentially dispassionate rather than passionate, and emphasizes individual rights and norms of formal equality and reciprocity in modeling our moral relationship. In contrast, in the care orientation the moral judgements are situation-attuned perceptions sensitive to others' needs and to the dynamics of particular relationships. This perspective construes moral reasoning as involving empathy and concern, and emphasizes norms of responsiveness and responsibility in our relationship with others. In the justice orientation we are viewed as individuals first, and in relationship to each other only secondarily, in the care orientation we are understood as essentially in relationship.

The Nature of Nursing Relationships

Patriarchal and bureaucratic institutions which include physicians, and within which most nurses practice, generally operate under a "justice orientation." Nurses, however, are coming from a "care orientation." With this basic dichotomy of orientation, it is clear that the problem then is more complex than a mere imbalance of power. How are nurses communicating with physicians and other nurses? Do practicing nurses recognize that their relationships with patients are different compared to physicians' relationships with patients? If not, could this be adding additional stress to our nursing profession, and as a result, how we communicate with each other?

Decentralization also points out that no one nurse can function independently of others. Nurses function optimally as a team, specifically in environments where providing nursing care is complex and integral, as seen in the specialty care units. These nurses work in relatively confined areas caring for complex patients, and require specific knowledge of the patients within their specialty. Patients are often unstable, and conditions change rapidly. Nurses are constantly reassessing their patients, the environment surrounding the patient, and their own knowledge base. Interpersonal communication between nurses becomes essential in order to provide care. Nurses become astute in

reading the responses not only of their patients, but also of their colleagues with whom they work. This is known as team work, and it develops over time on nursing units. One important aspect of teamwork is reciprocity.

Reciprocity has been defined as a mutual action or relation, a mutual exchange, an action or relation given in return, or a feeling in return (Webster 1968). For the most part, therapeutic reciprocity in the nursing literature has focused on the nurse-patient relationship. Marck (1990) defined therapeutic reciprocity between nurse-patient as follows:

> Therapeutic reciprocity is a mutual, collaborative, probabilistic, instructive, and empowering exchange of feelings, thoughts, and behaviors between nurse and client for the purpose of engaging the human outcomes of the relationship for all parties concerned. (p. 52)

Certainly, we could change nurse-client to nurse-nurse in the above definition, and see this happening when nurses work well together and reciprocity takes place and "energizeing" nurses. When there is a breakdown in communication between nurses, reciprocity, or lack of, can ultimately affect one's feeling about oneself and one's ability to provide care.

How do we as nurses learn the notion of reciprocity? Do we learn it in nursing school? Bough (1991) argues that today's nursing programs should be teaching students to "see with new eyes" human care from the feminist perspective,

placing high value on people as nurses and as clients. She feels that nursing students must be taught to care for themselves, both as individuals and as pre-professionals, before they can truly care for their clients.

Theoretical Framework

The theoretical framework for this study was guided by the larger study (Benner, Tanner, & Chesla, 1992) which used the Dreyfus Model of Skill Acquisition in the practice of critical care nursing (see Appendix A):

> Stuart Dreyfus, a mathematician and system analyst, and Hubert Dreyfus, a philosopher, have developed a model of skill acquisition based upon the study of chess players and airline pilots. The Dreyfus model (Dreyfus and Dreyfus, 1980) states that in the acquisition and development of a skill, a student passes through five levels of proficiency: novice, advanced beginner, competent, proficient, and expert. These different levels reflect changes in three general aspects of skilled performance. One is a movement from reliance on abstract principles to the use of past concrete experience as paradigms. The second is a change in the learner's perception of the demand situation, in which the situation is seen less and less as a compilation of equally relevant bits, and more and more as a complete whole in which only certain parts are relevant. The third passage is from detached observer to involved performer. The performer does not stand outside the situation but is now fully engaged in the situation. (Benner, 1984, p. 13)

As nurses move through the different levels of proficiency, they do so within a group made up of other nurses. Kurt Lewin, a social psychologist, developed Field Theory to describe the nature of individual and group behavior. Field Theory (Lewin, 1984) is an organic

approach, and in its holistic orientation is consistent with the systems point of view. Lewin, as a phenomenologist, viewed behavior from the perspective of the interactions of persons. He believed that social research should delve into the practical affairs of peoples lives. Lewin begins his thought with five assumptions about people. First, it is important to study the perceptions of the person, or the individual's psychological field or life space. Second, the person at any moment occupies a position in the life space that can best be conceptualized in its distance from other objects of the field. Third, the person has goals toward which she moves in the life space. Fourth, the person's behavior can be explained in terms of attempting to reach the goals. Fifth, the field also contains barriers to the goals, barriers that the individuals must surpass (Lewin, 1984).

Groups, too, have a kind of life space. While a group is a set of people, it is more than the sum of its members. When people join together in a group, a resulting structure evolves with its own goals and life space. Consequently, one's groups will create tensions in the life space, and therefore influence one's movement. This leads to the groups' impact on an individual's life. This impact has four qualities. First, the group provides stability to the person's life. Second, the group provides the person with a

means of achieving valued goals. Third, the person's values and attitudes are greatly influenced by the values and norms of the groups to which she belongs. Fourth, as a part of the life space, the person moves about within the group, and the person aims for various goals within the group itself.

The most important attribute of groups is cohesiveness (Lewin, 1984). Cohesiveness is the degree of mutual interest among members. In a highly cohesive group, a strong mutual identification is found among members. This quality is what keeps a group together, cohesiveness is a result of the degree to which all members perceive that their goals can be met within the group. This does not require that the members have similar attitudes, but that they are interdependent, that they rely on one another to achieve certain mutually desired goals. The more cohesive a group, the more force it exerts on its members.

Field theory respects the needs of the individual, at the same time it demonstrates how people and groups interact. The group is influenced by personal needs; the person is affected by group standards (Marrow, 1969). Nurses function within groups but remain individuals first.

CHAPTER III: METHODOLOGY

Data for this planned analysis comes from a larger study by Benner, Tanner, and Chesla (1992). Interpretive phenomenology studies everyday habits, skills, practices and meanings of people. The goal is to get beyond "subjectivism" and "objectivism" by critiquing the Cartesian view of the person as a private, disconnected subject standing over against an objective situations. As Benner, elaborates:

> Meanings and embodiment make it possible to understand others, not as private subjects, but as embodied participants and members of a common humanity, language and culture group. In this view the knower and the known are not radically separated. The common, taken for granted meanings and practices do not ensure agreement, indeed they provide enough commensurability for disagreement, and for different voices to be heard. However, being completely commensurable would not allow for meaningful differences to show up. Thus, interpretive phenomenology seeks to elucidate the meanings, knowledge, skill, and notions of good embedded in divergent human practices, in order to explicate the substantive alternatives offered and/or to provide a critical perspective based upon identified impediments and notions of good embedded in the practices. In this way interpretive phenomenology contains a positive project (a hermeneutics of understanding, or faith, i.e., giving voice to the observed practices) and a critical project of identifying the voice embedded in the practice as well as the conflicts, constraints and blocks to this voice and practice in its most liberated form. The focus tends to be on content, context, function and process as they are situated in everyday human practices. Because interpretive phenomenology focuses on lived experience and everyday comportment, it is well suited to the study of habits, skills, practices meanings and embodied ways of being (Benner, 1991, unpublished paper, p. 22).

Sample

The sample for this analysis was 130 nurses practicing in the intensive care units of eight hospital, seven of which were located in two far western regions of the United States, and one located in the eastern region of the United States. These nurses practiced in both pediatric ICUs and in adult ICUs, distributed evenly across surgical, medical, cardiac, and general specialties. These nurses were then clustered by expected level of practice based on years of experience and peer/supervisor nomination (see Appendix B for sample characteristics). The groups were as follows:

- Advanced beginner; up to six months work experience
- Intermediate; up to two years work experience
- Experienced but not expert; two to five years work experience
- Expert; at least five years of experience in the ICU and recognized by peers and supervisors as an expert practitioner

Ethics

Each of the eight study sites were given a copy of the grant proposal which was reviewed and approved by the institutional review board of each site. An information sheet explaining the study, and the time requirement to participate was given to each nurse prior to the beginning of the study. Informed consent was obtained from those who participated.

Methods

All informants from the larger study were interviewed in groups of four to six nurses, clustered by expected level of practicebased upon the head nurses' apprasial and years of experience. In these interviews, the informants gave narrative accounts of their clinical practice, describing specific patient-care situations. Group rather than individual interviews were used to create a natural conversational setting for storytelling and to encourage participants to talk with each other as practitioners in natural practical discourse about particular clinical situations. Each participant was encouraged to actively listen, ask questions for clarification and understanding, and to add similar or contrasting experiences from their own clinical practice. Discussions about generalities and ideology, while allowed intermittently, were limited by the request to "tell a story" about particular situations with as much conversation, thoughts, and expectations as possible while staying within the language of the familiar, narrative discourse about their everyday practice. In addition to these group interviews, 48 of the nurses were interviewed individually about their work history and early perception of nursing and nursing education. Each of these 48 nurses was also observed during practice at least three times.

Analysis

Analysis of the data from the larger study occurred in several phases. First, transcripts of interviews were reviewed by members of the research team individually. Interpretive summaries of each clinical episode were prepared by each member and discussed in group research meetings. These interpretive summaries were used to develop beginning descriptions of levels, and used as the basis for identification of early themes and issues. Second, observational notes were examined to reveal aspects of everyday practice that would not be apparent in the narrative accounts and to augment/dispute beginning interpretations of levels of practice. Third, and simultaneous to the early data collection process, themes were identified both from the background frameworks (e.g., Dreyfus model of skill acquisition, domains of practice identified by Benner [1984]) and from the interviews and observation. Fourth, the entire text of transcribed interviews were coded using themes so that related texts could be retrieved (Benner, et. al., 1992).

For this planned analysis, the Ethnograph program was used to generate data (see Appendix C Ethnograph codes for Clinical Nursing Expertise Interviews). The themes used to elicit data, for this study, were "learn," "make-case positive situation," and "make-case negative situation."

These themes elicited instances where nurses note how their understanding had changed and might also be called experience. This experience includes transformative experiences, discussions of how one learns, and clinical knowledge development related to technology, including clinical example or learning indirectly through the practice of another nurse. Themes of situational support and impediment to a nurse's practice were included in the data base.

These data were then analyzed, initially by this author to further narrow the text to situations where nurses talked about themselves in relationship to other nurses and their practice. At this point the text was reviewed individually by the author, and then collectively with Dr. Benner to elicit paradigm cases and emergent themes. The goal of this inquiry was to explicate common meanings and experiences so that they are recognizable and understandable by other practicing nurses.

CHAPTER IV:

FINDINGS: COPING WITH THE REALITIES OF PRACTICE

Nursing school tries to prepare nurses for the realities of their practice. Unfortunately, it is impossible to experience everything that could happen to patients with varying illnesses during the limited time in school. Because of this, many nurses are unprepared for the reality of nursing practice after graduation. Bearing the responsibility of caring for patients is a serious challenge for nurses. The type of responsibility varies for each nurse and is dependent on her practice. The following paradigm cases and subsequent themes emerged from the data.

Facing Death and Suffering

In the following excerpt this beginning nurse talks about the death of a patient the same age as herself, and of trying to come to grips with the reality of nursing involving death and dying inherent in nursing practice.

Nurse 1- I had my very first loss during my first week in preceptorship. I had lost a 26 year old. My same age - not that same day but the following day. And he had AIDS and he had pneumocystis and he had pneumonia. He had whited out and they had to put chest tubes in him. And he was really fighting for his life. And that was my loss. I think I grieved for a month after. It was so bad I was taking BART and I would cry going home, every single day. And I remember the first day I went home and I told my Mom, "I'm not going back." Because that day he was bleeding so badly and they didn't know where he was bleeding but his pressure had dropped real low into the 70s and 80s and we had to start him on Dopamine and his heart rate was going real, real fast so we had to control

that. I can't remember what we did with that. And he was - because of the Dopamine was so high to keep his blood pressure at least 80, his hands and his feet were really, really cold and they were turning blue. He was fighting the ventilators, so we had to Pavulonize him. So it was like he was out, but he was bleeding. And so we were hanging all sorts of - his labs came back and they were bad, real bad. So we were giving him frozen plasma, FFP, and some packed cells and he was just going down.

Nurse 2- What's FFP?

Nurse 1- Fresh frozen plasma. So.. And he had DIC and it was really sad that they had brought him that night for surgery for chest tubes and he died the next day. But, I had him when he was--Okay, when they first got him in and then the next night, he wasn't doing so good. And then the next day he was really going down and then in the night he went for chest tubes in the following day he died. But that was just so hard for me. We were just so busy. I had two patients and I couldn't handle my other one. Because I was in the room with this one patient who was just really crashing on me. We thought we were going to code him. But he just all of the sudden, just started going down.

INT- Did you get acquainted with him?

Nurse 1- I got acquainted more with his family, because he was fighting the ventilator and we Pavulonized him. He was pretty out. So, I got to meet his mom and his dad. I think that's the hardest, because you have to deal with the family. Especially when they're losing their only son. And that was hard for me. Because I couldn't - when I was in there I just couldn't cry. I would just sit there with this lady that I didn't know and just hold her hand. And I couldn't say, "It's okay." Because that would be false. But then the last day, the day before I was off because I had had him for I think three or four days, the nurse from the AIDS floor - Fourth - I guess he had been down there. And she came up and she started talking to him. Just like, I had been talking to him. But she said things that I hadn't said before. And I guess it really hurt me. I mean, she was just talking to him like he was there. And I was talking to him and telling him everything that I was doing. But she was carrying on a conversation with him. And she said - the last thing she said was "It's okay. Just go ahead

and let go. It's okay to die. I know you're afraid." and he started crying. He was crying. And I guess she was crying, too. And I was just standing there. And she turned around and told me that it was okay to cry, so I started crying. I walked out that day and I was crying. I went in the back and L. and R. were there and I was really bawling because I had a hard day. It was tough. But it felt real good to let it out finally, instead of you know, doing it on my way home. Just right there.

Nurse 2- Going on the BART crying with everyone wondering what was wrong with her?

Nurse 1- I would cry, all the way home. But the first couple of days I didn't want to go back. I told my Mom, "I can't handle the stress. This guy is dying and he's my age and he's fighting so badly." But, I did and I went back. I was really surprised that I went back. I didn't want to go back because it had just been a real bad day.

The death of this young patient affected this beginning nurse very personally, as "her loss". She talks about the difficulty of managing this critically ill patient and another patient at the same time. Her difficulty was not only the physical care of her patients, but the emotional aspect as well. She realized that this terminally ill young man was in her care, and therefore, her responsibility. Because he was close to her age, she identified with him, and this made her confront her own mortality. When the more experienced nurse came to talk with the dying patient, the beginning nurse felt that she talked to the patient's fears of dying. The experienced nurse gave the patient permission to "let go", while acknowledging how terrified he must feel. Both the experienced nurse and the patient began to cry, and the experienced nurse was thoughtful enough to

give the beginning nurse permission to cry as well. This open acknowledgement of the situation provided relief and an acknowledgement of the grief that they all felt.

Degner et al. (1991), identified a beginning list of seven critical nursing behaviors in the care for the dying in a qualitative study. Ten experienced, palliative care nurses and ten nurse educators were asked to describe situations in which a student or graduate nurse displayed attitudes of caring for the dying. Behaviors identified and relevant to our discussion are enhancing personal growth and responding to colleagues. Some nurses had defined a role for themselves in helping the dying. This clear role definition enabled them to receive emotional rewards and experience personal growth as a result of their involvement in caring for the dying. Other nurses, particularly students and beginning nurses, had difficulty confronting their own feelings about caring for the dying. Nurses who had developed a collegial network on their unit received emotional support and critical feedback about the quality of their nursing care. In contrast, nurses who felt isolated in their care giving experiences, had a difficult time either in providing or receiving support or criticism from their colleagues.

In the exemplar above, the beginning nurse's ability to express her feelings of loss and sadness in the room eased

the tension created by emotional control and denial. One can surmise that the open crying and acknowledgment of the situation made that patient feel less isolated in his fear and grief. This acknowledgement of her feelings about death and dying is an important step in the ability to care for dying patients; "I didn't want to go back. But I did. I was really surprised that I went back." Acknowledging the courage it took to go back as well as acknowledging the threat and grief of impending death in a young person is a rite of passage, a taking up of the inherent grief work and sorrow in nursing practice. Here the nurse confronts tragedy without any actions to ward off or prevent death. She confronts care of the dying rather than heroic, intensive care activity to save a life. The experienced nurse was a valuable role model who showed her how she communicates with dying patients.

Facing the Responsibility of Life and Death Situations

In the following interview, beginning nurses talk about their feelings of being responsible for the care of patients in life and death situations.

Nurse 1 - Yes, I feel overwhelmed a lot. And, in some ways I feel like perhaps I'm not living up to the expectations of my unit that they have of me. I keep saying woah, woah. And, I've started forgiving myself for that. It was a little hard at first. Because I have pretty high expectations of myself as it is. I wouldn't have even applied for this kind of position if I didn't.

Nurse 2 - That's just a little bit of an understatement. (laughter)

Nurse 1 - But, I have to feel like I'm not dangerous in order to live with myself. I already have nightmares every night about things that I have not done. They're nightmares of omissions. Things I missed. Babies I didn't take care of all night long and they're blue. (laughter) So, I just have to keep saying what I feel like I can handle. Because I know that if it's this way with the less critical babies, what could it possibly be like with the real critical ones. And, I could very easily get in way over my head very quickly and all the other nurses quite frankly are stretched to their limits. And, they say "Oh ask questions, be sure you ask all your questions". Sometimes they are just so stretched. They can't give you any help. And, I understand that. Or they say, "I've only had six months experience, you have to ask somebody else who has more experience, because I don't know". And, you know I have to go through and I'm beginning to define those people. There are 110 nurses on the unit. It's a huge unit.

Nurse 1 - So finding out who knows and who to ask and who will have the kind of information that you need is an art in itself and takes some time. Like Nancy I trust that it will get better. (laughter)

Nurse 2 - Did I want to go into Critical Care Nursing? No, I just have to admit that before we did this interview today, I really had to face up to the trauma that I went through when I first started nursing. (laughter) I just didn't know if I was ready to face you guys because I didn't want to relive that. (laughter)

Nurse 1 - I can really appreciate that. (laughter) It's tough. It's a tough time. I can see you all going like that, so it feels really good, it really does.

Nurse 3 - We've known each other for a while, what really helps is having a sense that you can't judge now, is this the place to be? And, that it makes sense. I mean if we weren't feeling these things than we'd be out to lunch in some very significant way.

Nurse 1 - Very dangerous.

Nurse 3 - And, so you have to temper your expectations of yourself or you can't do it. And, I know coming out of Nursing School I'm not sure how many people have, that I mean you expect some period of initiation and then to be on top of things. That period of initiation I think is longer than anybody is comfortable with. What I said during our training all the time is, it's hard to maintain a real strong sense of self-esteem because you're always confronted with what you don't know and what you're going to learn. And I mean just you know you can take these vital signs, you can look at this blood gas but what you understand about the implications of everything will grow with time and only with time and experience. So, you can't today, or I can't today, feel the level of accomplishment that I want to feel in my work over time. It's sort of like trusting in other people who have gone through and said yes it does take this time. You're right on track.

Nurse 1 - And, yes it will get better and you will sleep through the night.

Nurse 2 - Right!

Nurse 1 - Come to work with a sense of spaciousness rather than a sense of hanging on to this roller coaster and you can go through all those turns and do the right thing. Not fly off. Am I being too dramatic?

These beginning nurses talk about the expectations that they have of themselves since coming out of nursing school. There is the notion that because they have graduated from school, they feel they should be able to function up to their unit's expectation. The reality is that they find themselves in overwhelming situations; situations in which patients might die. In this case the nurse fears that a baby might die because she did not catch or notice something. The full impact

hits them of how critical their work is, and how narrow the margins of error are in caring for these infants, and the margin for error is indeed slim. They go to bed and dream about missing something and causing a child's death:

> Beginners experience complex agency in which they feel responsible for managing patient care fully for the first time, but at the same time they feel largely dependent on others. They question their own agency in and contribution to the care of patients but at the same time feel a remarkable sense of responsibility to perform.
> (Benner, et. al., 1992, p. 19)

Their hope is, "It will get better. And you will come to work with a sense of spaciousness rather than a sense of hanging on to this roller coaster and you can go through all those turns and do the right thing. Not to fly off". The sense of dangerousness and their limited grasp of the clinical complexity raises serious questions about the level of supervisory support for the beginner and the level of undergraduate preparation for critical care practice.

Realizing that their expectation of themselves are too high they feel overwhelmed. They also begin to question whether this unit is the place for them. Will they be able to learn safely, what they need to without jeopardizing the safety of their patients, and yet still be able to function as part of the team by pulling their share of the load. They realize that at

times other nurses are too busy to help them, and this is a concern. They are also learning who they can go to for reliable information and judgements. It then becomes a balancing act, trying to maintain their self-esteem so that they can continue to learn and grow as nurses. They struggle to find safe avenues in which to learn, while bearing the responsibility of caring for their patients.

Facing the Responsibility of Being a Source of Knowledge

One way the following expert nurse handles her fear of beginning nurses not asking the appropriate people for help, is by giving them less critical patients to care for. She is motivated by the fear of jeopardizing the safety of patients.

Nurse 1- We also hire a lot of new grads and it makes me a little nervous, because he doesn't know the difference. He doesn't know me from Adam or anybody else. He knows me because he sees me in the unit and stuff but it just makes me a little bit nervous that he might go up to someone whose been off orientation for two weeks and is out of school four months. God forbid that, usually we don't give those patients to new people. That's the scenario.

Experienced nurses also worry about travellers or agency people who are unfamiliar with the units, local customs, protocols, and equipment. This creates a further burden for the more experienced nurses, for

fear the travelers will ask less experienced nurses, critical questions about patient care.

Nurse 1- It's even hard when you have nurses who are not familiar with the environment, like travellers or agency people.
Nurse 2- Sure, definitely.
Nurse 1- Because at their skill is unknown to you unless you have a critical incident that you can relate to, and they're unfamiliar with the system, so they're not sure whom to call first.
Nurse 3- In CVS, our unit, we have so many travellers, like about two or three on a shift. It's kind of hard, because they only get two days of orientation. They're only supposed to stay there for three months.

Facing the Responsibility of Patient Advocacy

A group of more experienced nurses talk about the benefits of working in a supportive environment, and how this influences their team unity and patient advocacy.

Nurse 1- We can stand up for ourselves a lot more. Um! We don't have to answer to the administration like they do at some of the hospitals. If they cross us we just tell them how we feel about it. At a lot of places you could sacrifice your job over that from what I hear.
Nurse 2- We also have good staff physicians support, you know, Dr. M.'s is always very supportive of the nursing staff because they know that the nursing staff is real important to the care of their patients and they really are very supportive. We have lots of multi-disciplinary meetings and stuff. I mean, the nurses call the multi-disciplinary meetings.
Int- It seems like everybody helps each other and I don't sense a lot of competition between people like I do sometimes, you know, in other hospitals but more like we're all in it together and helping each other through some of this and I don't know if this is an

accurate perception or not but that was something we noticed by going through the transcripts.

Nurse 1- Yes, I think that's pretty accurate. We do feel like we're all in it together. And you know that the next day you're probably going to get that guy too so you'd better help this guy or he won't help you tomorrow.

Nurse 2- What you were saying about expertise, or different people having different expertise being able to rely on that kind of stuff. I think it's really true too. I think we can all identify who we would go to if you were to give us a certain problem and say how, you know, and we have these people on, we could probably identify the people that we would to go to either support what we felt or to help us through whatever it was because we weren't real familiar with it. You're right, we do that back and forth quite a bit. Well, we'll ask or even if you are busy we and somebody needs to have an autolet done or a swan readings done or something like that, you can pick on somebody and say yes can you do this for me because I'm real busy and they'll do it. But, unfortunately there are other factors that get in the way like personalities and politics and just I always think about study that was done on stress in ICU's and interpersonal relationship was more of a stressor for some people than your patient load. And, I can really see that if you're insecure about your Nursing care you're new or you have a really heavy assignment, but you don't feel supported by the staff, that it would be very hard for you to learn or to tune up your skills. I just remember how disoriented I felt when I was a new grad and I didn't know anything and I always thought that I was doing everything wrong. Finally a couple of people connected with me who supported me and I always went to them with questions and I think that's helped me a lot. But it really depends on who the strong people are there. In our unit we just started hiring new grads and a lot of the people had a problem with that. When the first couple of groups came off orientation the new grads were saying "we know this unit doesn't like new grads". And that's

> unfortunate. Very unfortunate. Sometimes, seniority has its benefits.

Nursing management and physician support have a positive influence on the delivery of care given by these expert nurses. They have the confidence to speak up when they do not feel that care is being ordered appropriately, because they have support from each other and the administration:

> Patients and families frequently need the nurse to run defense for them. They may be mystified by the medical jargon, or their understanding may be blocked by fear. The nurse can interpret patient to doctor and doctor to patient, I call this kind of power advocacy power. It is the kind of power that moves obstacles or stands alongside and enables. (Benner, 1984, p. 212)

These experienced nurses talk about knowing the different expertise their team members have, so that they can go to them with different patient care problems, or just for support. Their support network is known and in place, and this allows them to become patient advocates. They recognize the need for support when one has a heavy assignment or when one is new, yet many nurses are negative about hiring new graduates. Lack of support will increase the new graduate's anxiety about the care she is giving. A new graduate's focus is more narrow: am I giving adequate care versus a more experienced nurse's focus of, is this the best possible care for this patient?

The following beginning nurses talk about equating experience with being patients' advocates, as well as the problems when there is an imbalance between experienced nurses and less experienced nurses.

INT- I'm interested in how you feel about nurses making decisions. It sounded like maybe from all of you that you were anticipating a time when you would be really important decision makers in that kind of a situation? Is that the way you think of nurses with more experience?

Nurse 1- Definitely.

Nurse 2- I see nurses as patient advocates. And, particularly in an environment like this where you have residents that rotate every two weeks we get a new set who sometimes really don't know very much about that particular area and are learning themselves. And, over and over again particularly I've heard experienced nurses tell residents what needs to be done and/or not follow resident's orders because it is the incorrect order. For that particular situation and because the nurse has 10 years experience in that area and the doctor is one week, they just simply don't have the clinical judgement. And I see the nurses as having to teach the doctors a lot. I see that a lot. It's frightening for me as a novice. (laughter) Because I know less than they do and they're asking me things.

Nurse 3- For me as long as the balance in your unit between experience and your nurses is a good one you're okay. (laughter) And with the nursing shortage that's something that I think puts an extra stress on units having more. This last group in the PICU there were nine of us, one with experience. And eight were new grads.

Nurse 2- When I look at whose going to be on Christmas (laughter).

Nurse 1- We were having our staff meeting about the holidays and we were saying well "if it works out that you give a party to the people who have seniority", some one of the fairly new nurses she's probably six months into it

said, "yes but what about the safety on the unit if we have all these new nurses on" and it's really true.

Nurse 2- Oh yes, I really fear for the patients on Christmas. Christmas eve I do. I look and see whose going to be on I think there are probably two experienced nurses in the whole unit.

INT- So, what's a good balance? What are you comfortable with when you come on and you look around? You want half and half?

Nurse 3- I want two thirds and one third.

INT- Two thirds experience and one third...

Nurse 2- Of a year or more and preferably about one quarter who have five or more. So I know there's somebody who really knows what's going on and I can go and talk to.

Nurse 1- I would say that in our unit there's rarely a day where I walk in and I don't see at least three people off the top of my head that I know are extremely knowledgeable and I would feel very comfortable going and asking anything and respecting and accepting what they have to tell me.

To answer your question. I think it says a lot for Nursing that the nurses who are the ones that have been there for five or seven years and can say to a doctor, "I think this is what's best for the child" and have the doctor say, "you're absolutely right" or "okay I agree with you because you know best." I think that's a wonderful direction for Nursing to be going. As long as we maintain our education level and are able to be accurate in those assessments.

Nurse 2- Nursing is being held much more accountable. We can no longer simply follow a doctor's orders and be under that umbrella we are professionally the Nursing Standard Act holds us to know whether or not the treatment the physician has ordered or not ordered, is appropriate. We can be called to account for that legally. Which is one of the reasons I think that there is a nursing shortage. Because it is a tremendous responsibility and it is not commiserated or compensated. People don't want that responsibility. I hear that over and over again when I try to recruit.

These beginning nurses have observed experienced nurses become patient advocates because the nurses have greater clinical expertise than many of the residents present on this unit. The less experienced nurse fears that she will be asked questions she cannot answer. She sees the need for patient advocacy, but realizes her limitations, and therefore is not able to meet this responsibility. Balance between expert and beginning nurses will help to insures patient advocacy. Benner, et al. (1992), sees expert nurses' sense of agency and responsibility for the patients' well-being is more realistic in terms of actual possibilities inherent in the situation and in the nurse's capabilities, as compared to the burden experienced by the competent nurse. Expert nurses are responsive to and advocating for the patient and family concerns in ways that more closely match the actual concerns and needs. Threats to patient advocacy and quality of care arise during shifts where there is a lack of experienced compared to inexperienced nurses together at the same time.

For beginning nurses, the reality of nursing practice differs drastically from their nursing school days. The reality of bearing the full responsibility for their patients in many cases is shocking and very frightening. For more experienced nurses, being a

source of knowledge for those less sure of themselves, and thereby maintaining and protecting patient advocacy, is one of the challenges they face. Continued responsibility for patients confronts all practicing nurses.

CHAPTER V:

FINDINGS: CLINICAL LEARNING NEEDED TO GAIN PRACTICAL KNOWLEDGE

Nurses are dependent upon clinical learning in order to gain the practical knowledge needed to inhabit the role of a nurse to its fullest extent. Practice knowledge resides in the lived, everyday understandings and meanings embodied in skillful comportment. Theoretical is a derivative, it is a skeletal account of practical knowledge (Benner, 1991). In nursing school, heavy emphasis is placed on theoretical knowledge with little acknowledgement of the experiential learning required for developing clinical knowledge. The following themes with supporting paradigm cases emerged.

Who and What is Teachable

The feeling of incompetence, which many beginning nurses feel, arises partly from their lack of recognition of the difference between practical versus theoretical knowledge. The following narrative of expert nurses acknowledges that for some beginning nurses, practical knowledge is hard to assimilate. The problem arises when a beginning nurse cannot conceptualize, or have a "feeling" that treating blood pressure, for example, entails more than just giving a

vasopressor. The expert shows the difference between two beginning nurses in their understanding of theoretical versus practical knowledge.

Nurse 1- Well, there's two kind of new people, though. When you come down to the new grads there's the one's that do not know that they don't know something. Then, there's the one's that know that they're brand new and they need help. And, one is dangerous and one is not. In the unit right now, I mean we have a person whose brand new and she hasn't a clue on what she doesn't know. And, she's a danger, so we're doing whatever to teach her. But she just hasn't a clue and I have racked my brain open on how to teach her. And, no one has been able to come up with the right thing from her. She just will not learn because she thinks it's like if she doesn't know it now it's not there.

Nurse 2- It's not worth knowing.

Nurse 1- And, it's just simply horrifying, scary to know she's on and she'll take a sick person and every one in the unit kind of like walks, instead of walking down the middle of the unit, if her room is over here will curve over to just peak in and see.

Nurse 2- Why are you keeping her?

Nurse 1- Because she's brand new, she was just off her six month orientation, and she's new to critical care. We wanted to give her one last chance before they let her go.

Nurse 2- If she hasn't got it now, she's not going to get it.

Nurse 1- We just had her six month evaluation and everyone I mean precepted her and I was like...

Nurse 2- "You've blown it."

Nurse 1- Actually, they kept her on probation. So it was like still an option, but I precepted her and by the end of orientation I was frightened by her because I thought you don't know this and I know I've told you things and you can tell me verbatim what I said to you, but none of it sunk in. And she can still tell me verbatim everything I told her during orientation.

Nurse 3- She just can't apply it.

Nurse 1- Nothing! She can look at a patient and say that "gee when their cardiac output is 1 their probably in cariogenic shock" and she'll say it. And she'll say yes? She just doesn't put it together. I don't know how to put it together for her or show her how to put it together and during her evaluation we tried to approach it cautiously, so we didn't like crush her. We said "how do you think your doing". She said "great". Oh my God. What are we going to do? I still don't know

Nurse 2- It will never happen.

Nurse 1- I don't think it will. It's a rather horrifying experience, but then there's new people that are like running the joint in three weeks. I've had a new person say "I just got someone whose septic and hypotensive and they're on Levophed and Neosynephrine, and Dopamine and will you come in my room? Just stand there. I'll ask you questions if I need it and tell me if this is okay. But you stand there. So you know you lean up against the wall and let her do her own thing, and I know my drips well enough that I can calculate them in my head, so she goes Oh, my God, this is at so and so cc's, I say it's 14 meg's. per kilo. She says oh good, phew. Then she'll do this and da, da, da and then I turned this up, oh God where am I now? Because the doc will say how much is your Dopamine? It will scare her because she couldn't like give the calculations, she had things to do. She couldn't calculate in her head, she says "where's the calculator?" So I just tell her those things, but I knew it helped her just to have me there. And, she kind of talked out loud, "I'm going to do, this, this, this. "I'm going to do, titrate this up and titrate this down and if I didn't say it was wrong she just go ahead and do it. It was a real morals booster for her I know, because she gained so much out of it. All I did was like stand there and let her do her thing and I knew that she was doing exactly what she needed to do to figure out how to do it. There was no other way she was going to get this clump of information into her experience unless she sat there and did it. So you just let her do it.

But it's such a different person from that new person who doesn't know. I mean this other girl would have gone in there and started playing with the drips. Never have figured out why she was doing anything. Or maybe could have calculated it out with her mind, but still it would make no sense as far as the patient.

Nurse 2- I am somewhat of an expert on orientation in my unit.

Nurse 1- You had to be.

Nurse 2- And, I think that you cannot expect to be able to teach every monkey to work in CCU. You can't do it. The only thing you can do is cut your losses by, you know, being able to select between those people. It means it's clear to you what needs to be done but you have to face doing it.

Nurse 1- I essentially said my piece to my head nurse. I said, "this is how I feel, this is how lost I am on what to do with this person." I've talked to every single person in the unit. You're the boss, you know what to do, what you want to do and how you can do it. It's yours. She set up some criteria.

Nurse 2- It's been my experience and when you do it more, that you know in a week if someone's either going to do it or not do it.

Nurse 1- I've done enough orientation.

The experienced nurse recognizes that it is a valuable trait for a new nurse to realize her limits. Those who do not are dangerous to patients. She talks about having a dangerous nurse on her unit now because she does not understand or realize her safety boundaries. This new nurse is dangerous because she says all the right things verbatim, but the experienced nurse knows that she does not recognize the significance of the facts, nor can she necessarily "see" the facts in a clinical situation. She compares

this unsafe new nurse to new nurses who realize their limitations, but begin to test them with her present. These beginning nurses then begin to apply what they have been taught, one way is by talking out loud about what they are going to do next. They know that if the experienced nurse does not interrupt them, then they are doing it correctly, versus a new nurse who does something without knowing why. This experienced nurse, through many orientations, will know within a week if a new nurse is going to make it. The sense of agency, for the experienced nurse, and responsibility for the patients well-being, is more realistic in terms of actual possibilities inherent in the situation and in the nurse's capabilities. Part of this responsibility includes keeping track of what is going on with the patients of less experienced nurses and augmenting the less experienced nurses clinical assessments (Benner et al., 1992). Those expert in practice can recognize strong instances of excellent or poor practice (Benner, 1991), as recognized by this expert nurse in the beginning nurses discussed above.

On the one hand, these expert nurses feel that they can recognize who has potential and who does not. They feel that they are an elite group, "not every monkey can work in the CCU." On the other hand, this

behavior could show a devaluation of nurses who do not appear to have the talent and characteristics they value. It is impossible to tell how valid these conclusions are from this data set.

Beginning nurses realize that they need to expand their knowledge base to include practical knowledge gained from their clinical experiences. Support and finding credible resources is one way for them to gain practical knowledge, realizing that mistakes can and do happen. There is evidence that some experienced nurses will know within several weeks whether or not a new nurse is able to move beyond theoretical knowledge and gain practical knowledge. The only way currently to integrate new nurses is by preceptorship. As has been pointed out previously, the time limitation alone does not fulfill a new nurses' experiential needs required to become a competent nurse.

Finding Credible Sources of Knowledge

Finding out who a beginning nurses can trust on their unit, so that they can learn safely, is an important task. This next small group interview exemplifies this point.

Int- That was another kind of question that comes up as the result of interviewing other new graduates: How do you figure out who is reliable? Who can you trust to ask questions? Have you found that to be an issue or

difficult finding resource people that you could rely on?

Nurse 1- Well, yes on nights we are all so new in the nursery. There is a couple people I know and when I started they said, "She has been here for five years. This is the charge nurse." You know who everybody is, so that you pretty much know who to go to. But I also know who not to go to.

Int- How did you learn that?

Nurse 1- Just from asking them questions before and having them look at me like, it is just as foreign to them as it was to me. And then I just moved on to the next person. And asked the same question again until I found somebody that did know and then I would usually go back to that person. I figured if they knew the last question, they are going to know the next question.

Int- Yes. Have you had similar experiences?

Nurse 2- When you see something you do not just go and treat it. You assess first before you treat, and make sure that they have had that a little while before you go and start the Dopamine, or start the Lidocaine.

Nurse 3- I think they do that on purpose, too, though. Make you try to not constantly go to the charge for every little question you have. Because I know at first, I would ask ten billion questions in one night. Now I have gotten to the point where after asking all those questions the first time, I remembered the answers. Now I know that this is no big deal, I can wait until something more happens and then go to her.

These two beginning nurses have learned who they can go to get correct answers to their questions. They read the expressions on other nurses' faces after questioning them, judging whether they can properly answer the questions, using both interpersonal cues and the appearance of self confidence in the other nurses. They do this because they are unable to judge the

actual clinical performance of other nurses, and must rely on the comprehensibility of the answers received to their questions. Once they find someone whom they can trust, that person becomes their resource for learning. They also begin to develop a small comfort zone from their repeated questions. A certain symptom initially was worrisome, but through their questioning and then seeing how the answer fits, they now will treat the symptom as far as their knowledge and comfort level allow them. This is an example of learning to recognize and judge the importance of the practical manifestations of formal signs and symptoms that they have learned in the pathophysiological books. This is clinical knowledge that can only be gained experientially, but the experiential wisdom is dependent upon having reliable expert sources for clinical judgement.

Social Support of Other Nurses

A beginning nurse talks about having the support of more experienced nurses checking in with her to see if things are going well. This increases the comfort zone for this nurse as she learns to care for her patients. She is able to validate what she thinks is going on, and what she is going to do, and this allows

her to learn. Support is crucial, for her ability to provide care.

INT- So, at this point in your Nursing career are you comfortable relying on like in that situation were you comfortable relying on the people that were around you making the decision.

Nurse 1- Yes! I was. Much more comfortable than I would have been if I had had to make it myself certainly. And, it was very comforting having the nurses around me coming in and saying, "are you okay" and me saying, "this is what's happening, is this going okay, is this not going okay?" "What should I be doing, what shouldn't I be doing?" When I was getting positive feedback that was just kind of building on my feelings that okay everything's going fine and that helped a lot.

Not only is support crucial for beginning and competent nurses, but so is positive reinforcement, as the following interview of beginning nurses exemplifies.

INT- Do you get the sense that people are actually checking you out still?

Nurse 1- I think K. our charge nurse is.

INT- Does anyone ever say really positive things to you?

Nurse 1- Oh, sure.

INT- That's good to hear.

Nurse 2- I got it from K. that morning that I had done a good job. Which made me feel good because at the end, you know, finally when I did get to sit down, it just came all back to me. It was like--I did it. She said, "You know, you did a good job tonight." And it made me feel good, besides the patient saying that it was nice of me to do what I had done. But, yes, it does, it feels good when a person that's really important, when someone who has a lot of experience comes up to you and acknowledges what you've done.

Nurse 1- Or saying, "That was a good report." Or something like that. That's real positive. Or I started an IV in the foot and they said, "Now," uh--oh, I don't remember how they said it. It was "Now you're really a critical care nurse."
INT- Because you had started an IV...
Nurse 2- An IV in the foot.
INT- In the foot. Ouch.
Nurse 1- And so the next step is the thumb!

These beginning nurses felt good about the care they gave, but having their feelings validated by an experienced nurse helps build their self-esteem. It also allows them to think about increasing their clinical experience from this positive reinforcement. Their safety boundaries in clinical practice are expanding. A qualitative study by Dodds et al. (1991), examined the predictors of satisfaction in nursing by 84 new graduates and 75 registered nurses. Predictors of satisfaction with nursing were positive and personal, not negative and technical. Social recognition and positive feelings about oneself as a nurse were the major predictors of overall satisfaction, revealing that nurses distinguished between actual nursing environments and themselves as participants in the environments. Satisfaction with patient care was significant through its influence on these nurses' self-perceptions.

Limitations of Preceptorship

The current method of integrating new graduates with experienced nurses is by preceptorship. Unfortunately the time limitations are problematic, which is recognized by the following nurse.

Nurse 1- But what I see is the drawback is that you get a lot of the inexperienced together at one time (laughter). I don't know how that will ever change. That is true in almost any profession, I think, the longer you've been some place, it seems like experience goes with experience and then inexperience stays with inexperience, and how do you merge the two other than a preceptor oriented type position. But then once someone is off orientation, they're expected to function on their own. It's real difficult or it's almost inappropriate to expect someone to be able to function on their own in the setting that we present to them, in an acute care setting.

Here a nurse expresses the point that the longer a team has been together, the more experienced the nurses will be. Because of this more inexperienced and experienced nurses are segregated. She recognizes that this is a problem and beside the preceptor-orientator relationship, it is difficult and an unrealistic expectation for the new nurses to be able to integrate themselves fully into a team of more experienced nurses.

Coping with Failure

Support is crucial to beginning and competent nurses, not only to increase their self-esteem and

ability to learn, but also to help them through low periods in their clinical practice. There are times when situations do not go smoothly, as the following interview shows.

INT- Do you ever have any question that you have support should you get in a conflict?

Nurse 1- Oh no, we definitely have support. And it's been shown.

Nurse 2- Over and over.

Nurse 1- My overall sense is that we get better support in our unit. That people try unless staffing is stretched try and plan assignments for us that it's a little bit beyond where we've been.

Nurse 2- Just a little. Then they'll tell you "we know this is going to push you and we know there's a few things you won't be able to do but we'll be here to help you". I don't think I've ever gone on a shift and felt that there was not support there for me. Either by a fellow nurse, the charge nurse I've never felt that there wasn't a time where I could turn to somebody and say "help". Or, "one more time I still can't suction by myself can you come help me". And, there's always somebody there. I feel like we have a very supportive group and I think that makes a big difference.

INT- Who have you found to be most supportive in the unit? I mean, classes of people, I'm not looking for names.

Nurse 2- Actually that night that the patient crashed, I really was an emotional wreck, and I tend not to be a terribly emotional person, I think, you know. I mean in terms of breaking down in front of people, and here I was just, you know, like an exposed nerve. And uh, and I was sort of you know, my eyes welling up and feeling totally incompetent, like I should have caught that with the patient and watch my other patient better, and just everything. And I felt her arm around me and said, "Don't be so hard on yourself. Don't beat yourself up. You know, just learn from your experiences". And then she and the clinical nurse specialist, as well as some of

> the other nurses started telling me all the things that they had done wrong. "Oh, I remember I gave a third of a Digoxin dose." "Oh, I remember I had a patient whose pressure was dropping and we put the feet up and it was dropping, we upped the Dopamine, it was dropping. And finally after a half an hour we took off the covers and the needle had come out of the cord and she hadn't gotten any Dopamine for half an hour." And "Oh, I remember I had a patient that we rolled over and she had like hemorrhaged out and we never noticed it." And as people told me things, I thought well, people make mistakes, you know. And when they're your own, then you feel awful.

Here is a group of beginning nurses who feel they have support from other staff, as well as from their charge nurses, and this helps them in their nursing practice. Support is critical in times of conflict, and these nurses state that support has been there for them over and over again. Even in times where staffing is stretched, support is given by telling these nurses that help will always be close by. This allows these nurses to practice within safe boundaries, while being challenged so they can grow safely in their nursing experience. This also allows these nurses to be part of the team, by taking on more of a load to help out with the staffing pressures at hand. Nurse 2 talks about a time where she was in a crisis situation personally over a patient care issue, and having people whom she values come up to her and give her support. This was done by more advanced nurses sharing some

instances where situations did not go smoothly because of their nursing judgement, but the bottom line was realizing that mistakes do happen and the importance of learning from them and incorporating them into their nursing practice. These nurses are able to practice in an safe environment, learning that they are human and no matter how hard you try, situations arise where you feel out of control and mistakes happen. They know that even with plenty of support around them, they will have to make judgements on their own. Making decisions, and mistakes are necessary risks in order to gain experience.

CHAPTER VI:

FINDINGS: TEAMWORK AND SOCIAL INTEGRATION

Because nurses work together on units, groups develop and teamwork ensues. How do nurses become integrated into an already established group? How does group behavior influence teamwork and does this influence a nurse's self-esteem? The following emergent themes will begin to answer some of these questions.

Identifying and Conforming to Group Norms

Beginning nurses discuss the importance of being able to sit down, and talk together about patient care issues, and how this helps them to learn. Also, they talk about how they integrate themselves into the group and the importance of integration.

INT- I want to go back and pick up just a little bit. You were saying earlier, L., about sitting at the desk talking with the nurses. What are the benefits to that? You can now do that more than you could earlier.

Nurse 1- Well, it provides time to exchange information. Like, I called Dr. so and so and he said that I should wait on this, or give them, and so next time when I'm faced with that situation I'll be able to say, "Well, what did they say?" I find, the more I talk to people, the more I learn about things that I never would have thought of, or haven't been faced with, or wouldn't have known what to do. Especially when people make mistakes. I think it's really great to hear about it.

Nurse 2- It makes you feel better.

Nurse 1- Well, yes, that too. I'm always amazed at how much there is to know, and how little,

how really little even after this amount of time.

INT- I would think there are a lot of little tidbits that would take you a very long time to pick up without the exchange from other nurses.

Nurse 1- Right. And then, also, there's the kind of, there's the side that if you get to know them then when it comes time to turn your patient or do your weight, then they get up and they help you. Or when you're admitting a patient and you need a couple people to transfer onto the gurney, and stuff, they'll just come on over and you don't have to ask them to. So! That's why I try and help with weights if I can.

Nurse 2- But you know I do that before, after my 12:00 assessment, which usually ends at 1:00, before I sit down and chart, I always go around and ask everybody, "Do you need me anywhere." And I guess that's what I use, is, "Yes, I'm here if you need me." You know what I mean, sometimes I do find time to talk, but other times I just don't have the time. But, yes, I use that, even at other times, like at 4:00 or between, I'll say, "Are you okay? Do you need anything? Can I get you anything?" And I just use that to say that I'm here.

INT- Do you sort of deliberately think of this as ways of integrating yourself into the unit?

Nurse 2- Yes!

Nurse 1- What do you mean?

INT- Becoming a member, or becoming a part of the team, or whatever.

Nurse 1- Oh, yes. I think it's deliberate for L.

INT- It's deliberate on your part.

Nurse 2- Yes, cause you want them to be there when you need them.

Nurse 1- Oh, yes, definitely.

Nurse 2- Because you want to let them know that you will be there if they need you. Anything, be it minor. But yes.

INT- It's really interesting. I think that the newcomer is always working very hard to get into the group.

Nurse 2- To get acceptance.

INT- Yes, to get acceptance. I have a sense that it ought to be the group that's working a little harder to integrate the new--do you

feel like they're working very hard to integrate you into the group? So you go out of your way to be accepted and integrated, do you feel like they, that nurses on the unit sort of go out of their way to incorporate you, or to seek you out, or to make you feel like a member?

Nurse 1- No. I think we're pretty much on our own.

Nurse 2- I agree on our own.

Nurse 1- We're borderline accepted, but I think it's just a matter of time.

INT- There's reticence? Some sort of reticence on their part, or how do you understand this?

Nurse 1- It's almost like a good example is when one of the nurses came in the morning to give report and I said, "Oh, I'm ready, I've got bed 11 or whatever," and he said, "Fine, I'll go get a cup of coffee." And on the way he ran into somebody else and sat down and got a report from them, and I was livid. And I made a joke, and I said, "Oh, you know, you old-timers stick together," but you know I wanted him to know that I was aware of what he was doing, you know, and that it wasn't appreciated. But, you know what can you do?

Nurse 2- I don't know of any instances where they've tried to integrate us into their little group. Not once. I think we're fighting, I'm fighting--you are probably fighting real hard.

INT- To be integrated and to be accepted.

Nurse 2- And now I'll be switching from my old weekend to a new weekend with a group that has a reputation, so we'll see how that goes.

INT- They have a reputation for what? For being...

Nurse 2- For being...

Nurse 1- Strong willed.

Nurse 2- Strong willed, uh, what else? Gosh

Nurse 1- Domineering.

Nurse 2- Domineering, yes. Rude.

INT- Wow! This should be fun.

Nurse 1- Yes! Well, you know, everyone has their own little personality, you almost have to analyze every single one and say, "Well, this one thinks she knows everything, so." I mean this sounds terrible, it sounds really awful. But, if you approach her and say, "Can you show me this? Or what do you think about

this?" Then she responds really well. And then she's more than happy to show you.

Nurse 2- Instead of going up to her and telling her, "Well, this is what I see, and this is what I'm going to do, and then after, this is what I will do." Right? She doesn't accept that very well.

Nurse 1- And then other people are more laid back and it's just like, like W. She just gives me all kinds of responsibility. She thinks I can do anything. It's like really gratifying. But, but sometimes I think she like overestimates my ability, but I always feel like with her I can ask her anything, but with other people you know you're kind of careful. Just how stupid do you let them see you are.

INT- Because?

Nurse 2- They'll take advantage of you and they'll--I don't know. It depends on how they treat you. I remember that one morning, remember? Well, you really had to stand up for yourself that morning where you had to take the, remember the drug had already infused.

Nurse 1- Right, yes.

Nurse 2- And you did. She could have made you really look stupid in front of everybody, but you stuck your ground and said, "Well, after we do weigh the patient, I am going to flush it through the port." And that was that, period. Because that's just your way of doing it. But, yes.

Nurse 1- I thing sarcasm works well (laughter).

Nurse 2- Sarcasm does. I'm not really good at sarcasm. I have a hard time doing that.

Nurse 1- Well, that way you shine it on without leaving a lot of hurt feelings or whatever. I don't know. It's funny.

INT- I just want to go back to something you said because I was unclear about what you meant, you were talking about being accepted, and you said, we're borderline accepted, but I think it's just a matter of time. And I wasn't sure what you...

Nurse 1- Until we can prove that we're good. Until we can earn their respect.

Nurse 2- Until we're trusted, right.

Nurse 1- That we can be depended on. It's like, we've made it this far, so yes, you know, we passed the EKG class, and we passed the critical

care course, and we made it through the orientation, we made it through--oh I don't know the first couple of nights, the first couple of months on nights was sort of a test, you know. They give use a variety of patients to see what we can handle. K. will throw different assignments to see how we perform, and so it's like, so far so good.

Nurse 2- To see how we think.

By sitting down and talking with other nurses, these beginning nurses pick up valuable information about patient care situations. This time is a concentrated learning time for these new nurses. They create this time by offering to assist with simple tasks such as turning patients and helping with weights. This shows the group that they are willing to help out, and in exchange, the more experienced nurses share valuable information about their own experiences. These beginning nurses talk about the difficulty of integrating themselves into the group, and the importance of this. They are reminded through incidences that their status is tenuous, like when the experienced nurse gave a report to another experienced nurse bypassing the beginning nurse even though it was her patient. They recognize that their acceptance is borderline until they can prove that they can be trusted, and therefore respected. These beginning nurses learn the different ways to approach different nurses in order to get the desired responses without

offending them, which would hurt their chances to learn and become integrated into the group.

Developing Credibility and Proving Oneself

While it is important for beginning and competent nurses to realize the need for continual help in their nursing practice, they have a more difficult time asking for it, as compared to experienced nurses, as the following excerpt shows.

INT- Do you have a sense that the other nurses, the ones with seniority, do ask one another for favors and help more easily.

Nurse 1- They do, yes. I think they do.

INT- Why is that? It's probably real obvious to you, but say it anyway. Why do you think they can do that easily, ask for help more easily...

Nurse 2- I don't think they feel it's a reflection on their inability to do it, it's just they recognize when they're over their heads, and ask for help. Whereas I take it personally. Like if I can't do everything, I feel like I'm incompetent.

Nurse 1- You, too.

Nurse 2- I have to be able to do it all and do it all well. And do it now.

Nurse 1- That's right.

INT- And when you get really experienced, you won't have to do that anymore.

Nurse 2- I won't feel I have to kill myself that way, you know. You know, I'll be able to say, "Well, no, you know, I'm really busy." And it's not because I'm not good, it's just because I'm really busy.

Nurse 1- Well, it took me a little while to also ask the respiratory therapist to suction my patients. You know, I was the one that did it instead of asking. Now, seriously, when I am over my head I say, "You know, excuse me, can you suction." Cause I don't have time. "Go suction him for me, please." So, yes. It's getting better.

These nurses have realized the impossibility of providing all the nursing care to their patients themselves. Yet they must develop the confidence to ask for help, and to know that it does not mean they are incompetent. They are also becoming integrated into the notion of teamwork, and can see the benefits not only for themselves, but for the unit as a whole. Their self-esteem about their nursing abilities has to develop to a point where asking for help is not to them a reflection of incompetence, but rather of competence.

Embodiment of Teamwork

Teamwork is never more crucial than during a code involving a newborn. The following interview of competent nurses describe a code situation that went smoothly because of team work. There is a large number of nurses staffed at all times but teamwork has developed because of the structure of the unit, allowing them to interact well with each other.

Nurse 1- Well, we did one together at the change of shift. I was actually my first one to be involved with.

INT- Okay, that would be a great one.

Nurse 1- And that was S.'s third and fourth by that point. If they know ahead of time they try to deliver these babies on day shift where we usually have two physicians or two neonatalogists. Where our physicians usually go home at 5:00 p.m. and then there's one on call. So this one for some reason got bumped. It was around 3:00 or 3:15 p.m. I guess there was a lot going on that day; a bunch of deliveries. S. and I went to the

delivery room. Two physicians, G. and L., were both there. L. intubated and G. was doing a chest. S. and I were aspirating. We just took the kid over and S. and I put the lines in. L. stayed at the head of the bed and was in charge. He was giving all the orders and everybody was listening to him. All G. was primarily doing was putting a chest tube in on one side. It was kind of crowded at first because you have a picture of a bed that's maybe like 2x2. You got a doctor at the head, and then S. and I are down here trying to put the lines in, and then you've got a physician right here at the chest and there's not much difference between the chest and the abdomen. It's like this much difference. We had one person charting for us as we were calling things out. Each person was responsible for calling out what they had done and at what time, someone was just writing it down. And that one went real smooth. And actually we thought that kid was really stable when he left. I think he went over to Children's and got really sick. Actually went on ECMO (extracorpular membrane oxygenation). Like a heart-lung machine. It's really good for Mec-aspirations.

INT- Baby make it?

Nurse 1- Baby made it. So did that kid...I was really surprised that he had gotten that sick but it did. Went into, I think, pulmonary hypertension, and then it just went away really bad. But that one went really smooth. But it's so rare that you see something other than RDS. Guess they go in spurts.

Nurse 2- I think our advantage in our unit is that we have 10 nurses usually per shift and so we have lots of nurses to interact with to help make decisions with and because of that, that's why we can feel pretty comfortable when we call somebody above the resident because we've all decided they're wrong.

Nurse 3- Everybody's decided it is the thing to do.

Nurse 4- It's a group decision.

INT- Do you use a lot of validation?

Nurse 2- Yes, all the time. You know, is the IV in? or yesterday, it's well we titrate insulin chem strips between 120 and 180, 'well should we turn the insulin off, should we turn it down? What should we do?' That kind of

thing. 'This is what the chem strip is' and things like that all the time but you know, we have an advantage, we have so many nurses, patients don't care if we talk around them, and so ...

INT- That's true, that's got to be a big difference.

Nurse 2- It is. I think we probably know each other a lot better than we might on another floor because we spend time talking to each other all the time, whereas on other units, you spend time talking to patients. It kind of depends on whether families are there too. It's a real different thing than working on a floor. And we're all in one room. There's no separate rooms, so we can carry on conversations. It's noisy.

Running a code situation is always difficult, but even more so when the patient is a baby. The space limitations alone demand considerable organization. Teamwork between nurses and physicians is the key, as these nurses have validated. These nurses talk about being able to validate their decisions with each other, therefore feeling comfortable and able to stand up for their assessments. Knowing that a group is behind each of their individual decisions allows them to be patient advocates, and ensures that care for their patients falls within safe boundaries. These nurses have a sense of control when practicing their care. Not only does the large number of nurses present each shift influence this, but so does the small physical boundaries where they practice. They acknowledge that being in the same room all the time facilitates their

group teamwork, increasing the possibility of clinical learning. Nurses practicing on a floor do not have the benefit of this reduced area of boundary.

Scapegoating of a Nurse

Failure is not always handled responsibly, and sometimes instead of acknowledgement of responsibility, blame is assigned inappropriately in order to maintain an image of competence. The informal system of spreading responsibility among health care workers and the lack of acknowledgement and legitimacy of the nurses' influence on medical decision making, creates the possibility of role conflict and scapegoating (Tanner et al., in progress). The following story concerns a beginning nurse and a situation where she became a scapegoat for a whole unit, including the medical personnel.

Nurse 1- It was a lack of knowledge on my part at the beginning, I guess, I should say, that when I got my blood gas back, even though it looked similar to the previous ones, I should have noticed that this man was in metabolic acidosis, and maybe informed the physician that he was. This man was dying of AIDS and he had everything wrong with him. He had DIC, he had ARDS, he was septic and he was dying. They had put a triple lumen catheter in him and gave him a pneumothorax so he had chest tubes, and he had an infection in his bladder, so he had irrigations going via his catheter, plus he was getting a lot of medications, and he developed an allergic reaction to a couple of his antibiotics, so he had a rash all over his body. He also had Candida in his mouth. So he had quite a bit

going on with him. He was in renal failure so all his systems were bucking the ventilator so we had to pavulonize him, so neurologically he was pretty much out of it. This patient did not want to come to the hospital. His boyfriend was the one that had suggested that he should go in, so they admitted him. So he was here against his wishes. I had him when he first came in and he was really septic and he was on a ventilator and he had ARDS. Then a couple of weeks later he had the pneumothorax, so when I got him, the last time he was really sick, all his organs were failing. They were still trying to decide what they should do with him. What they did was try to de-pavulonized and try to remove the vent and they asked him if something were to happen after we extubated you, and you went into respiratory distress again would you want to be intubated again, and would you want everything done for you? And he agreed that he did. So, they extubated him and he began sounding really terrible, like he was in distress. As the night went, I felt really uncomfortable when I got him. Just looking at him, saying this man just looks like he is going to die at any moment now. You know his heart was taching in the 150's and I guess they had given him Verapamil the previous shift and it had not done anything so I was to repeat it. His blood pressure was okay. His respirations were fast 28-30s, and they had done blood gases before and felt they were satisfactory. Well I was uncomfortable. So by 5:00 I had gases done and I called the doctor and told him that I was really uncomfortable, that this man did not look good. I gave him my assessment and the blood gases. He did not want anything done, even after knowing about his declining neuro status, his heart rate taching, his blood pressure dropping, his urine output dropping and his blood gases. Because I was not comfortable with this decision to do nothing I called his AIDS doctor but unfortunately another physician was on call, and she did not know the patient that well. So I gave her a mini history of what had happened to him in the hospital, and the orders this physician gave me was to make

the patient a No Code. I guess this really hit me, because even though he was dying, I knew he was dying but also knowing this patient wanted to be a Full Code just really bothered me. Plus I do not think that she even knew him well enough to make that decision. So I then called the medical director, not to change the order, but to say, "Yes, I am very uncomfortable with this." And he said, "Well, she is the physician, she writes the order, you follow it." So I am uncomfortable, new, and no one else said anything, and everybody was uncomfortable with this guy, and nothing was done.

Int- Do you have an ethics committee that you could have consulted?

Nurse 1- Probably, but let me tell you what happened next. The 7:00 a.m. crew came on and the nurse who had cared for him many times, came to get a report from me. At this point the patient was being dialyzed and she pointed out, "Yes, he is metabolic acidosis. He should have been dialyzed a lot sooner than now." The dialysis nurses usually come in around 6:00 a.m. So it made me look and feel really stupid. Like, yes I should have caught it, but I did not, but no one else caught it either, and I had given the labs. I gave the scenario to two different doctors, and they did not do anything about it. Well, I came in the next night, and the patient was still there but someone else had got him, and I got a couple of different patients. What was going around the unit was complaints from day shift that I should have seen this and I did not, and something should have been done. Whereas no one else, you know, had seen it either, but they expected me to have treated it. The nursing director called me in along with the charge nurse of that night and the first thing she asked me, "Okay, I., these are the gases, I want you to tell me what you see." Right away I was able to say "Yes, he is in metabolic acidosis." And she said, "Well, do you not think something should be done about that?" And I said, "Yes." And then she relayed the case and said that the doctor felt that I did not give him enough

information when I called, and I had stressed something different...

Int- Than metabolic acidosis.

Nurse 1- Right, than the metabolic acidosis. So he did not catch it. So apparently, from what she was saying, was I only gave him the pO2 instead of the whole blood gas which was untrue. So to me it seems he was just covering himself and that's what angered me. Also that nobody supported me.

Int- So you were the scapegoat.

Nurse 1- It was unlikely that you would give just the pO2 without the rest of the gases.

Nurse 2- Right. So what happened, not only did I feel like I got bawled out, she said that I should take it constructively, and I do not think so.

Nurse 1- But, you gave the gases to two of the doctors and neither of them said anything.

Nurse 2- Yes, but I was the only new nurse on, so all the nurses that I was working with all had been there for at least a couple of years. I had only been there for about three weeks. So they expected me to know this. I apologized for not catching it and one of the nurses said, "There were four of us here and we did not catch it either. We have been practicing for longer than you, so do not take this too personally." Yet I felt like my nursing director did not support me, and in the end she said, "Well, next time you will know that if you see these gases you should look at the bicarbonate level and you will know what to do because this has happened before. Do not be surprised if you get a note in the mail from the day shift nurse saying that you should have acted upon this a lot sooner." So I felt really terrible.

Nurse 1- Did you get a note in the mail?

Nurse 2- No, I did not, but the story went around the unit for two weeks, and I also got in trouble because I "shopped around" for doctors because I did not get the answer that I wanted. That is not true, but still they said I should not have done that.

Int- What happened to the patient?

Nurse 2- He went down to the floor. He still remained extubated, and they stopped dialysis on him and he died two days later. The whole

> situation was so complex and I just let it hang there. So it is just sitting in the back of my mind unresolved. It is like I do not want to touch it, I just want to leave it alone.

This beginning nurse paints a good picture of just how sick this patient is. She starts her narrative with the honest assessment that "it was a lack of knowledge on my part at the beginning." Throughout this situation one gets the feeling that this beginning nurse with only three weeks on this unit, was operating alone. No one was there to help her; not before, during, or after this incident took place. She had nowhere to turn, and yet she had an intuitive feeling that what was happening to her patient was not right. However, she did not have the practical knowledge to draw upon. Consequently, she was faulted for this incident but she had nowhere to turn to for support or guidance. Feelings of helplessness abounded for this beginning nurse. She works with a group of nurses in an oppressed environment, with management causing the oppression. Attitudes and practices in a oppressive society include the following:

a) the teacher teaches and the students are taught;

b) the teacher knows everything and the students knows nothing;

c) the teacher thinks and the students are thought about;

d) the teacher talks and the students listen-meekly;

e) the teacher disciplines and the students are disciplined;

f) the teacher chooses and enforces his choice, and the students comply;

g) the teacher acts and the students have the illusion of acting through action of the teacher;

h) the teacher confuses the authority of knowledge with his own professional authority, which he sets in opposition to the freedom of the students;

i) the teacher is the Subject of the learning process, while the pupils are mere objects (Freire, 1970, p. 59).

You can change the above "teacher" to "doctor/management" and "student" to "nurse" and see how oppressive attitudes are practiced within this institution. There is no resolution of this situation for this beginning nurse. She had to live with the incident being "talked about" on the unit for two weeks. She now lives with this incident in her mind unresolved, "The whole situation was so complex and I just let it hang there. I do not want to touch it, I just want to leave it alone."

Horizontal Violence of Nurses by Nurses

A further story of oppression occurs here by a group of nurses. Nursing management in their decision about degree issues creates oppression for nursing staff. As the story unfolds nobody ends up feeling very good about themselves, their nursing abilities, or the people with whom they work with.

INT- How did you get this job?

Nurse 1- Oh I had to do it. If you have a bachelor's, you just do it and there's a lot of resentment from everybody else who had been nurses for 15 years and I've been a nurse a year.

INT- So you have a degree.

Nurse 1- Right and it's just, there's a lot of resentment and it's challenge. I'm finding more and more.

Nurse 2- I feel a little devious on my part too. I know K. wanted to get on day and I was on nights. So I sent in my request for days but I don't have to be charge on night but now I'm assistant charge on days so.

Nurse 1- I just feel like I need help.

INT- Well what kind of support is there? I mean when you were given this job...

Nurse 1- None, except R. who listens to me as a friend.

Nurse 3- Unfortunately, the old timers on the unit on our shift right now are two year degrees and very sensitive about it. In fact they went into this big long thing the other night about how... You know L. and I both admit that the X is very preferential toward BSN's.

Nurse 1- And our supervisor is very preferential too.

Nurse 3- And that we don't necessarily agree with that at all but we do have BSN degree; it's not like we can pretend we don't. And they are very sensitive to the issue and I think, and therefore, less supportive of L. than they would be if she didn't.

They really take it out on us. They love, I swear, that I mean I am getting really frustrated with these people on our shift

because I think they really love, I mean it's like how many new people on this shift? M., R., M., have all worked at the X less than six months and four or five of us are new to the ICU. So we're all very new to the ICU and very new to the V and so they are in very much position of control. They know what's going on. They know what to expect when things go bad and we don't. And they are not helpful when there's a crisis. And I'm really getting frustrated with it. In fact, I have gotten pushy that when there is a code or something, I just go in the room and be a bother because I am sick... of not... of having codes on the floor and being pushed out of the room. It's about time that R. knew that I'm on the code because some night they're not going to be there and...

Nurse 1- Yes, that's another thing.

Nurse 3- And I to this day, have never watched anyone intubated on our unit because if I make it in there, I'm sent for somebody like the doppler (laughter).

Nurse 1- Sorry, I sent you to get the doppler last night. (laughter)

Nurse 3- You know go get the doppler'.

Nurse 1- Yes and that was another situation last, when we were on, when we had two codes in 18 hours. Well as a charge nurse, I need to regulate how many people respond to a code but since I've never had a code while I'm a charge nurse, even though I know that there should be only a certain amount of people, didn't do anything about it, because I felt like, I don't know, I just didn't do anything about it.

Nurse 3- Well both of them were going to be chaotic codes anyways.

Nurse 1- Yes and R., this older nurse who had been there for a long time that knew that, instead of coming to me and saying, she did say that there was too many people in the room, but I thought everybody was listening to her...but instead of coming to me saying "L, you know, really, you're supposed to do this", she goes to the night nursing supervisor and complains to the night nursing supervisor that there was just too many people in the room, you know, and thankfully, J. and I are friends (laughter) and J. stuck up for me and said

"Well I think L. is the one that needs to know this", you know, after it passed down the line a couple of people down, the day charge nurse, and all this stuff and oh, it's just really frustrating to me and I really don't, you know, I'm at the end of my problem solving abilities in this one because I do agree it will take time but I feel like I'm not given time to learn how to do these things but I'm expected to just do it right.

Nurse 1- And I think it's the patients who suffer throughout all this, you know nurses just need to be more supportive towards each other and I think it's the patient that really get the brunt of all this hostility.

Nurse 3- It's a really frustrating situation. But it's reversed prejudice. I mean they're so sure that we're against them and their two year degrees...

Nurse 1- We could care less.

Nurse 3- And we get... I don't care.

Nurse 1- It's constantly brought up but it's not from the people with the bachelor's it's when people with associates, 'there's no way in hell I'd ever go back and get a bachelor's degree' (imitating what nurses on the unit say).

Nurse 3- Or if I did, I wouldn't tell anybody. And I said, "yes, you would. You get paid more money." And they said, "money's not everything." (laughter) You know, it's really frustrating. And it is because our supervisor does discriminate against them.

Nurse 1- She definitely likes me more than a lot of people and everybody knows that.

INT- And when you were put into the charge position, she just said "You're going to be charge nurse".

Nurse 1- Yes and I wasn't that against it because I like it for my resume.

Nurse 3- Well no one on your team wants to be in charge.

Nurse 1- Nobody else wanted to be charge.

Nurse 4- It's bad to decline a position like that in this hospital. It really is. If you start telling you supervisors, "no, I don't want to be charge", the people who refuse the charge position, you kind of find yourself...a lot of closed doors all of a sudden and I've seen

that happen. Sounds like you're afraid to say "no, I really don't want to do this."

Nurse 1- And then I feel like I'm a brown noser. Then there was just this huge production made out of it and I was supposed to be sent to another team to be charge and the other team, J., my supervisor held a meeting without letting me know with the other team that I was supposed to be going to because there was going to be somebody going on maternity leave. All of them said they did not want me for charge because I was too inexperienced. I was being brought from another team, I had not been a nurse very long, etc., so I felt horrible about that. But I learned about it painfully. A couple of nurses said "We really like her a lot and it has nothing to do with that" but they were just really resentful that I was being, that I was new and the only reason I was going to be charge was because I had a bachelor's degree. And a couple of nurses called me up and told me about the meeting or I never would have known about it, and it just gave me really hard feelings that I had to go to this team to "try out" so the supervisor decided to listen to this group of nurses and that we would try out the charge nurse, a couple people who didn't have a bachelor's but had been nurses for a long time and everybody would evaluate us. So I was new to this team, was only in charge like twice and there was nothing that came out that really needed any delegation or any sort of control or something while I was in charge so nobody did evaluations on me. And then the other team that I was originally on, the charge nurse decided to go to days so I was moved back to that team and so I was really resentful about how the whole thing was handled and just felt real dumped on. And felt like nobody wanted me to be in charge of their team. So my self-esteem was really decreased because everybody knew about it and everybody had known about this meeting, and I felt like well nobody wants me to be charge nurse. How can I be effective?

INT- But nobody else wanted to be charge nurse either.

Nurse 1- Well I think they do...

Nurse 3- Not in your opinion.

Nurse 1- Yes, if there hadn't been such a big bachelor's deal and...

Nurse 3- Who?

Nurse 4- Well, I've graduated from a diploma program and then went back and got my degree so I've been on both sides of the fence at the X. And when I did not have my degree, you--it's different because you don't go to classes, they don't send you to any educational classes. They don't...

Nurse 3- They do in our unit.

Nurse 4- Well where I was. I was over in X. (same institution but in a different city close by) on the rehabilitation; not the nursing but the rehabilitation center, I wasn't allowed to do anything and I was charge just because I was out of school, everybody else, I was more motivated than any of the other nurses and they were all senior graduate nurses and I'm a junior grade nurse and they put me in charge but I could not go to their leadership classes because I didn't have my BSN, I couldn't go to any of the research classes or anything like that. And it made me so bitter. I was so bitter and I really tried because nobody else could move fast enough to do it and I thought, this is, I'm going to be used and I thought well, I've got a lot of years in nursing and I'm not going to sit there. I'm going to go back and get my degree because I'm tired of people telling me "no, you can't do this because", you know, my feeling is and I know their attitudes because it gets really hard after awhile to be told us "you can't do this." The X, like constantly. The first day I was hired and was those orientation classes, oh that's okay, or no, it was "I thought the X wasn't hiring anymore non-BSN nurses." But that's okay, that you don't have your BSN, you'll probably go ahead and...", you know what I mean? It's just BSN, BSN, BSN and it just, so I thought I'm going to go back and get it so I did and so I've been on both sides and I know now looking back, exactly how they feel. But my feeling is go do it. Go back and get your degree and get it done with. Forget about it but a lot of people don't want to do that kind of--too expensive; it's too hard; it's too this, it's too that so I know that

attitude and it's completely sour grapes--totally sour grapes.

Nurse 3- I've always been, until now, I've been a real advocate (laugh) for the two year nurses and say once you have your RN, it's time to be supportive of each other and I'm really tired of nurses not being supported whether it's because of a degree or whatever the reason there is but I'm really resentful of the way I'm being treated. I mean I'm starting to--it's starting to affect me, what I see out there that I hate, it's starting to build up in me and I'm getting resentful.

Nurse 1- Well that was one reason why I came here. Someone suggested the labor and delivery, besides they're giving a $2,000 bonus but there was good nursing management and stuff. And especially (name of manager) there's always stuff you want but when you look at the whole picture, I mean she really does go to bat for us and I think most of us appreciate how much she works to try and get things for us and I think that's real important to feel that someone is supporting you that is listening to what you want and tries to go up to the other people to get it for you.

This institution openly discriminates against nurses who do not have a Bachelor's degree, irregardless of the nurse's level of expertise. This is a no win situation for all involved, and it becomes evident through this beginning nurse's voice how she feels. Even though she has support from nursing management, in order for her to function efficiently in her day to day activities, she needs the support and encouragement from her colleagues around her. The nurse with fifteen years of experience who sees a nurse, barely a year out of school, in a leadership

position in which she is told she cannot do it because of a degree issue, allows this new nurse flounder. Ultimately patients will pay for this through a decline in the level of care. Thus, because management's decision not to acknowledge the experienced nurse and the experienced nurse's decision not to support the new nurse, the confidence of both nurses is undermined.

Feelings of resentment and apathy are the norm here, and it is acknowledged that patient care suffers, as well as nurse's feelings about themselves. The illegitimate stresses (i.e., circumstances that prevent adequate caring) are the most damaging stresses and offer the fewest effective personal coping options. The illegitimate stresses (e.g., status inequity, staff shortages, work overload, and underpay) are damaging because they inhibit caregiving practices that are congruent with caring (Benner, 1989).

CHAPTER VII: DISCUSSION

There are many phases of nursing that a nurse must experience on her way to becoming an expert. No nurse can walk that journey alone. Support, teaching, and guidance are needed along the way. It appears that it is most beneficial if this support, teaching and guidance comes from other nurses. No one can really know what it is like to be a nurse except a nurse. A physician or administrator does not have the experiential knowledge of what it means to be a nurse.

There are many milestones nurses must work through in which support from colleagues is crucial. Accepting and learning how to manage the responsibility of a patient's life appears to be very difficult and in some cases "shocking" to a beginning nurse. Nursing school tries but cannot prepare nurses for the reality of this responsibility because nursing professors are like a security blanket wrapped around them. One is never entirely responsible for patients when a student. While preceptorship tries to give beginning or new nurses a chance to become acclimated to their setting, its main limitation is time. Patients are individuals and part of their individuality is how an illness is manifested, and therefore how they respond to treatment. Because of enormous differences in patients

and the wide array of illnesses possible, the time limitations of preceptorship is the worst constraint.

For the beginning nurse, learning how to take on the responsibility of caring for patients who are critically ill and/or dying is crucial to her development as a nurse. One way for this nurse to learn is by having positive role models showing her how to work through the array of emotions she could be feeling personally. Learning to cry with patients and families is an important form of communication for nurses, yet there is an appropriate place and time for this, and the only way to learn this is experientially. Communication with a more experienced nurse is the foundation needed to be able to care for these patients.

Facing the challenge of being responsible for patients in life and death situations must be met, and accepted, by beginning nurses. Even though a beginning nurse's practical world is very narrow, they experience complex agency in which they feel responsible for managing patients carefully for the first time. The importance here is whether or not they receive support from other more experienced nurses in learning how to accept this responsibility. From a beginning nurse's perspective, finding out whom they can trust and

thereby learn from is important and necessary in their ability to care for patients. Who these beginning nurses seek out is almost exclusively experienced nurses who, these beginning nurses judge who can help them, but mutual reciprocity needs to be present.

Conversely, for the more experienced nurse, facing the responsibility of being a source of knowledge for less experienced nurses ensures that safety and care of patients is maintained. Experienced nurses also worry and watch out for travellers agency and float nurses because their skills are unfamiliar to them. Who an experienced nurse connects with professionally probably has to do with who they are personally, for each experienced nurse will connect with and role model for only a few beginning nurses at one time, if for no other reason then time constraints. Do experienced nurses talk among themselves about whom they will help teach, or is this done intuitively?

Facing and meeting the challenge of being a patient advocate requires support at every level. Beginning nurses see the need for patient advocacy, but cannot meet this need due to limited clinical and practical knowledge. They delegate up this responsibility to a more experienced nurse with whom they have developed a rapport (Benner, Tanner, &

Chesla, 1992). If a beginning nurse is not able to meet this need, experienced nurses assume control. Patient advocacy demands competency in the assessment of the situation at hand and having a support network in place, because of the possible confrontations which may arise. A real threat to patient advocacy is when there is an imbalance of beginning to expert nurses. The responsibility of having a proper mix of nurses is that of nurse mangers and those in charge of scheduling.

Support from other nurses including experienced nurses is crucial for beginning nurses to gain clinical and practical knowledge. Because beginning nurses are constantly working at the "edge" of their safety knowledge and comfort level, having someone whom they trust checking on them in a way that is supportive, will help build their self-esteem. Building of one's self-esteem is important because it allows a nurse to feel confident in expanding her practice, taking on more challenges, coping with mistakes, and dealing with patient advocacy issues in a positive manner.

Gaining practical knowledge is not always assured by having a supportive work environment. Some beginning nurses have a difficult time seeing the possibilities of situation and instead become locked

into theoretical knowledge, and never gain practical knowledge. An experienced nurse's perception of a nurse who is unable to gain practical knowledge is one of danger, because of the limitations theory holds in our world of nursing. Only a more experienced nurse is able to see this distinction and potential problem when it arises. There is no easy solution to fix the problem, because gaining practical knowledge is dependent on experiential learning, and is therefore dependent on the person's ability to experience situations and then gain practical knowledge. This is an important point of reference which expert nurses are able to recognize in beginning nurses and possibly, recognizing when it is not achievable. If a nurse has a supportive environment and is given the opportunity to learn, but cannot assimilate practical knowledge, then a ethical dilemma arises for the experienced nurse. What do you do, or recommend when a nurse cannot move beyond the theoretical perspective and is potentially dangerous to those for whom she is caring? On the other hand, the devaluation of the "out" group - those who do not belong - may point to horizontal violence within nursing ranks. There is a risk that orientating the newcomer may be more testing and hazing than recruiting and developing.

Nurses, and specifically those working in a hospital or clinic, work together as a group. Whether it be due to the structure of the unit and/or the nature of the nursing task at hand, team work is important in the delivery of successful care. Beginning nurses becoming integrated into a group to meet their needs of maintaining safety, gaining clinical and practical knowledge, and developing support to increase their self-esteem. Next to identifying the nurses who can become their resource from whom to learn, becoming integrated into the group where one works is an important milestone. Beginning nurses early on learn what the group norms are and then conform with them, hoping to become integrated into the group. The benefits of becoming part of the group include having more experienced nurses sharing valuable information about situations from their perspective, and providing a "concentrated learning time" for these beginning nurses. As one nurse says, "I would think there are a lot of little tidbits that would take you a very long time to pick up without the exchange from other nurses".

One way for beginning nurses to become integrated into a group is by teamwork. Here teamwork is viewed as an avenue to become accepted by more experienced

nurses so that they can meet their needs at hand. Only later, as they gain some experience, do they see the necessity of teamwork, especially at critical periods involving patient care. Integration into the group happens over time, and beginning nurses have to prove to other members that they can be trusted and be of potential value to the team. Until they have gained enough clinical and practical knowledge, they are at risk at being reminded of their tenuous status. A beginning nurse's self-esteem is easily wounded because self confidence in their nursing ability is low. Support and positive reinforcement is crucial at this point.

While beginning nurses feel insecure about asking for help, expert nurses see asking for help as a sign of security. Experienced nurses partake in team work, and one way is by asking for help when needed. For beginning nurses, the importance of developing credibility has a negative impact on their ability to ask for help, which is so important for them to do because they need help in learning and developing their nursing skills. What helps beginning nurses is to see experienced nurses asking for help without this affecting their self-esteem or credibility. It is important for more experienced nurses to recognize this

fear and be supportive and role model for those less sure of themselves.

Teamwork is measurable and most crucial during patient codes. If teamwork does not take place, it is evident to all who participate. Conversely, if teamwork is present, the situation has a feeling of control and nurses feel less stressed irregardless of the outcome. Teamwork embodies the finest communication between persons. This ability to communicate is developed by nurses over time by working together. Each nurse is aware of her own skill level and the skill of those who work with them. Because of this need to understand skills, beginning nurses are never truly part of teamwork. This is not to say, however, that they are of no value to an already existing team. Because units are fluid and ever changing, beginning nurses are needed to fill in emptying spots from vacating nurses. Teams for the most part are dynamic. Characteristics of a team change depending on the persons and skills involved. For ICU nurses their confined work area facilitates communication between each, thereby facilitating teamwork.

Coping with failure is difficult for any practicing nurse but even more so for beginning and

competent nurses. Care in ICU units has become so technical and advanced that mistakes are bound to happen. These mistakes, while hopefully not life threatening, help nurses to learn the skills of their practice. For beginning nurses who already feel the tremendous weight of responsibility for their patients, mistakes are hard to view in any way but negative and as a reflection of their inability to maintain a patients safety and well-being. Many beginning nurses carry this fear home with them and often dwell on the possible or actual mistakes made. Beginning nurses need support and acknowledgement from more experienced nurses. This support allows the beginning and competent nurse not to take the mistake so personally and instead, to incorporate the experience into their learning so that chances of repeating it are minimal. This helps nurture their self-esteem, thereby allowing them to continue learning, knowing that learning involves taking some risk when caring for their patients. Humor and storytelling are positive ways to diffuse situations involving mistakes.

Nursing at times still operates in conditions of oppression. The story involving the nurse who was made a scapegoat told us how powerless she was in exerting her rights. The beginning nurse learning in an

oppressive environment will have a difficult time viewing her nursing work differently because she has no prior experience in which to relate back upon. Yet instinctively she knows that something is not right, and this causes her distress internally. If she never leaves the oppresive facility, her ability to become a patient advocate as she gains experience will never actualize because advocacy demands nurses' ability to stand up with their judgements and clinical expertise. The best hope for any nurse working in an oppressed environment is to find the courage to leave and find a job in which support and autonomy are the norms for learning. It is important for experienced nurses to be sensitive to the background of beginning, or new nurses on their unit, especially if a difficulty arises involving decision making, or taking on new responsibilities. These are possible indications that a nurse will require a more nurturing environment, and positive role modeling, until her self-esteem has developed sufficiently to embody the role of a nurse and one day, an expert nurse. An expert nurse walking into an oppressive situation would find her code of ethics involving her practice violated. She would never be able to voice what she thinks is right for herself and even less, for her patients. Benner (1991)

makes the point that ethics in health care must start with a practice-based understanding of what it is to be a person, what constitutes the relationships among the health care worker, patient, family and community, and what constitutes care and responsibility toward one another.

Caring for our patients is what nurses do, but we need to care for our colleagues in order to learn the skills of nursing necessary to provide care to our patients. Needs vary depending on the individual nurse and what level she is at in her practice of nursing. Nurses at all levels of practice need an awareness of the positive impact caring for each other has professionally and personally. As Benner and Wrubel (1989) write:

> Because caring gets up what matters to a person, it also gets up what counts as stressful, and what options are available for coping. Caring creates possibility. This is the first way in which caring is primary.
>
> Caring sets up the condition that something or someone outside the person matters and creates personal concerns. Without care, the person would be without projects and concerns. Care gets up a world and creates meaningful distinctions, with it is these concerns that provide motivation and direction for people (p. 1).

Limitations:

Many paradigm cases emerged involving nurse-nurse communication/integration because the methodology of the larger study encouraged this. However, the

possibility remains that the themes might be different if the purpose of a study were to look at nurses' relationships with each other exclusively? While the larger study involved only intensive care nurses, how do oncology, surgical, cardiovascular, medical, orthopedic, neuro, obstetric, geriatric and other nurses view each other and those across the different nursing specialties?

Implications for Research:

We have just a glimpse of what some of the needs nurses have while nursing. But this glimpse offers promising possible interventions for orienting the new nurses and integrating experienced nurses on a unit. One intervention worth studying would involve consciousness raising about extending the caring practice to one another.

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APPENDIX A

DREYFUS MODEL OF SKILL ACQUISITION

Dreyfus Model of Skill Acquisition

Novice: Novices have no prior experience in situations in which they are expected to perform and have to be given objective attributes (e.g., blood pressure values, temperature) and context free rules (e.g., rules with explicit cutoff points for determining dangerous vital signs) for approaching the clinical situation. They have little basis for varying the rules or identifying exceptions. In nursing much of the skilled performance related to technology and curative measures run counter to past experience or lay expectations. In these areas nurses are truly novices. However, many of the skills of caring developed from one's life experience can be appropriated for the nurse's care of patients. Therefore, even first year nursing students are not novices in all aspects of nursing care, though the intent and context of nursing brings many new dimensions and demands to caring relationships.

Advanced Beginner: Advanced beginners can demonstrate marginally acceptable performance. They have coped with enough real situations to note and to have pointed out to them by a mentor the recurring situational components termed aspects of the situation. Aspects, in contrast to the measurable, context-free attributes on the procedural lists of things to do, require prior experience in actual situations for recognition. Typically the newly graduated nurse performs at the advanced beginner level.

Competent: Competence is typified by the nurse who has been on the job two to three years, and develops when the nurse begins to see his or her actions in terms of goals or plans of which he or she is consciously aware. The competent nurse has perfected deliberative and analytical problem-solving in patient care. The plan establishes a perspective such that the nurse begins to approach the work more as a whole.

Proficient: The proficient performer regularly perceives situations as wholes rather than in terms of aspects, and performance is guided by maxims. Typically, the perspective is not "thought out" deliberately as it is at the competent level of performance, rather a plan just seems apparent based on past experience with similar and dissimilar situations and just seems apparent. The proficient nurse has learned from experience what typical events to expect in a given situation and how plans need to be modified in response to these events. The proficient nurse recognizes when the normal or expected pattern does not materialize. The nurse has a sense of salience with some aspects of the situation standing out as more or less important than other aspects. They often couch their clinical perceptions in terms of maxims, cryptic descriptions that reflect nuances of the situation only understandable to someone with a similar web of perspectives and skill level.

Expert: Unlike all prior stages of skilled performance, the expert no longer relies on an analytic principle (rule, guideline, maxim) to connect her or his understanding of the situation to an appropriate action. The expert nurse, with a large background of experience, now is able to zero in on the accurate range of relevant issues without wasteful consideration of a large number of unfruitful diagnoses and solutions.

Of particular interest in this study is improving the research definition and description of the expert nurse's use of a relevant clinical population when identifying the patient problem and pursuing an intervention.

Skill level	Components	Perspective	Decision	Commitment
1. Novice	Context-free	None	Analytical	Detached
2. Advanced beginner	Context-free and situational	"	"	"
3. Competent	"	Chosen	"	Detached understanding and deciding. Involved in outcome.
4. Proficient	"	Experienced	"	Involved understanding. Detached deciding.
5. Expert	"	"	Intuitive	Involved

From: Dreyfus, H. and Dreyfus, S. with Tom Athanasiou, Mind over Machine. Why computer programs can never match the power of human intuition and expertise---the consequences for management and education. Mac Millan Free Press (in press).

APPENDIX B

SAMPLE CHARACTERISTICS

equency distribution File: Judgment Date: 06-06-1990

LTER: None

bgroup: GROUP = 1 (ADV. BEGINNER)

riable: INITIAL, Years since initial nursing education

Label	Value	Frequency	Cumulative Frequency	Percent	Cumulative Percent
	0.33	1	1	5.00	5.00
	0.42	4	5	20.00	25.00
	0.50	8	13	40.00	65.00
	1.17	1	14	5.00	70.00
	1.42	5	19	25.00	95.00
	3.42	1	20	5.00	100.00

Number missing (-9) = 0 (0.00 percent of observations)

Statistics on 20 observations with non-missing data:

Mean = 0.885 Standard deviation= 0.736
Median= 0.500 Variance= 0.542

riable: BSNGRAD, Years since BSN graduation

Label	Value	Frequency	Cumulative Frequency	Percent	Cumulative Percent
	0.33	1	1	5.00	5.00
	0.42	4	5	20.00	25.00
	0.50	8	13	40.00	65.00
	1.17	1	14	5.00	70.00
	1.42	5	19	25.00	95.00
	1.50	1	20	5.00	100.00

Number missing (-9) = 0 (0.00 percent of observations)

Statistics on 20 observations with non-missing data:

Mean = 0.789 Standard deviation= 0.463
Median= 0.500 Variance= 0.214

ariable: HIGHDEGR, Highest degree earned

Label	Value	Frequency	Cumulative Frequency	Percent	Cumulative Percent
BSN	1	20	20	100.00	100.00

Number missing (-9) = 0 (0.00 percent of observations)

Statistics on 20 observations with non-missing data:

Mean = 1.000 Standard deviation= 0.000
Median= 1.000 Variance= 0.000

requency distribution File: Judgment Date: 06-06-1990

LTER: None

ubgroup: GROUP = 1 (ADV. BEGINNER)

ariable: CURRENT, Current unit experience (years/months)

Label	Value	Frequency	Cumulative Frequency	Percent	Cumulative Percent
	0.17	1	1	5.00	5.00
	0.25	1	2	5.00	10.00
	0.33	6	8	30.00	40.00
	0.42	5	13	25.00	65.00
	0.50	1	14	5.00	70.00
	0.58	2	16	10.00	80.00
	0.75	2	18	10.00	90.00
	0.83	1	19	5.00	95.00
	1.17	1	20	5.00	100.00

Number missing (-9) = 0 (0.00 percent of observations)

Statistics on 20 observations with non-missing data:

Mean = 0.483 Standard deviation= 0.237
Median= 0.420 Variance= 0.056

requency distribution File: Judgment Date: 06-06-1990

LTER: None

ubgroup: GROUP = 2 (INTERMEDIATE)

ariable: INITIAL, Years since initial nursing education

Label	Value	Frequency	Cumulative Frequency	Percent	Cumulative Percent
	1.50	1	1	3.57	3.57
	1.67	1	2	3.57	7.14
	1.75	1	3	3.57	10.71
	2.00	1	4	3.57	14.29
	2.50	2	6	7.14	21.43
	3.00	2	8	7.14	28.57
	3.50	1	9	3.57	32.14
	3.67	1	10	3.57	35.71
	3.75	1	11	3.57	39.29
	4.00	2	13	7.14	46.43
	4.50	1	14	3.57	50.00
	4.75	2	16	7.14	57.14
	5.00	4	20	14.29	71.43
	6.00	1	21	3.57	75.00
	6.17	1	22	3.57	78.57
	7.00	2	24	7.14	85.71
	8.00	1	25	3.57	89.29
	11.00	1	26	3.57	92.86
	12.67	1	27	3.57	96.43
	31.00	1	28	3.57	100.00

Number missing (-9) = 0 (0.00 percent of observations)

Statistics on 28 observations with non-missing data:

Mean = 5.703 Standard deviation= 5.603
Median= 4.625 Variance= 31.397

requency distribution File: Judgment Date: 06-06-1990

ILTER: None

ubgroup: GROUP = 2 (INTERMEDIATE)

ariable: BSNGRAD, Years since BSN graduation

Label	Value	Frequency	Cumulative Frequency	Percent	Cumulative Percent
	0.00	1	1	3.57	3.57
	1.50	1	2	3.57	7.14
	1.67	1	3	3.57	10.71
	1.75	1	4	3.57	14.29
	2.00	2	6	7.14	21.43
	2.50	2	8	7.14	28.57
	3.00	3	11	10.71	39.29
	3.50	1	12	3.57	42.86
	3.67	1	13	3.57	46.43
	3.75	1	14	3.57	50.00
	4.00	3	17	10.71	60.71
	4.50	1	18	3.57	64.29
	4.75	2	20	7.14	71.43
	5.00	3	23	10.71	82.14
	7.00	2	25	7.14	89.29
	8.00	1	26	3.57	92.86
	11.00	1	27	3.57	96.43
	12.67	1	28	3.57	100.00

Number missing (-9) = 0 (0.00 percent of observations)

Statistics on 28 observations with non-missing data:

Mean = 4.304 Standard deviation= 2.780
Median= 3.875 Variance= 7.727

'ariable: HIGHDEGR, Highest degree earned

Label	Value	Frequency	Cumulative Frequency	Percent	Cumulative Percent
BSN	1	25	25	89.29	89.29
MASTERS IN NURSING	2	2	27	7.14	96.43
AA	4	1	28	3.57	100.00

Number missing (-9) = 0 (0.00 percent of observations)

Statistics on 28 observations with non-missing data:

Mean = 1.179 Standard deviation= 0.612
Median= 1.000 Variance= 0.374

equency distribution File: Judgment Date: 06-06-1990

LTER: None

ubgroup: GROUP = 2 (INTERMEDIATE)

ariable: CURRENT, Current unit experience (years/months)

Label	Value	Frequency	Cumulative Frequency	Percent	Cumulative Percent
	0.42	1	1	3.57	3.57
	0.92	1	2	3.57	7.14
	1.42	3	5	10.71	17.86
	1.50	3	8	10.71	28.57
	1.67	1	9	3.57	32.14
	1.75	1	10	3.57	35.71
	2.00	5	15	17.86	53.57
	2.17	3	18	10.71	64.29
	2.33	1	19	3.57	67.86
	2.50	4	23	14.29	82.14
	2.83	1	24	3.57	85.71
	3.00	2	26	7.14	92.86
	3.50	1	27	3.57	96.43
	4.25	1	28	3.57	100.00

Number missing (-9) = 0 (0.00 percent of observations)

Statistics on 28 observations with non-missing data:

Mean = 2.105 Standard deviation= 0.781
Median= 2.000 Variance= 0.610

requency distribution File: Judgment Date: 06-06-1990

ILTER: None

ubgroup: GROUP = 3 (EXPERT)

ariable: INITIAL. Years since initial nursing education

Label	Value	Frequency	Cumulative Frequency	Percent	Cumulative Percent
	6.50	1	1	2.70	2.70
	7.00	2	3	5.41	8.11
	7.17	1	4	2.70	10.81
	7.50	1	5	2.70	13.51
	8.00	4	9	10.81	24.32
	8.25	1	10	2.70	27.03
	8.50	1	11	2.70	29.73
	8.75	1	12	2.70	32.43
	9.00	1	13	2.70	35.14
	9.50	1	14	2.70	37.84
	10.17	1	15	2.70	40.54
	10.25	1	16	2.70	43.24
	10.50	2	18	5.41	48.65
	11.75	1	19	2.70	51.35
	12.00	3	22	8.11	59.46
	13.00	3	25	8.11	67.57
	14.00	1	26	2.70	70.27
	15.00	2	28	5.41	75.68
	15.17	1	29	2.70	78.38
	16.50	1	30	2.70	81.08
	17.00	1	31	2.70	83.78
	18.00	1	32	2.70	86.49
	18.50	2	34	5.41	91.89
	21.00	1	35	2.70	94.59
	22.50	1	36	2.70	97.30
	24.42	1	37	2.70	100.00

Number missing (-9) = 0 (0.00 percent of observations)

Statistics on 37 observations with non-missing data:

Mean = 12.295 Standard deviation= 4.696
Median= 11.750 Variance= 22.056

Frequency distribution File: Judgment Date: 06-06-1990

FILTER: None

Subgroup: GROUP = 3 (EXPERT)

Variable: BSNGRAD, Years since BSN graduation

Label	Value	Frequency	Cumulative Frequency	Percent	Cumulative Percent
	0.00	3	3	8.11	8.11
	2.50	1	4	2.70	10.81
	6.00	2	6	5.41	16.22
	7.00	1	7	2.70	18.92
	7.17	1	8	2.70	21.62
	7.50	1	9	2.70	24.32
	8.00	4	13	10.81	35.14
	8.25	1	14	2.70	37.84
	8.50	1	15	2.70	40.54
	8.75	1	16	2.70	43.24
	9.00	2	18	5.41	48.65
	9.50	1	19	2.70	51.35
	10.17	1	20	2.70	54.05
	10.25	1	21	2.70	56.76
	10.50	1	22	2.70	59.46
	11.75	1	23	2.70	62.16
	12.00	3	26	8.11	70.27
	13.00	2	28	5.41	75.68
	13.50	1	29	2.70	78.38
	14.00	1	30	2.70	81.08
	15.00	1	31	2.70	83.78
	15.17	1	32	2.70	86.49
	17.00	1	33	2.70	89.19
	18.00	1	34	2.70	91.89
	18.50	2	36	5.41	97.30
	24.42	1	37	2.70	100.00

Number missing (-9) = 0 (0.00 percent of observations)

Statistics on 37 observations with non-missing data:

Mean = 10.268 Standard deviation= 5.304
Median= 9.500 Variance= 28.133

Frequency distribution File: Judgment Date: 06-06-1990

FILTER: None

Subgroup: GROUP = 3 (EXPERT)

Variable: HIGHDEGR, Highest degree earned

Label	Value	Frequency	Cumulative Frequency	Percent	Cumulative Percent
BSN	1	25	25	67.57	67.57
MASTERS IN NURSING	2	7	32	18.92	86.49
MASTERS IN ANOTHER F	3	2	34	5.41	91.89
AA	4	2	36	5.41	97.30
DIPLOMA	5	1	37	2.70	100.00

Number missing (-9) = 0 (0.00 percent of observations)

Statistics on 37 observations with non-missing data:

Mean = 1.568 Standard deviation= 1.015
Median= 1.000 Variance= 1.030

Frequency distribution File: Judgment Date: 06-06-1990

FILTER: None

Subgroup: GROUP = 3 (EXPERT)

Variable: CURRENT, Current unit experience (years/months)

Label	Value	Frequency	Cumulative Frequency	Percent	Cumulative Percent
	1.00	1	1	2.70	2.70
	1.17	1	2	2.70	5.41
	2.25	1	3	2.70	8.11
	3.00	1	4	2.70	10.81
	3.25	1	5	2.70	13.51
	3.50	1	6	2.70	16.22
	4.00	2	8	5.41	21.62
	4.08	1	9	2.70	24.32
	5.00	2	11	5.41	29.73
	5.08	1	12	2.70	32.43
	6.00	3	15	8.11	40.54
	6.25	1	16	2.70	43.24
	6.50	1	17	2.70	45.95
	7.00	3	20	8.11	54.05
	7.58	1	21	2.70	56.76
	8.00	1	22	2.70	59.46
	8.25	1	23	2.70	62.16
	9.00	1	24	2.70	64.86
	10.00	2	26	5.41	70.27
	10.17	1	27	2.70	72.97
	11.00	2	29	5.41	78.38
	11.50	1	30	2.70	81.08
	12.40	1	31	2.70	83.78
	12.50	1	32	2.70	86.49
	13.00	2	34	5.41	91.89
	14.00	1	35	2.70	94.59
	15.25	1	36	2.70	97.30
	22.00	1	37	2.70	100.00

Number missing (-9) = 0 (0.00 percent of observations)

Statistics on 37 observations with non-missing data:

Mean = 7.885 Standard deviation= 4.437
Median= 7.000 Variance= 19.684

requency distribution File: Judgment Date: 06-06-1990

ILTER: None

ubgroup: GROUP = 4 (COMPETENT)

ariable: INITIAL, Years since initial nursing education

Label	Value	Frequency	Cumulative Frequency	Percent	Cumulative Percent
	6.42	1	1	4.76	4.76
	8.92	1	2	4.76	9.52
	9.00	1	3	4.76	14.29
	9.42	1	4	4.76	19.05
	10.00	2	6	9.52	28.57
	10.50	1	7	4.76	33.33
	12.00	4	11	19.05	52.38
	13.00	1	12	4.76	57.14
	13.42	1	13	4.76	61.90
	14.00	1	14	4.76	66.67
	15.42	1	15	4.76	71.43
	15.50	1	16	4.76	76.19
	17.42	1	17	4.76	80.95
	17.50	1	18	4.76	85.71
	17.75	1	19	4.76	90.48
	24.00	1	20	4.76	95.24
	26.00	1	21	4.76	100.00

Number missing (-9) = 0 (0.00 percent of observations)

Statistics on 21 observations with non-missing data:

Mean = 13.632 Standard deviation= 4.870
Median= 12.000 Variance= 23.713

Frequency distribution File: Judgment Date: 06-06-1990

FILTER: None

Subgroup: GROUP = 4 (COMPETENT)

Variable: BSNGRAD, Years since BSN graduation

Label	Value	Frequency	Cumulative Frequency	Percent	Cumulative Percent
	0.00	4	4	19.05	19.05
	1.50	1	5	4.76	23.81
	3.42	1	6	4.76	28.57
	3.92	1	7	4.76	33.33
	4.00	1	8	4.76	38.10
	4.50	1	9	4.76	42.86
	8.92	1	10	4.76	47.62
	9.00	1	11	4.76	52.38
	10.00	2	13	9.52	61.90
	10.50	1	14	4.76	66.67
	12.00	2	16	9.52	76.19
	13.00	1	17	4.76	80.95
	13.42	1	18	4.76	85.71
	15.42	1	19	4.76	90.48
	17.42	1	20	4.76	95.24
	17.50	1	21	4.76	100.00

Number missing (-9) = 0 (0.00 percent of observations)

Statistics on 21 observations with non-missing data:

Mean = 7.930 Standard deviation= 5.918
Median= 9.000 Variance= 35.027

Variable: HIGHDEGR, Highest degree earned

Label	Value	Frequency	Cumulative Frequency	Percent	Cumulative Percent
BSN	1	16	16	76.19	76.19
MASTERS IN NURSING	2	1	17	4.76	80.95
AA	4	2	19	9.52	90.48
DIPLOMA	5	2	21	9.52	100.00

Number missing (-9) = 0 (0.00 percent of observations)

Statistics on 21 observations with non-missing data:

Mean = 1.714 Standard deviation= 1.419
Median= 1.000 Variance= 2.014

requency distribution File: Judgment Date: 06-06-1990

ILTER: None

ubgroup: GROUP = 4 (COMPETENT)

ariable: CURRENT, Current unit experience (years/months)

Label	Value	Frequency	Cumulative Frequency	Percent	Cumulative Percent
	1.00	1	1	4.76	4.76
	2.00	2	3	9.52	14.29
	2.50	1	4	4.76	19.05
	4.08	1	5	4.76	23.81
	4.50	1	6	4.76	28.57
	5.00	2	8	9.52	38.10
	7.00	2	10	9.52	47.62
	8.00	2	12	9.52	57.14
	8.42	1	13	4.76	61.90
	8.50	1	14	4.76	66.67
	8.75	1	15	4.76	71.43
	10.00	1	16	4.76	76.19
	13.50	1	17	4.76	80.95
	14.00	1	18	4.76	85.71
	15.00	1	19	4.76	90.48
	17.42	1	20	4.76	95.24
	18.00	1	21	4.76	100.00

Number missing (-9) = 0 (0.00 percent of observations)

Statistics on 21 observations with non-missing data:

Mean = 8.080 Standard deviation= 5.038
Median= 8.000 Variance= 25.385

rosstabulation File: Judgment Date: 06-06-1990

ILTER: None

ow variable: GROUP, Group #
ol variable: TYPE, Type of current unit
ell contents: Frequency/Row percent/Column percent

	PICU 1	NICU 2	SICU 3	CCU 4	MICU 5	FLOOR 6	
1	3	2	7	0	3	3	20
ADV. BEGIN	15.00	10.00	35.00	0.00	15.00	15.00	18.87
ER	30.00	9.09	41.18	0.00	23.08	100.00	
2	3	4	5	7	4	0	28
NTERMEDIA	10.71	14.29	17.86	25.00	14.29	0.00	26.42
TE	30.00	18.18	29.41	41.18	30.77	0.00	
3	2	10	3	9	1	0	37
EXPERT	5.41	27.03	8.11	24.32	2.70	0.00	34.91
	20.00	45.45	17.65	52.94	7.69	0.00	
4	2	6	2	1	5	0	21
COMPETENT	9.52	28.57	9.52	4.76	23.81	0.00	19.81
	20.00	27.27	11.76	5.88	38.46	0.00	
	10	22	17	17	13	3	106
	9.43	20.75	16.04	16.04	12.26	2.83	

	ADULT ICU 7	OTHER 8	
1	2	0	20
ADV. BEGIN	10.00	0.00	18.87
NER	10.00	0.00	
2	3	2	28
INTERMEDIA	10.71	7.14	26.42
TE	15.00	50.00	
3	10	2	37
EXPERT	27.03	5.41	34.91
	50.00	50.00	
4	5	0	21
COMPETENT	23.81	0.00	19.81
	25.00	0.00	
	20	4	106
	18.87	3.77	

Statistics for table of GROUP by TYPE

Chi-square (21 df) = 42.9518 (P<0.0032)
WARNING: P-value may not be accurate
Minimum expected frequency is 0.566

TABLE 1. Experience in Years by Group [a]

	Group											
	Adv. Beginner N=20			Intermediate N=28			Proficient N=16			Expert N=33		
	M	SD	Md	M	SD	Md	M	SD	Md	M	SD	Md
Years since Basic Nursg. Education	.89	.74	.5	5.7	5.6	4.6	13.6	4.9	12.0	12.3	4.7	11.8
Years since BSN	.79	.46	.5	4.3	2.8	3.9	7.9	5.9	9.0	10.3	5.3	9.5
Years in current unit	.48	.24	.42	2.1	.8	2.0	8.1	5.0	8.0	7.9	4.4	7.0

[a] Demographic data available on 106 cases from 7 hospitals. Does not include H7

1b/0253A.001
Table 1

TABLE 2. Unit of current Employment [a]

	Adv. Beginner		Intermediate		Proficient		Expert		Total	
	N	%	N	%	N	%	N	%	N	%
Children's ICU										
PICU	3	15.0	3	10.7	2	12.5	2	6.1	10	10.3
NICU	2	10.0	4	14.3	6	25.0	10	30.3	20	20.6
Adult ICU's										
SICU	7	35.0	5	14.3	2	6.3	3	9.1	15	15.5
CCU	0	0.0	7	25.0	1	6.3	9	27.3	17	17.5
MICU	3	15.0	4	14.3	5	25.0	1	3.0	12	12.4
Adult ICU	2	10.0	3	10.7	5	25.0	10	21.2	16	16.5
Floor	3	15.0	0	0.0	0	0.0	0	0.0	3	3.1
Other	0	0.0	2	10.7	0	0.0	2	3.0	4	4.1
Total [b]	20		28		16		33		97	

[a] On 106 cases from 7 hospitals.

[b] Per cents do not total 100 due to rounding.

1b/0253A.001
Table 2

Filename: Analysis.CEN Update: 4/14/89

Ethnograph Codes for Clinical Nursing Expertise Interviews

Clinical Episode

CE — Code from line 1 to very end. Can start and stop if there is a break in the story.

CONCERN — Central Nursing concern in CE

DEMAND — Impediment/ difficulties in situation that arise out of the clinical realities of that situation. This in contrast to NSit, which are institutional impediments to practice. These are situation specific.

Content of Practice

HELP — Helping Role. Include caring practices here: establishing a healing climate (formerly Environ), comforting, preserving personhood, interpreting illness experiences, providing emotional support to patients and families. This will be a big category.

TEACH — Teaching-coaching function with the patient and family. LEARN should always be used when a nurse is teaching another nurse.

DX — Diagnostic and monitoring function: Following and documenting patient changes, anticipating changes in the patient's status and needs. This should be double coded with early warnings.

RX — Administering and monitoring therapeutic interventions, including titrating drips, any therapeutic treatment, respiratory interventions. Instantaneous therapies, requiring judgement: NTG, Dopamine, Dolbutamine. Could be called RX & TX. Pavulon here.

QUAL — Monitoring and ensuring the quality of health care practices Maintaining care to standard practice, following unit protocols, etc. as well as advocating for the care of the a particular pt. (Include ADVOCATE here.)

ORGROLE — Organizational and work-role competencies. Will include: Orchestration of care across multiple disciplines and service providers in the hospital. Includes the capacity to orient the treatment team to the needs of the patient.

FAM — Family care. This is a broad code, helping, assessing families, skilled teaching, helping them with decisions, etc.

Levels of Practice Statements about and examples of practice.

N1 — Beginners' practice and anxieties.
Include here: Delegateup- Observing situational changes, but with limited grasp. Relying on others to make the clinical decisions.
Task- Responding to what one is socially expected to do.
Suspending self by the expectations of others.

N2 — Intermediates

N3 — Advanced Experts

N4 — Practice that misses the mark, not what we expect, there are problems or puzzles in the way the situation was handled. Includes those instances where the nurse doesn't pursue her goal (making case, advocating etc) strongly enough and is ineffective.

Background for actual practice

PERSKNOW Personal knowledge. Nurse understands because of personal experience. ie Family background, life experience outside of her direct practice.

FORMKNOW Formal Knowledge. Didactic, formal sources of learning. Include here: Nursing school experience, theory, learning that occurred in skills training or continuing education, use of rules. Include also: Deliberative rationality.

PRACKNOW Practical knowledge. Any kind of clinical experiential background that forms the basis of practice. Commonsense understanding, practical know-how. Includes: Intuition, sets, guides, maxims, sense of salience, graded qualitative distinctions, gestalts.

SOCEMBED Social Embeddedness of Knowledge.
This is a large and somewhat diffuse category that we want to work out with the text. This is knowledge that depends upon dialogues with others, knowledge that wouldn't work if it weren't shared.
It will include at least:
a) Examples where the nurse evaluates the information coming from others, from machines, from lab values, etc. (Formerly Epistem)
b) Instances of the nurse conveying information to others (nurses, docs) in report or in clinical situations, eg how to fine tune this patient. (Formerly Report)
c) Any evidence of a "community of memory" existing on a unit or within a hospital. This is knowledge that resides in the group that was present and involved. Examples from Hospital 1: Doc and Mary, although it doesn't have to be a memory of a particular patient.

PCASE Paradigm Case

PARTICGEN The relation of the particular to the general, especially in relation to physiologic parameters. Includes knowledge of patient's particular course, risks, meds to use and not use, etc. The more personal 'psychosocial' knowledge will probably be coded KNOWPT. Include here: Clinpop- Clinical population comparisons

LEARN Instances were nurses note their understanding has changed, might also be called experience. Includes transformative experiences, discussions of how one learns, clinical knowledge development related to technology, how one teaches another nurse.
Include here: Clinex- Clinical example or learning indirectly through the practice of another nurse.

EARLYWARN Instances of early warning of patient problem and nsg action

Levels of Involvement

PEMOT Emotional involvement that seems to work

NEMOT Emotional involvement that seems not to work, ie disengaged, overinvolved

KNOWPT Knowing a patient in his or her particularity, grasping patient's history, background, clinical course and using this knowledge in clinical judgements. Should include instances of empathic grasp, when nurse is deeply solicited, knows the person fully or richly beyond his/her patient status.

combined - any discussion of emotional involvement +/-

APPENDIX C

ETHNOGRAPH CODES FOR CLINICAL NURSING EXPERTISE INTERVIEWS

Moral concerns and practices

NOTIONGD Notion of the good. This is a positive statement of what patient care should be. Include moral agency, any remote language about shoulds, oughts, sense of the good, what should happen, moral outrage.

MDILEMMA Moral dilemmas, confusion, conflict, and generic discussions of these.

Institutional features of practice

PSIT (Pos Sit) Situational supports to practice. Examples include

NSIT (Neg Sit) Situational impediments to practice.
Include Breakdown: any instance where nurse describes the situation as falling apart.

DRREL Any discussion about MD/RN relations. This can be positive or negative. Can come up in relation to a particular CE or in generic discussions of the context of practice. Includes issues like getting the right physician, coping with physician ineptness, or personality, conflict.

Miscellaneous Codes

DEATH Any discussion of death and dying. Includes: quality of life for pt, DNR orders, heroics, calling a code.

MAKECASE Instances where the nurse is "making a case" for something to happen to a particular patient.

OPEN Ways that nurses stay open to the situation and its possibilities Include Enigmas or instances where nurse reminds self and group of enigmas that can't be fully understood or solved. This may be an important stance from which nurses learn, and prevent tunnel vision.

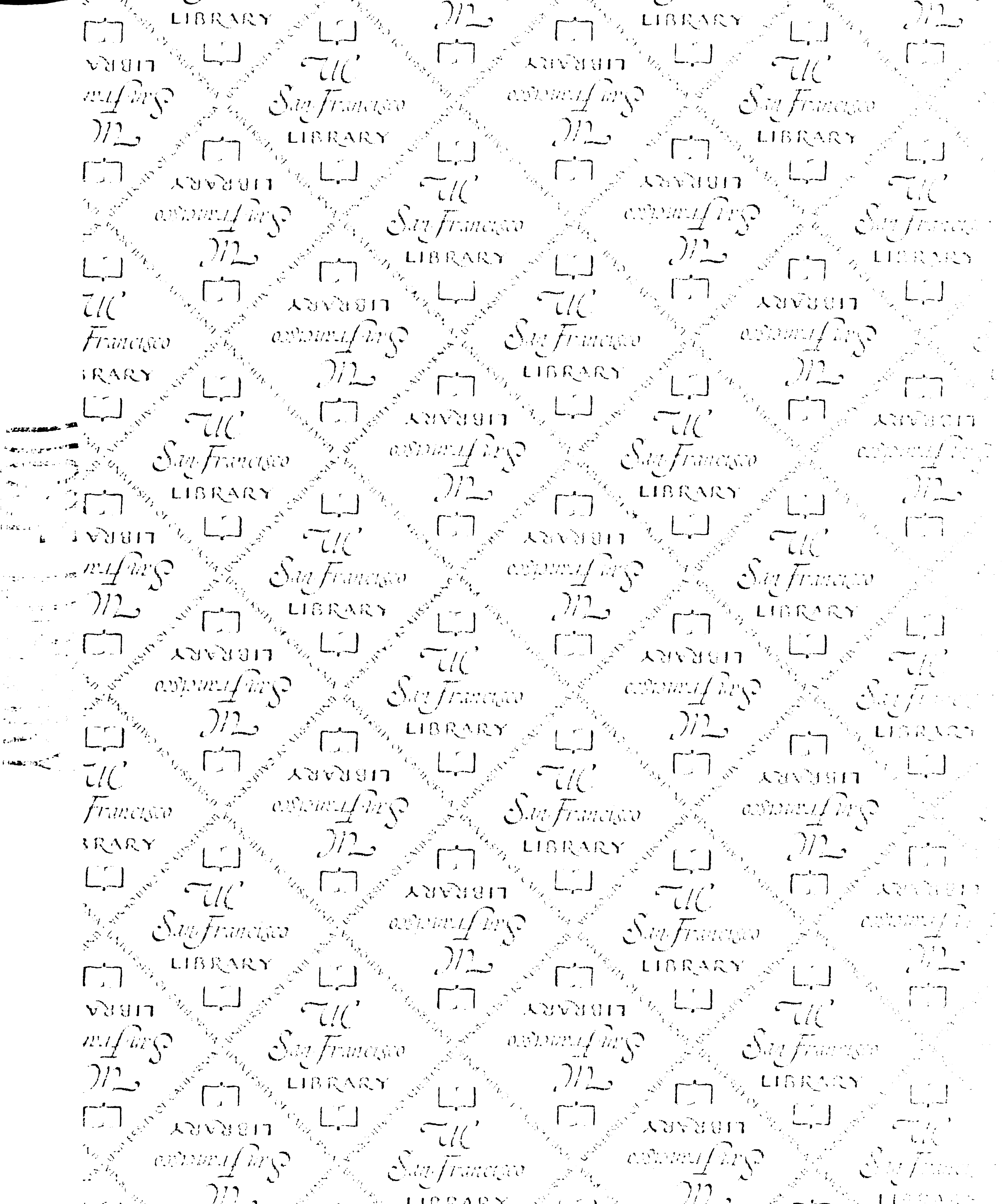
NSGBURDEN Aspects of nursing with which one must cope.
Invisibility, status inequity, responsibility without authority, care demands that are so great or complex.
Examples: N1 nurses struggle with gut meds, caring for a 200 lb pt, caring for a young, vibrant patient with whom the nurse identifies but must give care.

ROLESPEC Finding or breaking the boundaries of the nursing role. In beginners this is most often a discussion of what is and isn't nsg. In Experts it's the creative taking on of the role, often breaking the boundaries, eg H1G3 nurse who drank beer with cardiac pt on Christmas.

SELFREF Any reference to the self in the situation. May be most prominent in N1 exemplars, where self is object to be dealt with in situation.

RISKFLD Describes a risk field, competing concerns that carry risks.

Reflect Reflections about Practice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