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Dedication

For Dick, my love, who has been beside me the whole way
and who kept a light on in the window . . .

And for A. and T., my sweet pea and my beetle,
who made me believe in myself . . .

My love and gratitude goes beyond words . . .

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No work of any significance can occur in isolation. Such was the case with this dissertation. I thank especially

The twenty-six nurses

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REGISTERED NURSES "IN THE MIDDLE" IN CLINICAL PRACTICE

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University of California, San Francisco, 1999

Abstract

This was a study of the lived experiences of being and feeling "in the middle" in professional practice as described in the narratives of registered nurses. The data consisted of audio-taped interviews of twenty-six registered nurses who worked in acute hospital settings. The methodology, feminist narrative inquiry, emerged from the goal of the research: understanding "betweenness" or "middleness" as it is experienced by nurses in their everyday practice. Neomodern feminism was the conceptual framework of the research and both defined the feminist assumptions of the study and provided the study's philosophical stance.

The participants of this study described "middleness" in differing ways. The researcher concluded that two separate and distinct phenomena were being described although they sometimes carried the same nomenclature. The first phenomenon is labeled *being* "in the middle" and describes a nursing role that includes advocacy, communication and professional engagement as part of the effective, collaborative and empowered functioning of nurses as they care for patients. The second phenomenon is labeled *feeling* "in the middle" and occurs when the effective nursing role breaks down in situations where there is lack of knowledge or acknowledgment of the nursing role, when the system fails to provide staffing or other resources, when the systems fails to address legal and ethical issues, when there is unresolved conflict between professionals, when technology is privileged over patients, and when sexism, classism and power differentials occur. Feeling "in the middle" occurs in concert with disempowerment, ineffectiveness and marginalization.

The results of this study suggest that being and feeling "in the middle" are embedded in practice and exist most commonly within the ethical domain of nursing. The notion of cultural ethos, which includes the ideals of conduct, the ideologies, and the social and political organization of communities, is pertinent to the participants' ethical concerns about the values, structures and organization of their professional worlds. This research also suggests that support and connectedness within the workplace maximize the positive nursing role of being "in the middle." In their absence, marginalization occurs and the role breaks down, resulting in feeling "in the middle."

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CHAPTER 1

Introduction

The phenomenon of being “in the middle” and its impact on nurses and nursing practice, especially within the domain of nursing ethics, was the focus of this dissertation research. Nurses have often told compelling stories about patients and hospitals struggling with difficult practice issues that have, it would seem, no good answers (Fry, 1985). Nurses, by virtue of their complex roles, including vigilance, care, advocacy, and education, are actors in the moral pageants that evolve everyday in clinical settings. Sometimes they take active roles in dealing with these issues, sometimes they take passive roles and sometimes they are silent or silenced (Huggins & Scalzi, 1988). Often they are “in the middle” of ethical and other practice issues involving their patients, their colleagues and other medical professionals (Yarling & McElmurry, 1986). The phenomenon of being “in the middle” has been implied in many papers (Broom, 1991; Cooper, 1988; Fry, 1985; Huggins & Scalzi, 1988; Hutchinson, 1990; Johnstone, 1988; Pike, 1991; Soderberg & Norberg, 1993; Stenberg, 1988; Wilkinson, 1987/88; Yarling & McElmurry, 1986; Youngner, Jackson & Allen, 1979) and specifically described in many others (Astrom, Jansson, Norberg & Hallberg, 1993; Bishop & Scudder, 1987; Engelhardt, 1985; Erlen & Frost, 1991; Jameton, 1977; Ketefian, 1987; Mayberry, 1986; Watson, 1985; Zorb & Stevens, 1990), but to date, there have been no published studies specifically focusing on this nursing phenomenon. The literature links being “in the middle” to the domain of nursing ethics (Astrom, et al., 1993a; Bishop & Scudder, 1987; Broom, 1991; Cooper, 1988; Erlen & Frost, 1991; Fry, 1985; Huggins & Scalzi, 1988; Hutchinson, 1990; Jameton, 1977; Johnstone, 1988; Ketefian, 1987; Mayberry, 1986; Pike, 1991; Soderberg & Norberg, 1993; Stenberg, 1988; Wilkinson, 1987/88; Yarling & McElmurry, 1986;

Youngner, Jackson & Allen, 1979; Zorb & Stevens, 1990), but there are no practice-based accounts that confirm this link. Several nurse scholars have implied that ethical issues and other difficult situations place nurses "in the middle" and have impact on clinical practice which is sometimes positive and sometimes negative (Bishop & Scudder, 1987; Huggins & Scalzi, 1988; Hutchinson, 1990; Mayberry, 1986; Stenberg, 1988; Yarling & McElmurry, 1986). However, the connections between being "in the middle" and nursing actions have not been not clearly defined.

As a nursing administrator accountable for the clinical operations of a small, acute care hospital in the San Joaquin Valley, I believe that my primary role is to provide an environment and the resources that support the provision of excellent patient care while working within the realities of scarce funds and complex regulatory constraints. Intuitively, my studies had led me to believe that being "in the middle" powerfully influences how nurses' feel, respond and carry out nursing care. The next step was to study and understand how practice issues are linked to being "in the middle." Research aimed at understanding nurses' experiences of being "in the middle" is an important step in establishing stronger processes, better communications and more appropriate patient care interactions. It could give me insight as an administrator about blockers to effective nursing practice and about how to develop better tools for supporting effective patient care.

This research was a feminist narrative inquiry about the phenomenon of being "in the middle" as described by clinical nurses. The research was oriented by a nursing perspective, grounded in person and environment; an administrator's perspective, grounded in a respect for the finitude of resources and an awareness of the complexity of health care in the United States; and a woman-centered feminist perspective, grounded in a commitment to uncovering oppression and in attending to nurse's lived experiences in their practice. Recognizing that "every world, even the smallest world, is far more complex, with more characters, meanings, nuances and events" (Smiley, 1999, p.1) than even the largest and most comprehensive research project could hope to capture, this research contributes in a small way to understanding an important dynamic of nursing practice.

As a nurse, I value the profession of nursing. I believe nursing at times to be misunderstood, underutilized, and, simultaneously, capable of contributing perspective and expertise that is unique and unavailable from other professionals. I believe it to be essential to understand and articulate the value nurses bring to the care of patients. As a feminist, I also wish to contribute research that helps us to uncover women's oppression and to understand that women's perspectives and women's roles are valuable to society. This research adds to our understanding of the differences and similarities among humans and, ultimately, to a better understanding of the vicissitudes of human behavior. Additionally, such research may help hospital leadership to make better decisions about the provision of resources to support nurses in giving excellent patient care.

Statement of the Problem

The phenomenon of being "in the middle," according to both the nursing literature and to clinical nurses, is imbedded in practice (Astrom et al, 1993a; Edwards & DeJoseph, 1997; Erlen & Frost, 1991; Zorb & Stevens, 1990). Its dimensions are "taken for granted" but have appeared to mean different things to different nurses. My recent concept development of being "in the middle" (Edwards, 1998) found that it was characterized in the literature in four basic ways - having a duty or being obligated; being in a distinct position; being the sequelae of conflict; and resulting from power differentials. Additionally, that concept development was informed by the concept of marginalization as described by Hall, Stevens and Meleis (1994). To date, our knowledge about this phenomenon has created more questions than it has answered.

Nonetheless, the phenomenon of being "in the middle" is an important component of nursing practice. It appears within the domain of nursing ethics, and it has relevance to nursing interactions with people in varying positions of power, with different decision-making styles and with dissimilar perspectives. There are rich descriptions of this phenomenon in the nursing literature (Astrom, et al., 1993a; Bishop & Scudder, 1987; Engelhardt, 1985; Erlen & Frost, 1991; Jameton, 1977; Ketefian, 1987; Mayberry, 1986; Watson, 1985; Zorb & Stevens, 1990), but there are also gaps in current knowledge. These gaps include lack of research that focuses specifically on the phenomenon of being "in the middle," conceptual problems such as competing meanings and unknown dimensions, and lack of practice-based accounts that explore the impact on nursing. The phenomenon should be explored and clarified in order to define it and locate it in nursing practice. Clearly, there is a need to explore nurses' experiences and perceptions of being "in the middle" and the meanings they attach to those experiences and perceptions in order to clarify and understand the nature of the concept.

Aims and Goals of This Research

The basic goal of this research was to understand the phenomenon of being "in the middle" as it is experienced by nurses as part of their everyday clinical practice. My research explored how the phenomenon is articulated in the narratives of nurses in both individual and group interviews using a neomodern feminist framework to conceptualize this work. The research was meant to describe how nurses define and respond to being "in the middle" in their daily practice, and to determine whether it is a phenomenon which has impact on nursing care. It was research focused on nurses, the context in which nurses practice, and the nature of that practice. Therefore, this research was meant to clarify the concept of being "in the middle" by exploring the narrative descriptions of nurses. Also, this research explored whether the various conceptualizations of being "in the middle" taken from the literature are born out in clinical practice. I hoped to understand whether the characterizations were mutually exclusive, part of a continuum of nursing process and outcome related to being "in the middle" in ethical situations, or indicative of a transition from one way of being "in the middle" to the other. In addressing these issues, I aimed at exploring new ground in the development of knowledge about being "in the middle" in nursing practice.

Another goal of this research, as framed by neomodern feminism, was to explore women's collective consciousness as a source of data; to use interviews with individual nurses and small groups of nurses as sources of data; to uncover the previously "taken for granted" aspects of practice using research techniques that take account of and record everyday processes; to be concerned about the everyday life world of nurses, some parts of which may help sustain gender inequality; to honor and acknowledge the affective dimension of research assuming emotions and narrative to be a source of insight and/or a signal of rupture of social reality (Cook, 1988); to assume the interlocking nature of oppression as it manifests itself in nursing; and to evaluate the ramifications of dichotomous/oppositional thinking. As a feminist I sought to challenge prevailing assumptions, to analyze conditions of nurses' work lives, understand them, delineate causes and consequences of oppression and work towards improving their state, and to attend to the particularity of lived experiences (Sherwin, 1992; Tong, 1989).

Significance to Nursing

This research addresses the need for practice-based accounts in nursing (Meleis, 1991). It also addresses the need for qualitative studies grounded in feminist perspectives of women's day to day experiences (McBride & McBride, 1981, 1994). It was, in some respects, serious study about the "obvious" because the phenomenon has been so widely described in the literature and has been used comfortably and readily in the narratives of nurses (Edwards & DeJoseph, 1997). It explored the lived experiences of nurses and contributes knowledge about the ways that ethical concerns arise from practice. This research considered the nature of the concept of being "in the middle," looked at the meanings that have been applied to the concept in the literature, and explored antecedents and consequences, thereby helping us to understand the multidimensionality of this concept and its impact on interactions among nurses, their clients and their colleagues. It contributes to the development of nursing knowledge in general and begins to define a specific program of research addressing an important component of nursing practice. It will lead to better understanding of the phenomenon and to uncovering its impact on the lives of nurses and patients. The research meets some feminist goals in contributing to our understanding of being "in the middle" as a phenomenon that is an important part of the lived experiences of nurses, giving us insight about difficult issues without blaming.

Organization of the Dissertation

In the following chapters I have described the development of the study and its findings. In Chapter 2, I present the conceptual based for studying the phenomenon of being "in the middle." This chapter includes a review of the nursing literature that specifically describes the phenomenon, and the literature which describes the similar concept of marginalization. The chapter includes an evaluation of the meanings and contexts of being "in the middle" that emerged from the literature. It also describes ethical models that have had influence on nursing and, because it is commonly located in the moral domain, the phenomenon of being "in the middle." A synthesis of the meanings that emerge from the literature is presented is presented as two working definitions of being "in the middle." The remainder of the chapter focuses on a description of the conceptual framework of the study, neo-modern feminism. This framework informed the feminist narrative inquiry methodology of my data collection and data analysis. This chapter also includes a discussion of how feminist approaches inform nursing research, and concludes with the assumptions of the research. In Chapter 3, I describe the application of the methodological approach, feminist narrative inquiry, to the research design and processes and delineate the demographics of the study participants. Chapter 4 presents the findings of the study as described in the narratives of the research participants. Chapter 5 includes a discussion of the findings and their significance. I conclude the dissertation in Chapter 6 with some comments on what this research contributes to nursing knowledge, and the implications for future research, nursing practice, and the individuals who participated in the study.

CHAPTER 2

Conceptual Base for Studying Being "in the Middle"

Review of the Literature

In a pilot study that was designed to explore the ethical experiences of clinical nurses, one recurring theme was the phenomenon of being "in the middle" (Edwards & DeJoseph, 1997). This phenomenon has also been described by research participants in several other studies (Astrom, Norberg, Hallberg & Jansson, 1993b; Erlen & Frost, 1991; Mayberry, 1986), and it has been addressed or implied in other nursing literature as tangential to the behaviors and outcomes of nursing actions in ethical situations (Bishop & Scudder, 1987; Cooper, 1988; Fry, 1985; Huggins & Scalzi, 1988; Stenberg, 1988; Yarling & McElmurry, 1986; Zorb & Stevens, 1990). However, the phenomenon has not been specifically defined or studied.

To deepen my understanding of being "in the middle," I conducted a concept development in preparation for my qualifying examination (Edwards, 1998). In developing the concept of being "in the middle," I utilized Schwartz-Barcott & Kim's Hybrid Model (1993). I first conducted a search of the nursing literature published between 1965 and 1998 using key words such as "between," "betweenness," "middle" and "middleness." Between those that I collected in the course of my classwork and those identified in the literature search, I found twenty-one articles that were appropriate for the concept development. I included an article in my analysis if it addressed nursing and if the author used any terms that implied being "in the middle," such as "standing between," "caught between," "being divided," "feeling trapped, powerless and in between," or "the in-between position." I reviewed each of the articles in terms of the meanings, definitions and contexts the author assigned to being "in the middle" in nursing. I examined how the concept was used and what assumptions were made about it. I compared meanings, definitions and contexts among the articles. A complete listing of the nursing authors who have addressed the concept of being "in the middle," along with the contexts, meanings, levels of analysis, and outcomes are outlined in Appendix 1.

Thirteen of the articles were descriptive pieces on a variety of topics, mostly nursing ethics (Bishop & Scudder, 1987; Broom, 1991; Cooper, 1988; Engelhardt, 1985; Fry, 1985; Huggins & Scalzi, 1988; Jameton, 1977; Johnstone, 1988; Pike, 1991; Stenberg, 1988; Watson, 1985; Yarling & McElmurry, 1986; Zorb & Stevens, 1990;), and eight of the articles were reports of research studies (Astrom et al., 1993b; Erlen & Frost, 1991; Hutchinson, 1990; Ketefian, 1987; Mayberry, 1986; Soderberg & Norberg, 1993; Wilkinson, 1987/88; Youngner & Jackson, 1979) . Definitions and meanings of being "in the middle" were not directly addressed in any of the articles. None of the eight research studies specifically researched the concept of being "in the middle." Each study addressed some aspect of nursing ethics including levels of moral reasoning (Mayberry, 1986), moral behaviors (Ketefian, 1987), moral distress (Wilkinson, 1987/88), rule bending (Hutchinson, 1990), the responsible powerless (Stenberg, 1988), powerlessness in influencing ethical decisions (Erlen & Frost, 1991), and behaviors in ethically difficult situations (Astrom et al., 1993a; Soderberg & Norberg, 1993). Although none of the studies were looking for it, the concept of being "in the middle" emerged as a component of the narratives of the participants in all these studies.

In four of the research studies, being "in the middle" or a variation of that terminology - "caught between" (Mayberry, 1986), "caught in the middle" (Erlen & Frost, 1991), and the "in between" position (Astrom et al., 1993a) - was specifically used by the participants during their interviews or in other interactions with the researchers. Nonetheless, it is not possible to comment on the effectiveness of research about the concept, because that was not the focus of any of these studies, and no other appropriate research has been published. In general, the concept development was helpful in consolidating the literature that addressed being "in the middle" and in identifying where attention should be focused in future research aimed at clarifying the concept and building new knowledge.

Jameton (1977) was one of the first nursing authors to specifically discuss the phenomenon of being "in the middle." He wrote about the "nurse-in-the-middle problem" as one in which nurses assume many responsibilities but have little authority. This author's assumption was that ideal moral behavior exists but cannot be implemented (at least not by nurses!) given the realities of the practice setting. In a study of physician and nurse attitudes regarding care of critically ill adults, Youngner, Jackson and Allen (1979) found agreement among nurses and doctors about what constitutes an ethical issue, but also found significant differences in attitudes about the actual processes of ethical decision-making, the systems that support practice, the role of communications, and the emotional issues tied to ethical dilemmas - all potential components of being "in the middle." Engelhardt (1985) wrote that nurses are caught between "the traditional authority of the physician, the emerging rights of the patients, and the growing power of hospital bureaucrats" (p. 62). For Engelhardt, being "in the middle" assumes that nurses are powerless in the face of others in positions of power - nurses do not have the power of working as part of a team of professionals.

Using Kohlberg's (1978) model, Huggins and Scalzi (1988) linked being "in the middle" in ethical situations with power differentials between women and men. They suggested that women's concerns with care and responsibility occur within the context of relationships, and that they therefore solve problems with a focus on preserving the long term integrity of relationships rather than by applying principles and rules of right and wrong. These authors worried that framing nursing problems within the context of the justice ethic leads nurses to be "in the middle," powerless, and silenced. The Huggins and Scalzi article was a response to Ketefian's (1987) research which proposed that the "nurse in the middle problem" occurred when ideal moral behavior could not be instituted due to institutional constraints.

Watson (1985) focused both on the professional and the social aspects of being "in the middle." She described the profession of nursing as a means to preserve humanity within society, implying that nurses stand between the humanity of patients and the potential destruction of that humanity by society. Fry (1985) wrote about ethical tension and conflict, alluding to the concept of being "in the middle" and how it occurs both in situations of conflicting personal and professional obligations and in situations of conflict between the professional ethic and the prevailing ethic of public health. Mayberry (1986) specifically defined "being caught between" as occurring when nurses' loyalties to the physician, the patient, and the patient's family conflicted. "Being caught between" one's own values, obligations, and practice requirements, and the values of, and obligations to the patient was described as a source of conflict and stress for nurses. In addition, being "in the middle" implied a lack of opportunity to participate in decision-making processes.

Yarling and McElmury (1986) wrote a controversial article about the moral foundation of nursing, describing nurses as "conceived in moral contradiction and born in compromise . . . morally unintegrated professionals who are not self-determining moral agents" (p.67). The work of these authors was grounded in the assumption that moral agency is based on autonomy. They implied that being "in the middle" was a moral situation both of professional conflict, in which nurses are deprived of the free exercise of moral agency, and of personal conflict, in which individuals experience internal struggle. According to these authors, without moral agency, individuals experience psychological disequilibrium. Professionally, "being in the middle" impacts the quality of patient care. This reality puts nurses "in the middle" when they have the moral instinct to "do the right thing" for the patient, although doing so would be to act against a power structure that controls their professional and economic destiny. Yarling and McElmurry suggested that because nurses lack the autonomy needed to make ethical decisions, they should either find a way to become advocates within physician/administrator-controlled agencies, or leave these traditional settings and establish nurse-controlled environments for the care of patients.

Bishop and Scudder (1987) and Cooper (1988) specifically responded to Yarling and McElmurry's work. Bishop and Scudder said that the "in-between position" of nurses is privileged and allows them to make moral contributions in their everyday work as cooperative members of the health care team. Specifically, nurses add valuable perspective from their position "in-between." Nurses can be advocates of "communal decisions that bring together expert medical advice and treatment, sound hospital policy and procedure, and the realizable hopes and aspirations of the patient into the concrete practice of health care that fosters the well-being of the patient" (Bishop & Scudder, p. 42). These authors suggested that nurses should develop greater excellence in nursing practice within an expanding area of legitimate authority and contribute to decisions that are in the best interests of the patient. This "in-between position," rather than freeing nurses from responsibility, puts nurses in a position to "bring consciousness to the in-between nature of moral decision making" (p.41), and to teach the members of the health care team to act in concert.

Cooper (1988), on the other hand, supported Yarling and McElmurry's stance by implying that being "in the middle" was a position of conflict. She utilized a duty-based framework to describe the concept as a position which occurs when the nurse's duty of fidelity to the patient is threatened by either internal or external forces. She suggested the covenantal relationship model as a foundation for explicating an ethic that is grounded in, and thereby reflects the singular experience of nursing.

Zorb and Stevens (1990) wrote about being "caught in the middle" in their discussion of the ethical dilemmas of nurses on critical care units. According to them, the concept deals with three categories of moral dilemmas: treatment issues, such as resuscitation debates; utilization of resources, such as availability of ICU beds; and collegial disputes, such as differences of opinion with physicians. They stated that "the nurse may feel caught in the middle when a physician is pursuing a line of treatment that appears to be contrary to the best interests of the patient or not in accordance with the wishes of the patient or family" (p.517). Hutchinson (1990) expanded upon this theme in her research about rule bending among hospital nurses, implying that being "in the middle" results from conflicts among systems and/or people that prevent the nurse from doing what s/he believes is best for the patient. Likewise, Broom (1991) described strategies for the resolution of ethical conflict resulting from incompatible goals among clinicians - here being "in the middle" is the result of ethical conflict. Erlen and Frost's (1991) narrative analysis of nurses' perceptions of powerlessness in influencing ethical decisions evoked such terms as "caught in the middle" and "feeling trapped" by the participants. Two Swedish studies (Astrom, et al., 1993a; Soderberg & Norberg, 1993) further developed the theme of powerlessness and lack of influence in implying in one study, and specifically describing in the other the "in-between position" of nurses in ethically difficult situations.

Evaluation of Meanings

Several meanings of being "in the middle" emerged from the review of the literature and from my concept development (Edwards, 1998). In general, four basic themes were identified: 1. Being "in the middle" as a *function of power or lack of power* - words like victimization (Pike, 1991), influence (Erlen & Frost, 1991), constraints (Pike), moral agency (Yarling & McElmurry, 1986), control (Bishop & Scudder, 1987), helplessness (Huggins & Scalzi, 1988), autonomy (Bishop & Scudder, 1987; Engelhardt, 1985; Yarling & McElmurry), and status (Yarling & McElmurry) were used in talking about being "in the middle" in this sense; 2. Being "in the middle" as an *outcome of being obligated or having a duty* - words such as covenant (Cooper, 1988), accountability (Johnstone, 1988), advocacy (Bishop & Scudder; Cooper), duty of fidelity (Cooper) and preservation of humanity (Watson, 1985) were used in talking about being "in the middle" in this sense; 3. Being "in the middle" as a *distinct perspective or position* - in this sense, the words caught between (Mayberry, 1986), standing between (Watson), and in-between position (Bishop & Scudder) were used, and; 4. Being "in the middle" as an *outcome of conflict* - in this context, words such as moral distress (Hutchinson, 1990), threats (Cooper), dissonance (Stenberg, 1988), contentiousness (Johnstone), and being torn (Stenberg) were used. Many of these authors incorporated more than one meaning of being "in the middle" into their work. This, no doubt, adds credence to the need for carefully studying and explicating this concept so that it is more clearly understood, and more consistently utilized.

Meanings Related to the Concept of Marginalization. The concept of marginalization as described by Hall, Stevens & Meleis (1994), also helped me to frame meanings of the concept of being "in the middle" in nursing, although these concepts have not previously been connected in the literature. Two key constructs of marginalization, centeredness and peripheralization, are especially informative in locating being "in the middle" as a phenomenon within nursing.

Marginalized persons are those who exist away from the societal "center" or norm, based on their "identities, associations, experiences and environments" (Hall, Stevens & Meleis, 1994. p. 25). Hall, Stevens and Meleis identified seven characteristics of marginalization, some of which are similar to descriptions of being "in the middle": 1. *Intermediacy* is the quality of "betweeness" where human boundaries tend to act both as barriers and connections; 2. *Differentiation* emerges from boundary protection in the establishment and maintenance of distinct identities; 3. *Power* is the influence exerted by those at the center of society over those at the periphery via authority and control, and influence exerted over those at the center via innovation and resistance by those at the periphery; 4. *Secrecy* is the protection of information from outsiders to avoid betrayal, and to establish bonds; 5. *Reflectiveness* is introspection aimed at understanding and compensating for the effect of marginalization such as discrimination, isolation and invisibility; 6. *Voice* is language and other forms of communication specific to the marginalized group which especially results from being silenced by the dominant group; and, 7. *Liminality* defines the "altered and intensified perceptions of time, world view, and self-image that characterize and result from marginalizing experiences" (Hall, Stevens & Meleis, p.33). Several of the characteristics of marginalization, including intermediacy, power, reflectiveness, voice, and liminality, are similar to conceptualizations of being "in the middle." These characteristics may indeed be characteristics of the phenomenon of being "in the middle" and, if so, may give us insight as to how the phenomenon is situated in nursing practice.

Contexts of Being "in the Middle"

The majority of the work reviewed here and in my concept development project (Edwards, 1998), placed the phenomenon of being "in the middle" within the domains of nursing or biomedical ethics (Astrom et al., 1993a; Bishop & Scudder, 1987; Broom, 1991; Cooper, 1988; Erlen & Frost, 1991; Fry, 1985; Huggins & Scalzi, 1988; Hutchinson, 1990; Jameton, 1977; Johnstone, 1988; Ketefian, 1987; Mayberry, 1986; Pike, 1991; Soderberg & Norberg, 1993; Stenberg, 1988; Wilkinson, 1987/88; Yarling & McElmurry, 1986; Youngner et al., 1979; Zorb & Stevens, 1990). Two authors situated being "in the middle" within the context of nursing practice as professional obligation (Fry, 1985; Watson, 1985), and one author place it within the context of power and authority in hospitals (Engelhardt, 1985). Likewise, the narratives of the participants in our unpublished pilot study about ethical issues in discussed being "in the middle" in terms of their moral principals and how they understood their roles (Edwards & DeJoseph, 1997).

Ethical Models and their Influence on Nursing

Because so much of the literature about the phenomenon of being "in the middle" exists in the moral domain, a review of models of ethics that have influenced the evolution of nursing ethics is useful here in helping us to understand moral assumptions that may have been incorporated into the literature about the phenomenon. This review could also bring strong focus to the phenomenon. These ethical models were also the basis for what nurses have been taught about their professional practice and may be embedded in narratives about the practice of nursing (American Nurses Association, 1950; Bandman & Bandman, 1995; Davis & Aroskar, 1978; Levine, 1978; Robb, 1900; Veatch & Fry, 1987).

Until the mid-twentieth century, virtue-based theory, which proposes an agent-centered account of morality, exerted a very strong influence on biomedical and nursing ethics. The Hippocratic oath is based in virtue ethics with its focus on the virtues of benevolence, respect for human life, and the vulnerability of the sick. The moral values and characteristics of good persons have been formalized by every culture, and many philosophies and religions, including Plato, Aristotle, the Stoics and Epicureans, Thomas Aquinas, Confucius, Lao Tse, and Hinduism. Pellegrino (1995) calls the virtue ethic "the most ancient, durable, and ubiquitous concept in the history of ethical theory" (p.254).

Virtue theory focuses on the agent, his/her intentions, and motives, and the outcomes of his/her actions. The normative standard is the good person. Professional ethics include the domain of duties, obligation, and virtues "entailed in the health professional's role as a healer and as a participant in a special kind of relationship with a patient" (Pellegrino, 1995, p. 265). There is a basic essence to the encounter between the physician and the patient that can be articulated in terms of the virtues. But from its inception, the concept of virtue has had critics who are troubled by it a basis for morality (Pellegrino, 1995). The normative standard of the good person is seen by some as "circular logic that holds the right and the good to be what the virtuous person takes them to be while defining the virtuous person as the one who is and does what is right and good" (p. 255).

The ethical domains of virtue and duty have been an integral part of nursing scholarship and practice expectations throughout its history:

> To be a nurse requires the willing assumption of ethical responsibility in every dimension of practice. The nurse enters a partnership of human experience where sharing moments in time, some trivial, some dramatic, leaves its mark forever on each participant. The willingness to enter with a patient that predicament which he cannot face alone is an expression of moral responsibility; the quality of the moral commitment is a measure of the nurse's excellence (Levine, 1978).

There are many instances in the nursing literature where nursing ethics was described in terms of virtue and obligation or situated the phenomenon itself in instances of "having a duty" or "being obligated to act" on a patient's behalf or in the patient's best interests (Bishop & Scudder, 1987; Cooper, 1988; Johnstone, 1988; Levine, 1978; Watson, 1985):

Over the past twenty-five years, Beauchamp and Childress (1979/1994) have described a theory of biomedical ethics that has been widely influential and has come to be accepted by many as *the prevailing view* (Liaschenko, 1994). Although it draws from a rich variety of philosophies that have evolved throughout history, this view is basically a positivist morality that consists of "rules and principles, which, because they are normative, can be articulated and defended only on the basis of rational arguments directed at what ought to be the case" (Hoffmaster, 1990, p. 241). This morality is congruent with the empiricist approach common in the conduct of medical science today. Recognizing that the foregoing is one of several conceptualizations of bioethics, and is increasingly being contested, for the purposes of this dissertation, it serves as the definition of *the prevailing view* in discussions here.

One underlying assumption within the prevailing view of medical ethics is that there is a set of moral principles that inform and connect a wide range of dilemmas that arise in the practice of medicine (Beauchamp & Childress, 1979/1994). The two most important influences within this morality are the deontological approach, especially the work of Kant (1797/1959), and the consequentialist approach, most importantly John Stuart Mill's (1861) utilitarianism.

In principle-based theories, the four principles of beneficence (the duty to do good), nonmaleficence (the duty to do no harm), autonomy (respect for persons, and the freedom to determine and choose one's own ends), and justice (the equitable distribution of risks and benefits, and goods and services) are the most prevalent. Beauchamp and Childress (1979/1994) label both principles and rules as guides to actions: principles are more general in their scope, while rules are more specific and restrictive. There are substantive rules such as veracity (the duty to tell the truth), fidelity (the duty to keep one's promise), reparation (the duty to make up for a wrong); authority rules such as rules of surrogate authority; and professional rules such as those for determining eligibility for scarce medical resources.

The *prevailing view* of biomedical ethics relies on rationality, and the application of appropriate principles in ethical deliberations. Englehardt (1986), a biomedical ethicist, for example, admonished professionals to discard "irrational" emotions when dealing with moral conflicts, and to pursue resolution using impartial reasoning. His liberal view favored a hierarchical ordering of moral principles, giving first place to autonomy, although Beauchamp and Childress (1979/1994) described the four main principles of bioethics as being more or less equal to each other, no principle "trumping" any of the others.

Nursing ethics are interwoven with and influenced by the prevailing view of biomedical ethics, as well. During the past two decades, many works describing nursing ethics have incorporated the assumptions of the medical model (Benjamin & Curtis, 1986; Davis & Aroskar, 1978; Muysken, 1982; Thompson & Thompson, 1981; Veatch & Fry, 1987; White, 1983). The *1989 Annual Review of Research* (Fitzpatrick, Taunton & Benoliel, 1989) focused on writings and research about moral reasoning and ethical practice in nursing over the previous ten years. The editors found that research about ethics in nursing conducted in the 1980's almost exclusively used Beauchamp and Childress' (1979/1994) principle-based framework to interpret research about nurses' moral behavior, judgments and reasoning (Crisham, 1981; Davis, 1989; Ketefian, 1987; Ketefian & Ormond, 1988; Munhall, 1980).

The ethic of care is another ethical tradition that has had impact on nursing scholarship in recent years. It emerged from feminist research, the social sciences, and the practice of nursing itself. It has long been embedded in the practices and understandings of women, and was articulated, at least in part, in response to some of the prevailing assumptions within health care, such as rule-following morality, the primacy of technology, the neglect of women's issues, legalism and the ideal of disengaged reason (Liashenko, 1994; Jaggar, 1989; Taylor, 1991). In nursing, the ethic of care was also meant to respond to a weakness in biomedical ethics that fails to "take into consideration the role of nurses in health care, the social significance of nursing in contemporary society, or the value standards of nursing practice" (Fry, 1989, p.12).

Central to the ethic of care is the assumption that people are profoundly interdependent and vulnerable. The ethic of care assumes rules and principles to be less important than moral concern and responsibility that arise within the context of concrete relationships. In the care ethic, interdependence rather than autonomy is expected, and the individuals involved in an ethical situation are considered to be connected to each other.

Carol Gilligan (1982), an educator with an interest in developmental theory, was among the first to describe the ethic of care within a framework based on responsibility and care. Her research tested the widely accepted assumptions of Kohlberg's (1971) work, which was, in turn, influenced by the Kantian principle-based moral categories, and by Piaget's stages of cognitive development. Gilligan's (1982) research challenged Kohlberg's conclusions that *moral reasoning ability is developmental* with men being at a higher developmental level, in general, than women. Gilligan found instead that the participants in her study, all women, *made moral choices differently* than did the men in Kohlberg's studies. She suggested that women use moral reason in conjunction with the context of the problem, striving, at the same time, to sustain the connections essential to their lives.

Sara Ruddick (1989) suggested that maternal thinking, as evidenced in the difficult and demanding caring practices of mothering children, is a distinctive way of knowing and caring, and that it has implications for such social issues as pacifism and antimilitarism. She is part of a tradition of philosophers and academics who define practice as a socially organized activity that has notions of good internal to it (Aristotle, About 350 BC/1944; Benner, 1991; MacIntyre, 1984; Taylor, 1991; Whitbeck, 1989). Similarly, Held (1987) explored the relationships between mothers and children as a model for moral thought. She wrote that the realm of *particular others* is a domain frequently neglected in moral theory, and that caring about and valuing another is an important motivation for ethical action. Nel Noddings (1984), a professor of child education, uses the maternal-child relationship as an ethical vision about caring in which the "one-caring" manifests herself to the one "cared-for" in an attitude of acceptance and trust. Caring occurs as a result of what the carer does and how the one "cared-for" receives and responds to it (Gordon, Benner & Noddings, 1996).

Caring practices, which "always involve receptivity, engrossment...., attunement, engagement, intelligence, skill, shrewdness, and knowledge," are central to nursing practice (Gordon et al., 1996, p. xiii). Because the nurse-patient encounter is viewed as having important moral dimensions, caring becomes strongly linked to the moral and social ideals of nursing. To the dismay of some feminists, it is also related to the gender-specific division of social labor (Wolf, 1996).

Nurse scholars have conducted research about how caring manifests itself in nursing practice (Benner & Wrubel, 1989; Brown, 1986; Corcoran, 1986). They are beginning to build knowledge about how clinical nurse reflect and act on their definitions and understandings of good, caring practices. They differentiate between caring as an intent, sentiment or emotional attribute, and caring as "a set of relational practices that foster mutual recognition and realization, growth, development, protection, empowerment, and human community" (Gordon et al., 1996, p. xiii).

Critics of the ethic of care, especially those who view caring as a *sentiment or attitude*, call it an emotion-based theory without a disciplined framework - absent theoretical consistency and relevance (Olsen, 1992; Sarter, 1988). Some claim that it is basically anti-intellectual, and that caring as a guide to action escapes any possible verification or moral judgment (Loewy, 1995). There are controversies about the status of care as a formal concept (Nelson, 1992; Loewy, 1995). Nelson (1992) is not sure "that caring is so much a process, a way of being, a system, or a range of acts, as it is a stance toward processes, systems, or acts ....Caring can be....blind and indiscriminate, and there is nothing within the concept of care itself that can regulate its force or direct it toward worthy objects" (p.9). Some feminists are concerned that the ethic of care valorizes the negative traits of caring that are secondary to subordination and the need to please (Wolf, 1996). They also cite a lack of analytic rigor in facing moral problems, believing that a caring framework can't be used exclusively, to the exclusion of rights and justice.

The vast majority of the ethics literature in nursing addresses individuals interacting with individuals, the ethical questions related to individual situations, and the roles of nurses in working through individual dilemmas. With few exceptions, the focus does not include the ethical implications of social ideologies, organizations and structures. These factors are all part of the cultural ethos that impacts all components of life. Liaschenko (1993) described cultural ethos as one of three aspects of our ethical lives, the other two being virtues or "excellences of character and intellect" (p. 71), and injunctions or "the minimum set of expectations of a culture" (p. 71). Cultural ethos is the community way of life that is defined by ideals of conduct, both implicit and explicit, by ideologies, and by how the community is socially and politically organized. Cultural ethos is generally ignored in traditional ethical theories, although ethical problems often stem from how we structure our social organizations.

In addition, Liaschenko (1997) contends that the work of nursing occurs in specific physical and social spaces that are defined by cultural ethos and, in turn, have ramifications for the nurse-patient relationship. For the nurses in her study there were serious ethical concerns about how spacial vulnerabilities and gendered space impact these relationships and thus, impact the work of nursing.

In spite of the dearth of literature about the ethical implications of social organizations and ideologies, it is apparent that this needs to be a focus in nursing. Interpersonal ethics cannot be limited to either the language of caring or the language of rights:

> ...poverty, exploitation of patients, homogenization of identity, and fragmentation of care lie beyond the capacity for action of any one individual. These large-scale ethical concerns are reflective of the vision of the kind of world we want to have and they demand collective action at the political level. Yet nurses' concerns often go unnoticed and unlistened to precisely because they work in a gendered space. The political implications of working in gendered space ensure that the invisibility and instrumentality of nursing work, as well as the relations between nurses, can be ignored. The knowledge embedded in these concerns is a threat to the instituions of medicine and the health industry...(Liaschenko, 1997, p. 57).

Working Definitions of Being "in the Middle"

In synthesizing the meanings which emerge from the literature about ethical models, nursing ethics, betweenness and middleness in nursing, and the concept of marginalization, I constructed two working definitions of being "in the middle." The first definition is being "in the middle" as *effective advocacy*: An experience in which a nurse who by virtue of her training and "situatedness" employs professional knowledge and skill to integrate a wide variety of perspectives, thereby being in a privileged, centered position which allows for effective advocacy. This definition incorporates the literature that talks about being "in the middle" as resulting from professional obligation or duty, and being "in the middle" as a position or perspective distinct to nurses (Bishop & Scudder, 1987). Effective advocacy results from knowing the patient, having a professional duty to the patient, having professional access to many sides of the moral story, being trained to hear and acknowledge all sides of the story, having a professional ethic that informs professional practice, and having a personal ethic that assumes the power of advocacy, knowledge and persuasion. In this conceptualization, the nurse is at the social "center," with access to and influence on perceptions and meanings attached to transitions which occur during illness (Hall et al., 1994). Nurses act as intermediaries (having the quality of *intermediacy*) between patients and their experiences of illness. This is a strong position of advocacy, trust and caring, although there is a tension inherent in this definition because being "in the middle" is both an outcome and a process: by virtue of her position as an effective advocate, the nurse has the opportunity and responsibility to take certain actions, and, because she takes certain actions as a nurse, she is "in the middle." Understanding this tension was predicted to be another key in understanding the professional realities of being "in the middle."

The second definition is being "in the middle" as *ineffective peripheralization*: It is the personal, professional or social experience of ineffectiveness of nursing action resulting from conflicts and power struggles, from traditional or institutionalized views of nursing roles, from societal stereotypes of women, and from the marginalization and disempowerment of nurses. This definition incorporates three of the characteristics of marginalization discussed previously: *power* (in this case, the influence and control exerted by those at the center of society on those at the periphery - most commonly cited as physicians, administrators and third-party payers); *reflectiveness* aimed at understanding and compensating for discrimination and invisibility; and, *voice* in finding ways to communicate with other nurses and with patients in spite of being silenced by the dominant group. This conceptualization emerges from the traditional gender roles of men and women, as well as from the hierarchical roles and societal expectations of doctors and nurses. In the literature, this conceptualization is discussed as a function of power or powerlessness, and as an outcome of conflict. This type of being "in the middle" can occur on a personal, professional, or societal level, and has been frequently described in the literature (Astrom et al, 1993a; Broom, 1991; Engelhardt, 1985; Erlen & Frost, 1991; Huggins & Scalzi, 1988; Hutchinson, 1990; Jameton, 1977; Johnstone, 1988; Mayberry, 1986; Pike, 1991; Soderberg & Norberg, 1993; Stenberg, 1988; Zorb & Stevens, 1990).

These two definitions, *effective advocacy* and *ineffective peripheralization*, seem to describe opposing concepts. One is a positive, empowered role in a position of centrality, while the other assumes nurses to be powerless, silenced and in positions on the margin. One goal of my research was to explore whether these two conceptualizations are mutually exclusive, part of a continuum in the nursing process or indicative of a transition from one way of being "in the middle" to the other. By answering these questions we may better understand how "being in the middle" impacts how nurses function and carry out their roles, and what we can learn about the realities of the clinical workplace.

How Can Feminist Approaches Inform this Nursing Research?

Using a feminist approach to frame issues within the domain of nursing practice provides a lens with which to view particular questions about the experience of being "in the middle," the contexts in which those questions are situated and the roles that professionals play in shaping and answering those questions. While feminist approaches have not typically been the norm in nursing research in the past, they can help us address questions about meaning and lived experience - questions that are germane to the development of nursing knowledge. As early as 1983, MacPherson presented feminist methods as a partial shift away from empiricism. She stated that

> [Feminist] theories have a dual function. They offer descriptions of women's oppression, and prescriptions for eliminating it. They are empirical insofar as they examine women's experience in the world, but they are political insofar as they characterize certain features of that experience as oppressive and offer new visions of justice and freedom for women (MacPherson, 1983, p.19).

For the purposes of this study on being "in the middle" in nursing, the following feminist perspective informed the research: Challenging prevailing assumptions, exposing oppressive practices, attending to social context, attending to the particularity of lived experience, and assuming that there are both differences and commonalties among individuals (Sherwin, 1992). In the following sections, I have delineated these perspectives in more detail.

Challenging Prevailing Assumptions. Underlying assumptions, whether explicit or implicit, have impact on the conduct of research and scholarship. In nursing practice, as in other domains, underlying assumptions drive which research questions are asked, which research gets funded, which research is taken seriously, and who are selected as research participants (Sherwin, 1996). My feminist approach focused especially on how these underlying assumptions might propagate oppression of women, specifically, nurses. One assumption that feminists have addressed in the past and that was relevant to this research was the fundamental assumption that generic, white, middle-class males are the empirical and moral norm (Tong, 1996).

> ...an account of human nature and agency which takes [men] as central must either be admitted to be radically incomplete, or it must be understood as implying that what it leaves out is unworthy of inclusion - that if we have difficulty in recognizing our own subjectivity in the dominant theoretical models,

> this is evidence that we are something other than fully fledged human subjects (Frazer, Hornsby & Lovibond, 1993, p.5).

Likewise, the assumptions of the reigning conceptions of justice and autonomy have been challenged by feminists as not serving women equally and fairly (Wolf, 1996):

> Theories that place priority on autonomy - at least as the concept is commonly interpreted -must be understood as primarily protecting the autonomy of those who are already well situated, while sacrificing the necessary prerequisites for autonomy for others...philosophers have traditionally presumed that justice belongs wholly in the public realm, and have paid no attention at all to the injustice that characterizes the private lives of most families (Wolf, 1996, pp. 53-54).

Nurse feminists question whether the medical model is congruent with the goals of nursing (Warren, 1992). For example, the technocratic medical model represents an ontological view which conceptualizes disease as self-contained and apart from the person it attacks (Hughes & Kennedy, 1983). Medical technology is concerned with research about the diagnosis and cure for each of thousands of conditions. For the most part, disease is treated as a biological malfunction, independent of patients' whole physiological, social and psychological realities, and outside of the environments, cultures and societies in which they live. Disease is understood apart from contextualizing factors, and causation is presumed to be monoetiological (Allan, 1988). This diagnostic labeling leads to several negative consequences: 1. It robs patients of control over their lives; 2. It has led to the medicalization of life processes such as pregnancy, menopause, aging and dying; 3. It has led to the medicalization of social and ethical problems; 4. It ignores quality of life issues, and; 5. It directs a treatment orientation which neglects health promotion and illness prevention (Allan & Hall, 1988). The assumption that the medical model should be the basis for all thinking might lead nurses to feel "in the middle" in another way - between the assumptions and beliefs of the nursing profession and those of medicine.

Feminism suggests a basis for caring that stresses individual discretion and values, and acknowledges that the nurses' right to care is commensurate with physician's right to cure (Reverby, 1987). This stance brings the traditional health care and medical hierarchy into question. Likewise, it brings the personal and private into public and political spheres. Many feminists believe that the personal is fundamental to how one exists in the world. In nursing this is the basis for practice-oriented theory and care-based praxis (Chinn, 1989).

<u>Exposing Oppressive Practices</u>. "Feminism expands moral vision, offering a way of seeing otherwise obscured injustices" (Nelson & Nelson, 1996, p. 354). A feminist approach challenges us to look at the political and cultural barriers to women's full participation in the health care system (Dresser, 1996). It claims that gender bias produces violation of the basic bioethical principles of autonomy, beneficence, nonmalificence, and justice (Dresser). It challenges the power of those in medical authority to define illness.

Some believe that nurses are dominated by several groups within western civilization, specifically, physicians, hospital administrators, university administrators, insurance company administrators, and politicians (Dresser, 1996). Feminist theory holds that these dominant groups, like dominant groups within any society, identify their norms and values as the correct ones. Those groups have the power to enforce them and they have the mechanisms to maintain the oppressive structures. Education is controlled by them and supports their values. Members of subordinate groups may be rewarded or incentivized for preferred behaviors, although they are also identified as different and are negatively valued. Essential to liberation from such oppression is unveiling it and rejecting the myths developed by the persecutors (Bent, 1993).

Research itself can also be a form of oppression, and should not be exempt from a critical examination both of the institutional structures that shape the lived experiences of women, and of the historical context of the domination (Anderson, 1991). Persecution in the conduct of research can stifle women's voices, editing them out so as to conform with acceptable scientific discourse. Oppression occurs when women's knowledge is appropriated, and when research with women is not used to improve their lives (Anderson). In addition, researchers should be acutely aware of the unequal power relations that can occur between researcher and participant, being sensitive to ways that equalize that power. Oakley (1981) suggested that equalizing power occurs when the interviewer sees the relationship as non-hierarchical and is prepared to invest her own personal identity in the relationship.

When studying biomedical and nursing ethics, feminism prompts us to explore whether bioethics is itself an instrument of gender domination that helps to legitimize existing patterns of dominance (Sherwin, 1992). We might ask what role medicine (and nursing) plays in the oppression of women.

Attending to Social Context. My feminist framework prompted me to expand away from viewing problems dyadically, either as problems among individuals, or more globally, as problems within entire societies. This leads me to focus on an intermediate level of significance in this study, specifically to clinical nurses working in acute care hospitals - considering race, ethnicity and gender (Wolf, 1996). The poststructuralists challenge researchers to extend their analysis of phenomena related to the lives of patients beyond the micro level to an examination of the broader social processes that influence health and illness behavior (Anderson, 1991). Here feminism not only grapples with the significance of gender difference, but cultivates a heightened sensitivity to other kinds of difference (Nelson & Nelson, 1996).

Nursing roles reflect the society in which nurses practice. Certainly these roles are socially constructed. Nursing has historically been deeply bound to traditional female roles, while medicine and the institutions in which nurses practice have been dominated by traditional male roles (Star, 1996). A hierarchy of power and authority continues to exist among nurses and other professionals with whom they work, and mirrors the hierarchy that exists among men and women in the western world (Balsamo, 1993). While the nursing profession reflects these hierarchies, it also reflects the influences of feminism as a political and social voice in western civilization.

Meleis (1987) suggested that there are three considerations that help us explicate the meaning of contextuality described by a feminist approach in the development of nursing theory. These include experiences, perceptions, and meanings. The *experiences* of nurses and patients must be considered and utilized in the development of nursing theories in order to authenticate their descriptive and explanatory power. Likewise, the *perceptions* of patients and nurses must be accounted for in the development of nursing knowledge. And personal, societal, and cultural *meanings* all create the context for the understanding of responses to health and illness. This research explored nurses' experiences and perceptions, and the meanings they attached to their experiences and perceptions.

Attending to Particularity of Lived Experience and Differences Among Individuals. One goal of my feminist research was to analyze conditions of women's lives, specifically nurses' work lives, to understand them, delineate causes and consequences of oppression, and work towards improving women's state. The aim was "to explicate the actual social processes and practices organizing peoples' everyday experience from a standpoint of the everyday world" (Smith, 1987, p. 151). Feminist research is grounded in women's actual experiences, valuing continuous, interactive dialogue, and making women visible. Researcher's are charged with being consistent to feminist goals in making methodological decisions, in dealing with sexual division in the research team, in deciding upon the language of the research findings, and in controlling the ways the research is published and used (Roberts, 1981). But striving to make women visible is not a value-free proposition. Researchers can't help but be influenced by their own values in selecting the research problem, making day to day research decisions, and in interpretation of the research findings. The key is for the researcher to recognize her own values and assumptions as they influence the conduct and interpretation of the research and to honestly articulate them to her participants and colleagues when it is appropriate. The key values that drove my own research assumptions and decisions included my belief in the importance of the roles of nurses in caring for patients, the necessity for understanding and articulating nursing practice, and the need to identify and deal with the oppression of women and other marginalized people.

Differences in lived experiences, in perceived worth, and in physical attributes all add complexity and richness to the human experience. Understanding these differences, which is integral to feminist approaches, is key in developing nursing knowledge (Nelson & Nelson, 1996).

As a feminist, I looked further than research based solely on analytic inquiry - focusing not on subjects, but on discourse, and how people talk about their subjects. Allen, Allman and Powers (1991) says that as long as inequality is attributable to biology, it is politically easier to maintain the inequality - but if it results from the social systems, change becomes more possible. I do not wish to make claims on women's experiences, or create a phenomenology that leads to further subdivisions among sexes/genders, for this is inconsistent with my belief that women do not speak with one moral voice, and that there is anything to be gained in dualistic thinking. Like the poststructuralists I believe that there is no one single correct approach to knowledge development. I challenged myself to question dualistic thinking - dichotomous ways in which human activities are described, analyzed, and categorized. I challenged myself to ask whether my research was generative in the creation of new information about women, and whether it highlighted previously unnoticed aspects of women's lives and contributes to the closer inspection of women (Allen et al.).

The Research Questions

The research questions for this study emerged from my review of the nursing literature about being "in the middle" and marginalization, from my review of the impact of models of ethics on nursing scholarship and education, and from my feminist commitment to challenging some of the prevailing assumptions in mainstream research. The research questions were meant to address some of the gaps in our knowledge about this phenomenon and to begin to shape a program of research. The five questions defined for this research were: 1. What are nurses' experiences of being "in the middle"?; 2. What does being "in the middle" mean to clinical nurses?; 3. What is the nature of "betweenness" or "middleness" in nursing?; 4. Are there patterns of dealing with or responding to being "in the middle" by nurses?; 5. And, what are the consequences of being "in the middle" to nurses and others?

The Conceptual Framework for this Study - Neomodern Feminism

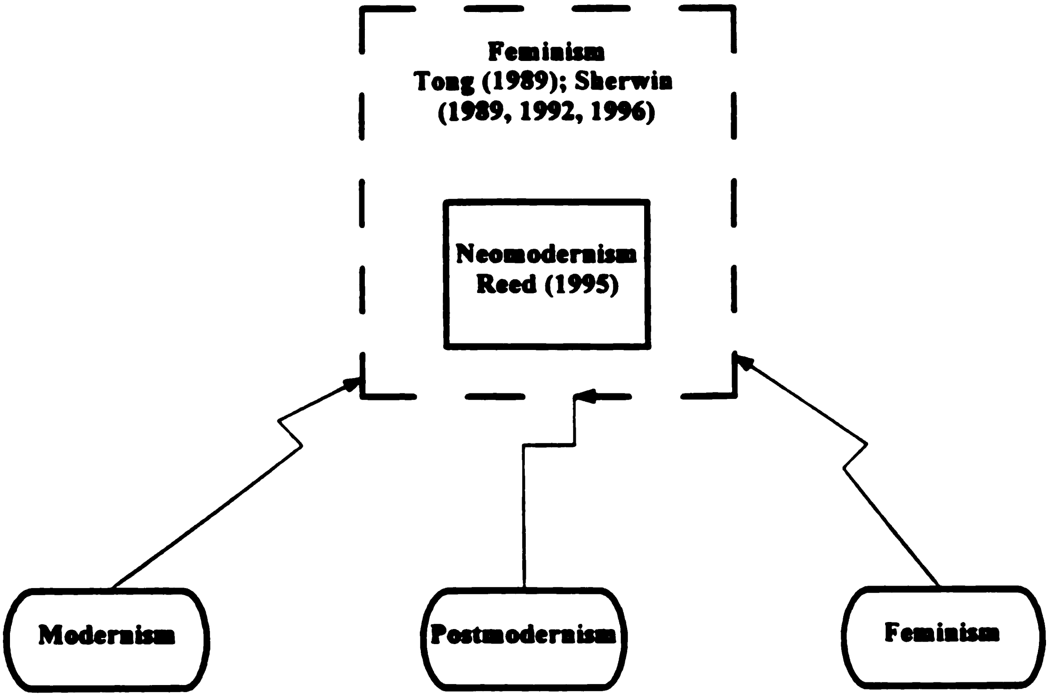
Morse (1991) observed that in the nursing literature there is diversity in defining the same concepts. An example is the concept of "phenomenology" that has been used to refer to a research method, a philosophical stance, and as a term denoting qualitative research. Although my research methodology was feminist narrative inquiry for the collection and analysis of the data, neomodern feminism defined and framed the methodology and provided the study's philosophical stance. It is important to explicate this unique feminism because it is one of many feminisms, each with its own strengths and weaknesses. In general, neomodern feminism takes a step beyond postmodern feminism in helping us understand how nurses are situated in their profession and in society, and in theorizing about nursing roles.

Neomodernism calls for the integration of postmodern critique that incorporates the lived experiences and situadedness of participants and modernist empirical inquiry that calls for systematically examining research data. It therefore helped in understanding individual experiences as distinct and separate from all other experiences but that were essential in helping to recognize reoccurring themes and common threads.

Specifically, the conceptual base framing this research was the neomodern framework suggested by Reed (1995) with which I have integrated the feminist assumptions of Rosemarie Tong (1989) and Susan Sherwin (1989; 1992; 1996) to create neomodern feminism. Reed described neomodernism as a framework that "upholds modernist values for unified conceptualizations of nursing reality while recognizing the dynamic and value-laden nature of all levels of theory and metatheory. It ....extends beyond the postmodern critique to identify nursing metanarratives of nursing philosophy and nursing practice that serve as external correctives in the critique process" (Reed, p.70). In other words, the neomodernist framework embraces both systematic, empirical inquiry which searches for "reoccurring distinctions, themes and commonalties, and common clinical entities and issues" (Benner et al., 1996, p. xiv), and recognizes the reality of social and cultural context and the particularity of lived experience. In combining the strengths of modernism and postmodernism into a neomodernist framework and overlaying that with feminist assumptions, theories can result which maintain a sense of the whole rather than resorting to fragmentation, dualistic thinking or permanently breaking things into component parts (Figure 1). This is consistent with the assumption within nursing that patients are individuals who have the capacity for unlimited growth, who evolve in interaction with their environment, and who have both unique and predictable characteristics (Allen, et al., 1991).

Figure 1

A Conceptualization of Neomodern Feminism



Neomodernism

Reed (1995) described neomodernism as a framework that "will help nursing science bridge modernist and postmodernist philosophies as nursing clarifies contemporary approaches to knowledge development" (p.71). Basically, this framework incorporates "metanarratives of nursing philosophy and nursing practice into scientific inquiry" (Reed, p.71). Empiricism clearly moved science away from religious and metaphysical approaches to reasoning about reality and towards systematic methodologies for exploring and knowing that claimed to be theoretically singular and transcendent as well as devoid of bias, contradiction and values. What empirical scientists failed to fully recognize was that the development of knowledge is always impacted by bias, values, and situatedness, and that "theories, like the fisherman's net, inevitably influenced what data were caught by the scientist" (Reed, p. 71). Postmodern thought suggested that research data were socially and culturally embedded and that the nature of theory was more transitory than fixed. "Whereas modernists fragmented the whole to study parts in the attempt to ultimately unify knowledge about the work [the research focus], postmodernists fragment and dissolve unities, universals, and metanarratives believed to be entangled with values and beliefs that oppress people and fabricate reality" (Reed, p. 71).

Nursing knowledge development has evolved in response to these shifts in philosophic thought to incorporate both modernist and postmodernist influences, deriving knowledge from the typically separate domains of empirical, conceptual, and practice activities of nurses (Carper, 1978; Chinn & Jacobs, 1991; Schultz & Meleis, 1989). Polis (1993) suggested a move toward an "open philosophy" which links phenomena and empirical concepts that can be known through the senses with theoretical concepts that can be known through thought. This integration of thought is similar to what Peirce and his colleagues (1934) called *abduction* in their system of scientific reasoning. *Abduction*, in which the scientist hypothesizes about theory based on experience, beliefs and study of patterns, is followed by *deduction* in which the theory becomes the basis for predicting empirical events that may occur, and then arriving at the research question. *Induction* is the process of empirically testing the research question (Reed, 1995).

Postmodern critique suggested that abductive reasoning had become primary in scientific inquiry, but that it was, nonetheless, never free of values and subjectivity. Likewise, the postmodernists extended the concept of empirical testing to include interface with the domain of practice suggesting that "the merit of a theory is found in its practical implications and usefulness in solving problems of the discipline" (Gergen, 1994, p.412). I would suggest that neomodernism allows us to engage in postmodern *deconstruction* of narrative in order to understand context and assumptions, and then to *reconstruct* meanings and theory based on these new insights and understandings.

For many nurse researchers, empirical data extends beyond modernism to include qualitative data such as narrative and *in situ* ethnographies which are not necessarily empirically verifiable (DeJoseph & Messias, 1996; Messias, 1997; Miller, 1994). The resulting knowledge is intersubjective rather than hierarchically ordered. The call for validity, reliability and replicability then becomes less relevant (Denzin & Lincoln, 1994). These issues, as they relate to this qualitative research, will be discussed later in this paper.

This type of intersubjective openness leads to a framework in which scientific inquiry and philosophical nursing metanarratives are linked with the realities of nursing practice to strengthen the professional approach to knowledge development (Reed, 1995). I believe that the feminist neomodern approach allows for culturally sensitive inquiry, as well, because it focuses on lived experience and social and cultural context.

Although not specifically labeled as such, other nursing scholars have suggested a neomodernist type of conceptualizing knowledge, as well. For example, Donchin (1995) said that "professionals should recognize that the knowledge they possess is generic, even if extrapolated from previous cases. It needs to be sensitized to the circumstances of the particular patient whose own situated knowledge and life plans may be determinative considerations" (p. 48). Meleis (1987) suggested that "our commitment to health has significant social value and therefore can have a global impact if we follow a systematic, conscious, and global approach to nursing knowledge development" (p. 13). She asks, "Have we made attempts and plans to cross boundaries such as class, culture, and national boundaries, by making our work relevant to those other than white middle-class males and females?" (p.16). She challenges nurse scholars to look towards the development of midrange theory that is gender and culturally sensitive in developing nursing knowledge. Hagell (1989) contends that the development of women's knowledge must account for context, subjectivity, and caring.

But "neither intuition and empathy nor scientific expertise and statistical significance are enough to reveal the full meaning of the data" (Reed, 1995, p. 75). No matter what the methodology, science is incomplete without a critical, reflexive and analytical approach to the work. Saying that, we must recognize that critique is also not adequate in itself for the development of knowledge, providing, as it does, process without substance (Reed). For nursing knowledge development, the substance should be provided by an overarching "ideal" or metanarrative which functions as "a 'narrative foil' against which scientists critique their work to form and reform knowledge" (Reed, p.76). The metanarrative proposed for purposes of this paper is the feminism exemplified by Tong (1989; 1996) and Sherwin (1989; 1992; 1996).

The Feminist Metanarrative

> To study ethics without paying particular attention to feminism is to be disadvantaged from the outset. For it is to assume that we are all equally well equipped to understand ourselves in terms of theories which draw most of their vitality from the experience, not of human beings at large, but of *male* human beings (Frazer, Hornsby & Lovibond, 1993, p.3).

What does this mean for nursing research? If the utility of a feminist approach to a specific research question is examined - for example, an exploration of nurses' experiences of being "in the middle" - one can see that such an approach could provide valuable insights by providing gender-sensitive, as well as culture-sensitive assumptions. Epistemologically, we know that women's experiences (e.g. nurses' experiences) are legitimate sources of knowledge - women are knowers; subjective data are valid; informants are "experts" on their own lives; knowledge is relational and contextual; and, definitive boundaries between personal and public, or personal and political spheres are artificial, as are sharp distinctions between theory and practice (Campbell & Bunting, 1991; Wheeler & Chinn, 1991).

Studying ethics from a feminist framework, according to Sherwin (1992), brings nurse researchers into mostly uncharted territory. A feminist framework looks at what effects this research might have on the lives of women. It demands a moral analysis that fits the actual worlds in which the study participants live. The researcher must seek to give voice to those who have been silenced and to those with alternative perspectives. A feminist approach demands that researchers explore assumptions that are central to nursing, especially: which questions get asked; who controls the research agenda; what is held to be normative; and what is held to be acceptable professional ethical comportment. Such an approach should expand our scope in order to make us look further than the male perspective, and to point out the complexities of life (Sherwin).

Obvious issues within nursing ethics that demand a feminist focus include issues of power, oppression, silencing, the social and personal components of ethical decision making, the complexity of illness, the social consequences of illness, and retaining personhood within illness. Some of these issues have been described in conceptualizations of being "in the middle" (Astrom et al., 1993a; Bishop & Scudder, 1987; Broom, 1991; Fry, 1985; Huggins & Scalzi, 1988; Hutchinson, 1990; Johnstone, 1988; Ketefian, 1987; Pike, 1991; Soderberg & Norberg, 1993; Stenberg, 1988; Watson, 1985; Wilkinson, 1987/88; Yarling & McElmurry, 1986). Feminist scholarship, which can be effectively utilized to frame qualitative research, not only helps us to describe and interpret phenomena that impacts women's lives, but also seeks to raise consciousness and affect changes (Hall & Stevens, 1991).

While recognizing that there is not a single female perspective, qualitative, narrative analysis of interviews with nurses about being "in the middle" using feminist assumptions provided some unique insights about the ethical voices of nurses (Tong, 1996). Both the ethos of nursing and nurses themselves are predominantly feminine, and therefore these voices are legitimately studied in terms of gender. We develop new knowledge about ethical decision making, interactions, and behaviors among nurses, and among nurses and other people, by challenging the prevailing bioethical assumptions. What is distinctive in nurses' ethical experiences is worthy of exploration in its own right. The feminist approach is congruent with my nursing perspective which values subjective experience, finding it central to humanistic, interactive practice.

Assumptions of the Research

The assumptions of this research emerged from the conceptual framework of the study - neomodern feminism - and from my own values and experiences as a human being, as a woman and as a nursing administrator. I was able to identify most of these assumptions before beginning the research, but there were some that became apparent as I interacted with the participants and after reflecting on my experiences as a researcher during data analysis. No doubt, there are some assumptions that remain hidden in my subconscious to this day.

I assumed that the roles of nurses are important, and that there is an ongoing need to understand and articulate the many components of nursing practice. While a unique nursing standpoint exists and is different, for example, from a physician or patient standpoint, its contours may not be clear to nurses themselves. I sought to clarify the unique standpoint of nurses by articulating how different nurses express common themes (Collins, 1991).

However, the primary assumption that drove this research was that understanding being "in the middle" is important to the profession of nursing because it is an integral role in nursing and it is embedded in the everyday practice of hospital-based nurses. In the following sections, I have incorporated the other assumptions that emerged from that basic assumption into three categories: gender and diversity; ways of knowing, and; sources of knowledge. No doubt, all these assumptions were highly influential in how I approached and interacted with the participants, how I organized the data and the conclusions I have drawn from this dissertation research.

Assumptions about Issues of Gender and Diversity. Not surprisingly, assumptions about issues of gender and diversity arose from my feminist perspective of my world. These assumptions included the following: In much of the biomedical research, the generic, white, middle-class male is taken as the empirical and moral norm; there are some basic differences between genders and among cultures, but knowing and viewing the world varies more between individuals than between genders or among cultures; difference should be recognized and respected as equally valuable within and among genders and cultures; most women and many cultures and ethnicities are oppressed and marginalized, and there is a pressing need to identify and deal with those oppressions; and, there are social behaviors that mute or silence the voices of nurses that must be revealed and understood, but that there are also individual nurses who are neither muted nor silenced.

Assumptions about Ways of Knowing. My assumptions about ways of knowing and ways of developing knowledge were influenced by my feminism as well as by my experiences as a researcher, a nurse and a woman. Those assumptions included: The medical model is not always congruent with the goals of nursing and would not be helpful in studying this phenomenon; feminism provides gender sensitivity that is not consistently employed in other frameworks; knowledge is relational, interactive and contextual; sharp distinctions between theory and practice are artificial; and, we can't separate structure and thematic content of thought from historical and material conditions of people's lived experiences (Collins, 1991).

Assumptions about Sources of Knowledge. Likewise, my assumptions about sources of knowledge were influenced by my feminism. These assumptions were also instrumental in my selection of this research topic, the conceptual framework and the research methodology. The assumptions were: Women's experiences are legitimate sources of knowledge; informants are experts on their own lives; the narratives of the participants were a means to achieve their active involvement in the construction of data about their lives; nurses possess unique perspectives about their experiences that may also have certain commonalties of perception that they share as a group; diversity of class, race, religion, age, sexual orientation result in different expressions of these common themes; narratives are the product of individual thoughts, activities, social organization and cultural patterns; knowledge is jointly constructed between the researcher and the participants; narrative is conversation; and, realities are multi-layered (Campbell & Bunting, 1991; Wheeler & Chinn, 1991).

Conclusion

In this chapter I discussed the conceptual basis for studying being "in the middle" in nursing. The chapter included a review of the nursing literature that address this phenomenon and the similar phenomenon of marginalization. It delineated models of ethics that have influenced nursing scholarship and education. Also discussed were meanings and contexts of being "in the middle" that emerged from the literature. Two working definitions of being "in the middle were proposed based on a synthesis of the literature, and the research questions for this study were delineated. I then described how feminist approaches can inform research. The chapter proceeded with a discussion of the conceptual framework of this research - neomodern feminism. The chapter concluded with the assumptions of the research.

CHAPTER 3

Methodology - Feminist Narrative Inquiry

"To Speak of All Kinds of Things"

In an intermediate French class at Merced College a few years ago, the students were assigned a five-minute oral report, to be delivered in French. The second student to stand up in front of the class was a young Hmong man. His chosen topic was a recipe for *la soupe de poisson*: Fish Soup. To prepare Fish Soup, he said, you must have a fish, and in order to have a fish, you have to go fishing. In order to go fishing, you need a hook, and in order to choose the right hook, you need to know whether the fish you are fishing for lives in fresh or salt water, how big it is, and what shape its mouth is. Continuing in this vein for forty-five minutes, the student filled the blackboard with a complexly branching tree of factors and options, a sort of piscatory flowchart, written in French with an overlay of Hmong. He also told several anecdotes about his own fishing experiences. He concluded with a description of how to clean various kinds of fish, how to cut them up, and, finally, how to cook them in broths flavored with various herbs. When the class period ended, he told the other students that he hoped he had provided enough information, and he wished them good luck in preparing Fish Soup in the Hmong manner. The professor of French who told me this story said, "Fish Soup. That's the essence of the Hmong." The Hmong have a phrase, *hais cuaj txub kaum txub*, which means "to speak of all kinds of things." It is often used at the beginning of an oral narrative as a way of reminding the listeners that the world is full of things that may not seem to be connected but actually are: that no event occurs in isolation; that you can miss a lot by sticking to the point; and that the storyteller is likely to be rather long-winded (Fadiman, 1997, pp.12-13).

As a neomodern feminist researcher, I chose a naturalistic methodology - feminist narrative inquiry - as a means to elicit oral narratives from nurses and to conduct research about their clinical experiences of being "in the middle." DeJoseph and Messias (1996) called it a "method in the making," and a particular blend of postmodern, feminist and narrative perspectives. This qualitative methodology provided a systematic way to study and understand complex human behavior and theorize about nursing practice. It is inherently paradoxical, as Lincoln and Guba (1985) pointed out, to "design" qualitative study within the naturalistic paradigm because design, as we understand it in the quantitative sense, implies hypotheses, specific procedures for sampling, instrumentation and data analysis. It implies controlling for variance which is not an objective in qualitative designs. However, for qualitative research, "rather than attempting to control variance, the researcher hopes and expects to uncover diversity" (Messias, 1997, p. 70). "The essence of qualitative research is twofold: a commitment to some version of the naturalistic interpretive approach to its subject matter, and an ongoing critique of the politics and methods of positivism" (Denzin & Lincoln, 1994, p. 4).

Qualitative research designs, according to Denzin and Lincoln (1994), adapt, change, and mold the very phenomena they are intended to examine. Likewise, as an understanding of the phenomenon develops, the research design must adapt and change. Our pilot research (Edwards & DeJoseph, 1996) assisted me in developing a research plan, refining my interview technique, having experience with research participants, setting, methodologies and documentation, and trying out data analysis techniques. More importantly, that study elicited stories that have been important to generating my understanding of being "in the middle." Those stories informed the assumptions I incorporated into this study, they framed the study, and they were integral to my conclusions.

Narrative Inquiry

Human life has been understood from earliest times in narrative forms. Narrative forms are ordered either temporally, with a beginning, middle and end (DeConcini, 1990), or by subject or reasons that unite characters, context, actions, meanings or intentions (Fisher, 1987). There are narrative conventions and audiences that differ among cultures, and between everyday conversations and more formal research or clinical interviews (Sandelowski, 1991). Narrative imposes order on life and helps us to understand the differences between life-as-lived, or what actually happened; life-as experienced, or the feelings, thoughts and meanings interpreted by the person living the life; and life-as-told in narrative (Bruner, 1984). Narrative offers a format that supports the rich descriptions of the experiences and concerns of nurses in clinical practice. Nurses' narratives about their work are layered, complex and represent many truths because their practices are filled with ambiguity and paradox, just like life itself (Messias, 1997).

Nursing research, by virtue of the perspectives and interests of the profession, must continue to directly explore the storied nature of human interpretation (Sandelowski, 1991). In this research, narrative is the framework for "understanding the human being, in this case the nurse, as subject of nursing inquiry; conceptualizing the interview; and analyzing and interpreting interview data" (Sandelowski, p. 162). This research, in turn, is meant to make the link between nursing practice, ontology and epistemology (Boykin & Schoenhofer, 1991). It was grounded in nurse's actual experiences as they remembered and described them in an interactive dialogue with me:

> Given the ubiquity of the term [experience], it seems to me more useful to work with it, to analyze its operations and to redefine its meaning. This entails focusing on the processes of identity production, insisting on the discursive nature of "experience" and on the politics of its construction. Experience is at once always already an interpetation *and* is in need of interpetation. What counts as

> experience is neither self-evident nor straightforward; it is always contested, always therefore political (Scott, 1992, p. 37).

As previously discussed, one of my underlying assumptions was that knowledge is jointly constructed between the researcher and the participants, and that experiences are both interpretations and sources of knowledge. Likewise, I assumed that the narratives of my participants were a means to achieve their active involvement in the construction of data about their lives, and that the narratives were the product of individual thoughts, activities, social organization and cultural patterns.

In research meant to describe in detail how nurses define and respond to being "in the middle" in their daily work, it was important to hear the participants' own voices as they described how they experienced and practiced as nurses within the existing health care system - a system known to be patriarchally defined. I have strived to allow all the voices (the individual's many voices, and every voice within each group) to inhabit the narrative, to have opinions. None (and therefore, all) were privileged. The aim was to understand meaning that is "everyday," focusing on the personal and individual, as well the groups in which the individuals dwell. Like Oakley (1981), I advocated for a model of feminist interviewing that aimed for intimacy, mutual self-disclosure, and "believing the interviewee," rather than the detachment and role differentiation expected in most empiricist research.

There is controversy in mainstream, crosscultural, and feminist schools of thought about interviewing and the risks and benefits of "being a stranger" or "being a friend" to the research participants (Powdermaker, 1966). In many ways, I was conducting this research among "my own," as a woman, and as a nurse, and tried to be mindful of how I interacted with the research participants. However, I sought to be perceived as an "outsider" not unlike the position of the "outsider within" described by Collins (1991) who wrote about African American researchers. Collins described this status as beneficial in providing both nearness and remoteness, concern and indifference; in promoting the tendency for people to confide in such an outsider in ways that they never would with each other; and in putting the stranger in a position to see patterns that those immersed in the situation were less likely to see. I tried to be careful not to make assumptions about existing knowledge, alert to avoiding exploitation of the group being studied, and open to the chance to learn something about myself and about my professional colleagues. While recognizing that experience and meanings are often co-created, I sought to avoid substituting my own experience for that of others, and open to asking questions that challenged my own assumptions. I also tried to mediate between speaking "for" and speaking "from," making an effort to include the many voices, and offering various levels of knowing and thinking through. I was, in the end, an interactive researcher, rather than a disembodied, objective knower.

> . . . The rapport that developed in many interviews resulted in part from my own and my informants' confidences that my prior research and my personal experience together allowed me to comprehend what they had to say in a way that no "outsider" could (Evans, 1979, p.x).

Ethical Component

An application to the UCSF Committee on Human Research was submitted in November, 1998 (Appendix 2). Expedited review was requested since this research fit the criteria as "research involving survey or interview procedures, except where all of the following conditions exist: a. Responses are recorded in such a manner that the human subjects can be identified directly or through identifiers linked to the subjects; b. The subject's responses, if they became known outside the research, could reasonably place the subject at risk of criminal or civil liability or be damaging to the subject's financial standing or employability; and c. The research deals with sensitive aspects of the subjects own behavior, such as illegal conduct, drug use, sexual behavior, or use of alcohol" (CHR, 1998, p.2). Approval of the application occurred in January, 1999.

Risks to Participants and Methods of Minimizing These Risks

One risk to the participants was a potential for loss of some privacy because the subjects' words will be used in reporting the outcomes of the research. However, identifying material has been removed to eliminate the ability to tie the words back to a particular person, and only I am able to link any identifying data to the person. Loss of privacy occurred among the group members, but they were informed that each member could autonomously choose to decline to disclose information and/or discontinue participation in the group without repercussions. All of the above was explained to each participant before obtaining consent. No participant requested to discontinue an interview, to delete any information or to turn off the tape recorder during any of the interviews. Several participants asked for clarification about the protection of their confidentiality before relating stories that were particularly troublesome or painful to them.

A second risk to the participants was the possibility that the nature of the interview might bring up painful or uncomfortable issues. Each participant was informed that he/she could decline to answer any question, and could terminate the interview at any time without repercussions. Again, while painful and uncomfortable issues arose for many of the participants, they indicated willingness to continue the interviews without qualification.

Consent Process and Documentation

I asked each person to participate in a way that gave them as much information as they needed to make a decision. The content of the consent form was discussed, and they were each informed that the interview would be tape recorded. Written consent was obtained from, and a copy of the consent offered to each participant (Appendix 3). Many of the participants did not want a copy of the consent. The signed consent forms were stored in a locked cabinet that was separate from the tapes and transcripts. Once the tapes were transcribed and the transcription verified, the tapes were destroyed.

Data Collection

Participants

The social group that I studied was registered nurses working at least one shift in a two-week period in clinical practice in acute care hospitals. All of the participants were working either in one large Northern California metropolitan area or in a more rural area about 100 miles away. Excluded from the study were nurses who worked exclusively in management or education or who worked in non-hospital settings. This population was chosen because these nurses worked directly with patients. I predicted that they could provide insights about being "in the middle" in their clinical practice. In addition to CHR approval from UCSF, I had maintained ongoing CHR approval since 1996 at another large university hospital in the area to recruit participants from their nursing units . I also received permission from my employer to recruit participants from their hospitals in the area. Because I am the Chief Nursing Executive at one of these hospitals, I did not actively recruit participants from that hospital. However, several staff members volunteered for my study without my solicitation, and I interviewed some of them.

The participants were selected according to the criteria for "good" participants - articulate and interested nurses - rather than just randomly selected, as is expected in quantitative research (Morse, 1991). I posted flyers in the hospitals, on the nursing unit bulletin boards, requesting volunteers for the research (Appendix 4). Registered nurses who were self-selected and volunteered to participate, were able to consent, and practiced in an acute hospital setting met the inclusion criteria. Nurses were solicited from all clinical areas within the acute hospital setting. There were no other inclusion criteria and no special subject populations were utilized.

Both individuals and groups were interviewed for this research. While individual interviews were vital for articulating personal experiences in ethical situations, the nature of being "in the middle" in clinical settings suggested that groups of nurses might also have collective experiences that could inform us. Likewise, "...a group interview format facilitates women building on each other's ideas and augments the identification of patterns through their shared experience" (Callahan, 1983, p.38). Benner (1994) suggested that small group interviews achieve several purposes including the creation of a natural communicative context for narrative about their practice in a setting where peers are talking in ordinary ways to each other rather translating their practice to researchers; providing a setting for active listening in which more than one listener is trying to understand the story; finding links in meanings among the stories and clarifying the participants' understandings of their stories; and creating "a forum for thinking and talking about work situations" (p. 110). I found this to be the case with the three groups that I interviewed. They built on each other's ideas, they articulated shared experiences and they talked together about meanings and memories.

Size of the Study Population

The issue of size of the study population, while difficult to define in qualitative research, becomes even more complex when a feminist framework is fused with it. The selection of participants and the sample size in qualitative research are often not representative in the quantitative sense. Since the goals of feminist research include privileging the particularity of experiences and examining both differences and similarities among people (Sherwin, 1992), an infinite number of nurses would theoretically need to be interviewed to achieve a "complete analysis" since each person has a unique story to tell. The responses of any nurse informant who agreed to be interviewed about being "in the middle" in nursing practice was appropriate for this qualitative inquiry because each perspective added to our knowledge. However, the reality of this research was such that both the time and the workload associated with interviewing, transcribing and analyzing many hours of interviews limited the number of participants. Therefore, I interviewed a total of twenty-six nurses, nineteen individuals and three groups of nurses, in order to access as wide a spectrum of perspectives as possible while keeping transcription and analysis of the interviews to a manageable size.

I conducted interviews over a period of two months, starting in January, 1999. Two of the individuals volunteered to participate as a result of recruitment flyers at their institutions, one participant came forward after I made a presentation at her department staff meeting, one volunteered and spoke to me during a party, five nurses were personally known to me, and the rest came via snowballing and were referred to me by others who had previously participated in the research. One of the groups included members of a larger professional group to whom I had made a presentation about this research, one group worked together in a hospital where I had posted recruitment flyers, and one group was personally known to me.

Interviewing

A semi-structured interview technique was employed in interviewing both the individuals and groups for this research, and was organized around the specific areas of interest, while still allowing considerable flexibility in scope and depth (Polit & Hungler, 1991). The goal was to discover the informant's perspective on the topic, and to allow the informant's story to "structure" the interview as it unfolded (May, 1989). May also suggests that the researchers can expect that there will be an overall trend from unstructured to more focused interviewing as a study progresses, as more data is collected and the investigator becomes more familiar with the area of discussion, and as data analysis occurs. I found this to be the case in this research.

Semi-structured and unstructured interviewing included opportunities for free interchange, clarification and discussion between the participant and the researcher (Reinharz, 1992). This technique maximized discovery and description (Sexton, 1982). It also offered me access to the participants' thoughts, ideas and memories in their own words rather than in the words of the research. Saying that, it must be recognized, however, that by nature, semi-structured interviews are intersubjective - between the researcher and the informant - and the data are mutually created (DeJoseph & Messias, 1996). Rather than structuring the research around an "observer-observed" model, the investigator and the participants engaged in mutual "dialogical production of discourse" (DeJoseph & Messias, p.1).

As described above, registered nurses who worked in acute care hospitals as staff nurses were asked to tell me stories that exemplified their experiences of being "in the middle" in situations involving their clinical practice. I specifically asked the participants to relate stories about their hospital-based practice. This yielded single stories, communally constructed/ remembered stories and multiple stories with common themes.

The specific type of group interview conducted was the formal field interview as categorized by Fontana and Frey (1994). The goal of the formal field group interview is phenomenological and thus was more appropriate for achieving the goals of this particular research than was a focus group format. Each group included no more than four nurses who worked together. They came together in a predetermined setting. The interviewer's role was to be somewhat directive in putting forward questions for discussion (Fontana & Frey). As with individual participants, the groups self-selected. In the past, I had had groups of nurses volunteer to participate based on a mutual story they wished to tell or because they were members of a pre-existing group who had a mutual interest in this research. For example, at one hospital several members of their Shared Governance Committee came to me after I had spoken to their group and asked to be interviewed. Likewise, a group of Emergency Department nurses came to me stating they had two stories they wished to tell me about their mutual experiences.

I sought to listen with care and caution, and to develop ideas, construct meanings, and use words that said what was meant by the participants. Both meanings of the term being "in the middle" - the nurse as effective advocate, and the nurse as ineffective and marginalized - were explored with such open-ended questions as: "Tell me about some of your clinical experiences in which you have felt really conflicted"; "Tell me about some of your clinical experiences in which you have felt torn, confused, pressured or pulled in several directions"; "Tell me about some of your clinical moral experiences in which you felt particularly effective in your role as a nurse, or felt your perspective on the situation was helpful in its resolution"; "Tell me about a situation in which you felt your duty to your patient influenced your actions in an ethical situation" (Appendix 5). The framework of the questions remained open-ended, allowing for the participants to shape the interview, and decreasing the chance that the interviewer would impose external meanings and interpretations onto the participant's responses.

Each interview was arranged for a time and place that was convenient for the participant or the group. The interview venues included study rooms in a library, an empty classroom, a quiet corner in a university cafe, participants' homes, my office, and a quiet room in a home where a party was taking place. After obtaining informed consent from each of the participants, the interviews were tape recorded in their entirety. The interviews were transcribed verbatim by a professional transcriber with whom I had worked in the past. Issues of participant confidentiality, security of the written and recorded interviews, and accuracy of transcription were reviewed in detail with the transcriptionist before she began this project. After she transcribed each tape, I reviewed each one for accuracy by comparing the written transcript to the recorded tape.

There are always concerns in transcribing tapes including inaudible words, slurred or muffled voices, inarticulate speakers and unintelligible phrases when using taped interviews. However, I encountered only a few such problems, and none of them were insurmountable. The problems included several almost unintelligible words which I was able to understand after slowing the tape down and listening to it several times; a very loud parrot who talked and sang throughout the interview and who made both the participant and me laugh several times, thus interrupting our thoughts; and a participant with bronchitis who insisted on continuing the interview even thought she couldn't talk above a whisper.

I also recorded field notes of my observations and perspectives regarding the interviews as I conducted them. The field notes were helpful in remembering the social and environmental contexts in which the interviews occurred, as well as articulating aspects of the interactions which could not be tape recorded such as facial expressions, gestures, and other types of non-verbal communication.

Demographics of the Participants

I also collected demographic data from each participant after the interview. The variables studied included age, gender, ethnicity, marital status, education, experience in nursing, and religious and ethical training (Appendix 6). The demographic information was intended to help describe the participants when reporting the results of this research, and to help in speaking to patterns of coping and dealing with being "in the middle." A complete demographic profile of the study participants is listed in Table 1.

Table 1

Demographics of the Participants (n = 26)

Demographic	Number/Percent of Total
Gender	
Females	23 (88%)
Males	3 (12%)
Race/Ethnicity	
White or Western European	21 (81%)
Black or African American	3 (11%)
Filipino	1 (4%)
Spanish	1 (4%)
Age - Range from 33 - 62 years	
Mean age	44.5 years
Median age	43 years

Marital Status	
Married	19 (73%)
Single	5 (19%)
Divorced	2 (8%)
Clinical Unit	
Med/Surg	5 (19%)
ER	5 (19%)
OR	4 (15%)
OB	3 (12%)
ICU	3 (12%)
CCU	2 (8%)
Oncology	1 (4%)
Surgical Unit	1 (4%)
NICU	1 (4%)
Dialysis	1 (4%)
Number of Shifts Worked Per Two Week Period - Range from 1 - 10 Shifts	
Mean	7.3 shifts
Median	7 shifts
Shift Worked	
Days	16 (62%)
Evenings	4 (15%)
Nights	5 (19%)
Rotating Shifts	1 (4%)
Years of Experience as an RN - Range from 5 - 42 years	
Mean	19.7 years
Median	20 years

Highest Educational Degree	
AA or ADN	5 (19%)
BSN	12 (46%)
BA	2 (8%)
MSN	5 (19%)
MS	1 (4%)
Unspecified university midwifery degree	1 (4%)
Highest Degree in Nursing	
Diploma	1 (4%)
ADN	6 (23%)
BSN	13 (50%)
MSN	5 (19%)
Unspecified university midwifery degree	1 (4%)
Childhood Religious Affiliation	
Protestant	12 (46%)
Catholic	9 (35%)
Mormon	1 (4%)
Seventh Day Adventist	1 (4%)
No affiliation	3 (4%)
Current Religious Affiliation	
Protestant	9 (35%)
Catholic	7 (27%)
Non-denomenational	2 (8%)
Seventh Day Adventist	1 (4%)
Jewish	1 (4%)
No affiliation	6 (23%)

Studied Ethics or Philosophy	
Yes	20 (77%)
No	6 (23%)
Ever a Member of an Ethics Committee	
Yes	2 (8%)
No	24 (92%)
With whom the Participant Talks about Difficult Ethical Situations*	
Co-Workers	18
Supervisor	10
Spouse	5
Friends	4
Family member	1
Pastor/Rabbi	1

*Some participants gave more than one answer

Analytic Component - Feminist Narrative Inquiry

Narrative analysis "reflects the 'storied nature' of social life and attempts to analyze the nature of such stories taken from persons undergoing similar experiences - emphasis is on the narratives of particular experiences. Such narratives are thought to illustrate individuals acting within social and personal constraints" (Olesen & Clarke, 1994, p.14). Likewise, oppression occurs at personal, group or community, and systemic levels of social institutions, and within the contexts of race, class, and gender, and at the junctures of their intersections. These meanings need clarification at each level. Therefore, narrative analysis attempts to identify both differing and invariant meanings of the subjects discussed.

Analysis of the data from this research centered around one version of feminist narrative interpretation described by DeJoseph and Messias (1996). Here narrative was assumed to be conversation, set apart from "just talk" because it is bounded by particular topics or a prevailing thematic thread such as that described in the Hmong story of fish soup. Ontologically, postmodern feminists find that realities are multi-layered, fluid and changing; constantly shaped by context and perceptions. Epistemologically, they presume that relationships among the knowers and what is to be known are subjective and interactive (DeJoseph & Messias). Feminist narrative inquiry embraces these assumptions, and making it an appropriate qualitative approach for studying the concept of being "in the middle."

In asking individuals and groups of nurses to relate stories that exemplify their experiences of being "in the middle" feminist narrative analysis directs us to fuse the ontologies and epistemologies of the knowers and what is to be known, recognizing that the interactions themselves mediate what is known. I looked to mutually articulate explanations of phenomena that affect the lives of my participants by pulling together individual experiences and understandings, looking for patterns and processes that tie them together. This served to "make explicit" their perspectives, their priorities and their ways of being "in the middle." It gave voice to these nurses which is, in turn, a step towards overcoming oppression, reclaiming the environment and achieving solidarity or coalition. By defining access to power and the hierarchy of influences, empowerment of practice occurs.

Some researchers believe that the grounded theory approach immediately reduces participants' words into codes and categories, thereby decontextualizing them, whereas narrative analysis allows the researcher to examine the stories without losing the context in which they dwell (DeJoseph, 1996). My goal was to preserve the participants' words as much as possible. This meant moving sections of text that exemplified themes or story lines to files also containing text from other participants. In analyzing narrative, I attempted to understand how individuals made links among story lines, and whether themes reoccurred across individuals. Using feminist narrative analysis, I attempted to identify both differing and shared meanings of the topics that were discussed (Reinharz, 1992). This meant thinking about whether every participant or a significant number of the participants talked about a certain theme, and, if so, what specific words did they use describe these themes. Likewise, recognizing differences and inconsistencies between participants was crucial both to respecting and understanding these nurses as individuals, and to articulating the realities of their lived experiences. Dealing with the data in this manner allowed for the "co-creation of meaning" among the researcher and the participants, and resulted in interpretations illustrated with the women's actual words (DeJoseph).

The actual process of data analysis was based on techniques described in research by DeJoseph (1996) and Messias (1997). Specifically, after comparing the recorded interview with the written transcript, I read through each transcript again in its entirety at least once without making notes or thinking about thematic content in order to renew my memory about the stories and comments that were made by the participant and to begin to see things that were not seen before. I then read through the transcript again and began making notes about themes, story lines, how stories illustrated any of the conceptualizations of being "in the middle," links between story lines, and what other ideas were being expressed. After analyzing two or three of the transcripts in this way, I went back and forth among them engaging in constant comparative analysis, thinking about similarities and differences in thematic content and conceptualizations of being "in the middle." As themes emerged, I kept track of all the stories that were illustrative of those themes using the NUD*IST software program. All of the themes were illustrated with participants' actual words.

Extending the Qualitative Approach

In the process of analyzing the data, I was also guided by the work of DeVault (1990). She suggested that qualitative approaches can be extended by experimenting with *constructing topics, listening, editing* and *writing. Constructing topics* involves going beyond the standard research disciplinary categories to topics that are more descriptive of and meaningful to women's lives. This meant allowing the exploration of nurses' experiences where we lack vocabulary to easily share meanings, as well as the recovery of unarticulated experience (DeVault). An observation central to feminist thinking is that language itself reflects male experiences, its categories are often incongruent with women's lives and can never fit perfectly with individual experience - a so-called "linguistic incongruence" (DeVault, 1990). Furthermore, the language and topics available from within various research disciplines, including nursing, medicine, sociology, or anthropology, do not necessarily correspond to categories and language that are meaningful in women's lives.

Existing language may not allow for the preciseness that some researchers seek to describe either the actions that give rise to the phenomenon, or the concept itself. DeVault (1990) suggested that researchers must be open to building upon the language and the categorizations that exist within a discipline as they learn from their research encounters. They must be willing to go beyond "received theory." Indeed, since the words available often do not fit, women may learn to "translate" when they talk about their experiences, which means some components may "disappear" into existing language when they talk about being "in the middle." Feminist researchers have an obligation to build language and themes that better articulate the lived experiences of nurses and other women.

Listening means hearing everyday "translation" of experiences into language which may be descriptively inadequate or linguistically incongruent. DeVault (1990) has come to believe that when words such as "you know" occur in the midst of narrative, they don't mean that the speaker is inarticulate, but rather is requesting understanding of something that cannot be articulated given the inadequacy of the language or existing common frames of reference. In listening, I tried to be attentive to attitudes, feelings, and other subtleties embedded in women's speech itself, such as hesitations and word usage.

Editing has to do with the decisions researchers make about recording, transcribing and excerpting from interviews with informants:

> I have argued that one purpose of feminist research is to recover and examine unnoticed experience, and that standard language and forms are likely to be inadequate for describing those experiences. Standard practice that smoothes out respondents' talk is one way that women's words are distorted; it is often a way of discounting and ignoring those parts of women's experiences that are not easily expressed (DeVault, 1990, p.107).

The language of research participants can be both powerful and complex. In searching for higher levels of abstraction by editing and simplifying interview material, the power, complexity and essence of the responses may be lost. Indeed, some suggest that these editing strategies suppress the emotion of naturally occurring speech (Paget, 1981; 1983). Likewise, many feminists believe that naming is political, that the labels attached to activities establish and justify their social worth, and that often women's activities are labeled in controlling and subordinating ways (Frye, 1983). Thus, I attempted to be very careful in *writing* about what has been learned.

> If the language is "man-made," it is not likely to provide, ready-made, the words that feminist researchers need to tell what they learn from other women. Instead of imposing a choice among several labels, none of them quite right, feminist texts should describe women's lives in ways that move beyond standard vocabularies, commenting on the vocabularies themselves along the way. Instead of agreeing on what to call women's activity, we should make our talk richer and more complex - we should use many words, and put them together in ways that

> force readers to imagine the reality we're describing in the new way (DeVault, 1990, p.111).

Reliability and Validity of the Study

> Far from encouraging our ability to think creatively about discovering the truths in personal narratives, our academic disciplines have more often discouraged us from taking people's life stories seriously. Disciplines have mainly done this by elevating some kinds of truth - the kinds that conform to established criteria of validity - over others. Generalizations based on these elevated Truths become norms which are rarely challenged for their failure to consider or explain exceptions. This elevation and generalization serve to control; control data, control irregularities of human experiences, and, ultimately, control what constitutes knowledge. Considered in these terms, the truths in personal narratives cannot stand the tests to which they are subjected, i.e., the tests of verifiability, reliability, facticity, or representativeness. Using such a limited definition of Truth admits only one standard at a time for the perception and interpretation of a small segment of a complex reality (Personal Narratives Group, 1989, p. 262).

Although the appropriateness of applying the standards of reliability and validity to qualitative research is debated by some nurse scholars (Kahn, 1993; Keddy, 1994), those who do subscribe to the standards agree that questions of validity and reliability are examined at the data analysis phase rather than at the instrument development or data collection phase (Guba & Lincoln, 1982; Meleis, 1996; Sandelowski, 1991). This is a different paradigm than that of quantitative research and the one I employed in this research. The critics base their rejection of these standards on the differences in perspective and goals between the quantitative and qualitative research. The point of qualitative research, according to Brink (1989), is to describe and explain phenomena, rather than to generalize findings. Leininger (1985) stated that "validity in qualitative research refers to gaining knowledge and understanding of the true nature...and characteristics of a particular phenomenon under study. Measurement is not the goal; rather, knowing and understanding the phenomenon is the goal" (p. 68). Thus, probability sampling techniques are not at issue, nor is external validity a goal. Likewise, quantitative studies are concerned with internal validity or control over the independent variable, whereas qualitative research, by its nature, is not experimental research requiring manipulation of independent variables. Thus, internal validity is also not a goal. Many forms of qualitative work eschew the search for valid findings and strive instead for an adequate interpretation that makes sense given the context, history and meanings of the person or group under study (Chesla, 1992). Scott (1992) finds that the "evidence of experience then becomes evidence for the fact of difference, rather than a way of exploring how difference is established, how it operates, how and in what ways it constitutes subjects who see and act in the world" (p.25).

The issue of "truthfulness" in narrative is elusive. "Fictions are not opposed to truths in the narrative context, but rather they are truths within the stories that contain them (Sandelowski, 1991, p.161). Likewise, "Stories represent experience, they are not the experience themselves. Narratives are in and of themselves interpretations, which are re-interpreted with each telling/hearing/reading" (Messias, 1997, p. 82). Our interest is not in whether narratives are "historically" true, and we must therefore frame our questions about quality in different ways than those traditionally employed in quantitative research.

Several qualitative researchers have suggested criteria for judging qualitative research (Fanow & Cook, 1991; Hall & Stevens, 1991; Guba & Lincoln, 1982; Meleis, 1996; Reissman, 1993). Messias (1997) incorporated many of these criteria into her model for evaluating the focus, methods, process, sensitivity and interpretations of feminist narrative research. I will use her model to review the quality of my research, including the six dimensions of *relevance*, *appropriateness of the methodological approach*, *engagement*, *contextuality*, *presentation* and *ethics*.

Relevance

The first criterion for evaluation of this research is *relevance* as suggested by Hall and Stevens (1991). Both the focus and results of the research must be considered in evaluating relevance. Additionally, as a feminist researcher, I was obliged to evaluate whether the study was relevant to women and whether it addressed issues that are of concern to them.

Appropriateness of the Methodological Approach

The second criterion for evaluating this research, *appropriateness of the methodological approach*, addresses whether it is suited to goals of the study. In this case, the question was whether feminist narrative inquiry as a methodology was congruent with understanding the phenomena of being and feeling "in the middle" among clinical nurses.

Engagement

Issues of *engagement* by the researcher and the participants is the third dimension of evaluation of the quality of this research. Messias (1997) incorporated the concepts of *rapport*, *mutuality*, *disclosure*, *reflexivity* and *consciousness-raising* into her evaluation of engagement in feminist narrative inquiry.

Hall and Stevens (1991) suggested that *rapport* between participants and the researcher can be evaluated by the depth and breadth of the information that is shared, by the participants' apparent level of comfort during the interview, by feedback given to the researcher and by the participants' willingness to refer others to the researcher.

Mutuality also impacts engagement because it asks us to evaluate whether the power differentials that are often inherent in researcher/participant dyads existed in a particular study situation. The goal is to foster an environment of mutual cooperation and trust which in turn allows for rapport, spontaneity and meaningful exchange.

Disclosure requires trust and mutuality in being willing to reveal marginalized identities and experiences (Meleis, 1996). The researcher must engender trust and sensitivity in order for a participant to feel willing to freely disclose difficult issues.

Reflexivity is another measure of engagement in narrative inquiry and is a hallmark of feminist research. Reflexively, I recognized that I did not stand outside of the narratives of the participants and merely listen and observe them, nor could I interact passively with the data as I analyzed and reported it. The narrative becomes the story of the person who lived it and narrated it, the researcher and the intended audience of the research. Lastly, in evaluating engagement we should consider what effects the research has on *raising the consciousness* of both the participants and the researcher.

Contextuality

The fourth dimension in evaluating quality of the research is *contextuality*. This assesses the degree to which the research takes into account the situatedness, the context of the narratives, and the lived experiences of the research participants (Meleis, 1996). The most important way that I worked to honor the contextuality of the narratives and the lived experiences of the participants was to ask questions about where an event occurred, what the participant's role was, how she felt about the event, why she chose that particular event to illustrate a particular answer.

> Redefining respondents as informants, explicitly introducing personal contexts as grounds for interpretation, granting respondents the right to control how meanings are constructed from their responses as well as control over whether and how they will be identified - all confront us as investigators with questions that must be thought through in fresh ways at each stage of the research process in each particular study (Mischler, 1986, p. 127).

Another was that I dealt with contextuality was to make field notes about side comments, discussions that occurred after the tape recorder was turned off and other observations about non-verbal signals and the like. In general, I believe contextuality is difficult to ascertain in narrative inquiry because of the nature of remembering.

Presentation

The fifth dimension in evaluating quality of this research is *presentation*. My presentation incorporated DeVault's (1990) ideas of experimenting with *constructing topics*, *listening*, *editing* and *writing* in order to extend qualitative approaches and speak to issues that are meaningful in women's lives.

Ethics

The last dimension of evaluating quality is *ethics* or the honesty of the research. This addresses both the spoken and unspoken intentions of the participants and, in the case of feminist research calls for liberally illustrating the analysis with the actual words of the participants. In addition, the honesty of the research is supported by going back to the participants and asking them for feedback about the analysis and fairness of the representation.

Feminist Narrative Analysis - Reflections about the Methodology

Feminist narrative interpretation was an appropriate methodological approach given the goals of this research. It was well-suited to eliciting and analyzing oral, first-person narrative accounts of experience about a topic that had not previously been studied. It allowed me to focus on the lived experiences of individual nurses and to interact with them in co-creating meanings.

This study was about nursing, a predominantly female profession. The study took its questions and answers directly from the narratives of nurses. The narratives were driven, for the most part, by the nurses themselves, so we can assume that they chose to talk about issues that were of interest to them. Furthermore, several of the participants told me that they felt this was an important study and that they wanted people to hear what they had to say.

I found that my rapport with participants varied from person to person. There were many interviews where it was difficult to elicit specific stories from participants until we had talked together for thirty to forty-five minutes. It seemed like it took some people longer to warm up to me and/or to the topic than others. One participant never seemed very willing to talk to me about anything specific. There were two interviews when I felt like I didn't have the energy or focus to connect with what was being said. In looking back at the transcripts of those two interviews I was very surprised at the richness and depth of disclosure of the narratives in spite of my lack of engagement. From that, I learned that perhaps not every participant needed to feel rapport in order to discuss issues of interest to them. With the exception of the three participants I discussed above, I felt almost instant rapport with all of the others. Many indicated that they felt comfortable talking to me. Some indicated that they welcomed the forum for talking about this subject. Some participants came to their interviews with a list of stories they wanted to tell. Clearly, those participants anticipated an equal and trusting relationship before we ever met.

Five groups of nurses were interviewed for this research. The sizes of the groups ranged from two to four members. I assumed that participation in the group was interactive because each individual's input existed within the social context of the group (Smith, 1995). But I also tried to be mindful that each participant in the group was an individual who spoke with her own voice, and that each participant was a collaborator in this research. Before beginning each of the group interviews, we discussed not only the general risks and benefits of this research, but also the issues that might be of particular concern within the group context including privacy concerns related to disclosure to the researcher and to the group and the subsequent inability to ensure strict and absolute confidentiality. By discussing this before the interview, people's concerns seemed to be alleviated.

I also tried to be aware of participant's feelings as they left the group. In two group interviews, there was some very intense and emotional dialogue which left the participants feeling "wrung out" and "emotionally drained." I found that my past experience as a social worker gave me some tools to intervene when the session became stressful. I stayed behind with those who wished to decompress after the interviews. This seemed to be helpful in bringing people back to equilibrium and balance. I do not underestimate the power that the group dialogue had on me and the other participants.

In this research, it seemed helpful that I was a registered nurse interviewing participants who were registered nurses. Some of the participants prefaced some of their narratives with statements like "you know what I'm talking about, I'm sure" that indicated to me that they were assuming that I had similar experiences and could therefore understand what they were saying. I neither emphasized nor hid that fact that I am a hospital administrator, but that didn't seem to impact mutuality. I did emphasize that I was a doctoral student and that this research was meant to help nurses understand the phenomenon of being "in the middle." As discussed above, many of the participants immediately engaged with the topic and quickly began talking about it. Although one participant was concerned about appearing "stupid" and wanted to be sure to give me what I looking for, she was still spontaneous and willing to discuss her experiences. None of the other participants acted intimidated or aware of any differences in our status; I assumed no differences except in acknowledging the superiority of their clinical knowledge and expertise which I mentioned to most of the participants at some point in each interview. Therefore, in this research, I believe that the asymmetry of power that often exists between researcher and participant, for the most part, did not occur during the conduct of my research.

In addition, in most research, the researcher defines and reports meanings within the data based on her analysis, whereas the participants have no opportunity to comment upon those interpretations. In the case of the data collection for this research, I often restated the participant's words and put an interpretation on them during the interview. I then asked the participant if I had correctly understood and/or interpreted what she was saying. After the interviews were completed and during the data analysis stage, I went back to eight of the participants and asked for clarification and/or feedback about my analysis. I also discussed questions and interpretations of the data with individuals and groups of registered nurses who had not participated in the research. All of these steps contributed to the *mutuality* of the data analysis and to the quality of the research.

There were several participants who disclosed marginalized experiences to me. Two participants talked about being asked to participate in hastening the death of their patients. One nurse talked about being the victim of racist comments, and one nurse talked about long-term verbal harassment by a department physician. Many of the interviews were interspersed with crying, anger and/or hostility directed at a remembered event or person. Several nurses said they had told me stories that they hadn't planned on telling, but that were obviously emotionally difficult and meaningful to them. This occurred both in the individual and group interviews. No participant indicated that they had any issues with overdisclosure. I found that each person taught me something new and unique about the research topic, about human nature and about myself. As time passed my knowledge began building on itself, and I realized I was learning things I hadn't expected to learn.

I tried to remind myself at all points along this research path that the participants were human beings who were neither objective nor impartial, and who incorporated their values in their narratives. Many of them were willing and able to take a stand and to speak their minds about issues of professional importance. Many examples, including the narrative about the nurse whose feelings and actions as a professional were colored by her values and emotions as an individual and a mother of a child with cancer, characterized the complexity of events and emotions that factor into one's way of responding to the experiences of clinical practice. It also reminds us that narratives, among other things, are moral enterprise "used to justify and serve as models for lives" (Sandelowski, 1991, p. 163).

In exploring being and feeling "in the middle," I addressed incompletely articulated aspects of nurses' experiences. I tried to *construct topics* that were descriptive of those experiences. Most of the topics were labeled by the participants themselves: speaking for, providing support; protecting; practicing on patients; who makes the decision; miracles happen; accumulation of treatments; knowing the patient doing for the patient; being there; being fair; getting for; and many more. In two cases, I named topics myself after seeking feedback from some of the participant. Those topics were "professional engagement" and "professional passion."

I attempted to *listen* to the participants and to the tapes of the interviews attentively, openly and respectfully, assuming that there were subtleties embedded in the speech and narrative that could be very instructive. I found that allowing silence during the interview sometimes helped participants frame their thoughts. Likewise, asking questions of clarification like, "How did that make you feel?" sometimes led to extended discourse about emotional topics of great importance to the participant.

In *editing* the transcripts, I made decisions about how to excerpt the participants' words and meanings. As a feminist researcher, I feel obligated to always be careful about what I might impose on the data in the way of bias, overlooking subtleties or misinterpretations which might support women's subordination or oppression. Likewise, when writing about and presenting the data, I tried to be mindful of how labels can be political.

While trying to be careful in editing and writing the data, I recognize that ultimately, I am part of the data. Who I am impacted what questions were asked, what topics were constructed, what was heard, how the data were edited and how it was written. I co-constructed this data. But my goal was always to make space for the voices of the participants to shine through. I wanted to report this research in a manner that was respectful of the professional concern and caring that showed through in the narratives of the participants.

Conclusion

In this chapter, I discussed feminist narrative inquiry, the methodology used for this research. In addition, I delineated the steps I took to conduct the research about being "in the middle" among nurses who have hospital-based practices, the process I used in analyzing the narratives of these research participants, and the criteria for determining the reliability and validity of the study.

The Personal Narratives Group (1989) found that when talking about their lives people sometimes lie, forget facts, exaggerate, become confused and get things wrong. In doing so, however, people also reveal truths. These are not the objective truths sought by the empiricist scientific ideal, but are rather the "truths of our experiences and the subsequent translations of experiences that integrate our interpretions of experience inside the telling" (p.261). The Personal Narratives Group concluded that narrative interpretation allows for different perspectives which, in turn, reveal multiple truths of a life. These truths are essential to knowledge because they are specific and must be incorporated into any generalizations that are made about life. The focus must be on the links between nurses' perspectives and the truths they reveal. Feminist narrative inquiry allows for those links to be made.

CHAPTER 4

Results of the Study

Being in the Middle and *Feeling* in the Middle are Two Different Phenomena

> 'I want to know the truth,' Sidda said.
>
> 'We don't deal in truth,' Caro said. 'But I've got some stories. Will that do?' (Wells, 1996, p. 298)

The primary interest of this study was to explore the phenomenon of being "in the middle" as it is experienced and described by nurses in clinical practice. This interest arose out of my observation that the phenomenon has been both implied and specifically named in the nursing literature and by nurses in clinical practice as being a pervasive and important part of the profession, especially within the domain of nursing ethics. The nurses in this study used many rich exemplars to illustrate their lived experiences of being "in the middle." Importantly, the words "in the middle" resonated in one way or another for every nurse participant and, for that matter, every clinical nurse with whom I have discussed this phenomenon over the past four years.

The meanings and contexts of being "in the middle" in clinical practice began emerging almost immediately as I began the interviews. Starting with the first participant, their narratives indicated deeply held beliefs about how being "in the middle" manifested itself in their own practice. In asking questions about experiences where they felt conflicted, torn, confused, pressured or pulled in several directions, or where they felt particularly effective in their roles as nurses, or where they felt their duty to their patients influenced their actions, a variety of terms, stories and narratives were offered as examples of their experiences. I then asked specifically what being "in the middle" meant to each of them, and again, no participant hesitated in answering about personal meanings. After the first interview, I asked each of the rest of the participants about the terms and meanings that had been used by those who had interviewed earlier: whether those terms and meanings were part of their own experiences. Similar to what I found in the review of the literature, the nurses in this study disagreed among themselves about meanings and how being "in the middle" was experienced by each of them.

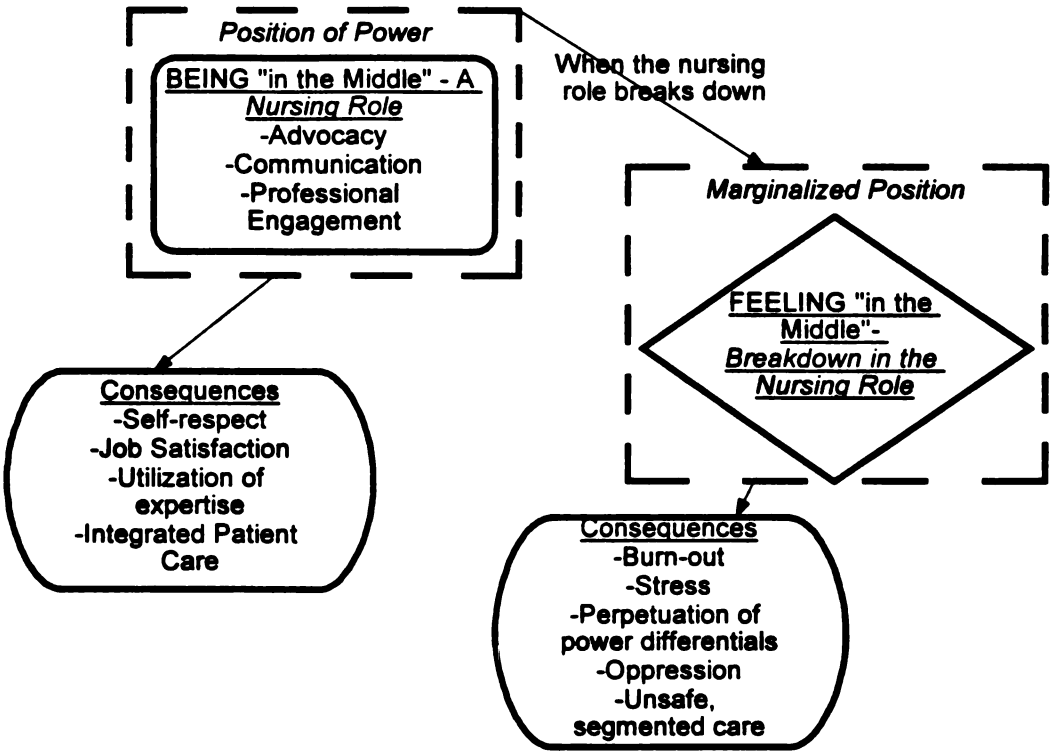
The interview stage of the research became the stage of *deconstruction.* All the terms and meanings that the participants of the research could articulate about being "in the middle" were elicited during the interviews. Deconstruction continued into the data analysis phase where the terms and meanings that were hidden in the narratives were uncovered. It was only after all the terms, phrases, stories and meanings were listed and pondered in the manner described in the previous chapter, that I could begin to *reconstruct* the data into a larger thematic picture in order to consider relationships, patterns, and impact. It was during the analysis of the narratives that my understanding of how all these narratives of these clinical nurses who work in diverse specialties and who have a wide variety of experiences, education and perspectives were connected to each other - and it was apparent to me that there were connections among the themes, contexts and meanings. Those connections began to make sense during the data analysis when a very important distinction emerged: the phenomenon of *being* "in the middle" is separate and distinct from the phenomenon of *feeling* "in the middle." *Being* "in the middle" and *feeling* "in the middle" are two different, although related, phenomena. For example, I asked one participant to clarify her thoughts about feeling "in the middle" in her practice:

> [My question]: So, for you, is one aspect of feeling "in the middle" to act as the person who clarifies the situation and communicates things back and forth between you and the doctor so that there would be a better working relationship? [Participant's answer]: I think I haven't given you any real good examples of being "in the middle" because when you say this, it doesn't seem like "the middle" to me. This seems like my responsibility for care of the patient, for both people [both the patient and the patient's family] (Participant #015).

Being "in the middle" was described as a nursing role, while episodes of *feeling* "in the middle" were described as resulting from a breakdown in the effective functioning of that nursing role. Although the two are labeled almost identically, their characteristics are very different, and, in fact, the one, *feeling* "in the middle," can only exist when the other breaks down (Figure 2). Knowing this, it is, of course, crucial to understand the important distinctions between the two phenomena.

Figure 2

Two Conceptualizations of Middleness in Nursing



Being "in the Middle" - The Nurse's Role

Components of the phenomenon

The phenomenon of *being* "in the middle" was very clearly described by the research participants as the nurse's role, the nurse's professional, moral and/or legal obligation or the nurse's responsibility:

> If I hadn't advocated for her rather aggressively [to get the patient an MRI which subsequently revealed a herniated disc], most people would have said, "Oh,

> okay. I will do what the doctor said." But I do feel, like I said, that it is a part of my job. In the ER, part of your job is to educate, I think (Participant #017).
>
> I don't think it's really an optional thing that, because I think, because legally, I think legally if I didn't act as the mediator and make sure, because I'm having them sign a consent, that they don't really understand what they're signing to have done, they don't really understand the process, or whatever, and my name is on there as a witness, and they wind up going to court or something, doing legal action, then I'm in there in the middle of that.....It is something that I feel I have to do (Participant #009).

Several of the participants cited what they had been taught in nursing school about nursing roles as having relevance to the phenomenon of being "in the middle." Specifically, the participants described the role of being "in the middle" as having many components, all of which were connected in some way to caring for patients, including: 1. *Advocacy* - speaking for the patient; providing support for the patient; protecting the patient; knowing the patient; doing for the patient; being there; being fair; dealing with pain and other symptoms; getting for; and, mediating. 2. *Communication* - interpreting/ translating "after the doctor has left"; educating; clarifying; and ensuring informed consent, and; 3. *Professional engagement* - caring; professional passion; trusting one's own judgment; collaborating, and rule-bending.

Advocacy

Several of the participants specifically used the words "acting as the patient's advocate" as part of their everyday role as clinical nurses. To them, this meant placing themselves either literally or figuratively "in the middle" of patient caregiving and carrying out acts that were directed towards the best interests of patients. Many other participants used words that are equivalent to patient advocacy including speaking for; providing support; protecting; knowing; doing for; being there; being fair; dealing with pain and other symptoms; getting for; and, mediating. The following section gives exemplars from clinical practice of each of these categories.

Speaking for the patient. The participants in this research described their efforts in acting as patient advocates as being by far the most important, the most compelling in their practice, and the most worthy of their professional time and attention. They used a variety of words and phrases to describe their acts of advocacy, such as *speaking for* the patient:

> In terms of being an advocate for my patient, one of the things that I'm getting better at is suggesting to the doctor what I think is best and then making suggestions. I feel I am often in a very good position to speak for my patients when they can't really speak for themselves (Participant #021).
>
> Then the nurse's role is to influence the physician to take a different role. Like with the patient we had recently, Mrs. H, who was terminal and really wanted to get her life in order before she died. The oncologist kept pushing her to have IV chemo in the hospital. She was very upset, but couldn't speak out against the doctor's wishes. Patients often do whatever the doctor says, even when they don't agree. In that case, I don't come on strong to the doctor. Rather, I say, "Could we consider sending this patient home and have home health help with her chemo at home?" It didn't work in this case, because Dr. L. kept the patient in the hospital and gave her chemo until she died (Participant #012).

This nurse felt that by speaking to the physician for her patient or on her patient's behalf, she was advocating for respect of the patient's wishes. She was carrying out her responsibility as a nurse.

Providing support. A second component of advocacy was *providing support,* either to the patient and/or to the patient's family:

> Boy, there was a big stink one day because I fed a family, a pregnant...or a new mom. The baby was like two weeks old. The dad was detoxing from ETOH

> and she won't leave his bedside, and she's breastfeeding and she's feeling dizzy and she hasn't eaten for twelve hours. So I grab a sandwich and a couple of cartons of milk, Jello-O. I really gave her a deluxe meal, by our standards. My charge nurse had a fit that I was feeding a family member. I said, "You know, I've been a nurse with this organization for thirty years, and when they can't give somebody a sandwich, it's time to get out of the business, babe" (Participant #013).

This nurse clearly saw her role as a patient advocate translating into supporting both the patient and the patient's family. The participants described many instances in which their support made a difference in patient outcomes.

Protecting the patient. A third characterization of nursing advocacy was described by many of the participants as *protecting* the patient. This included questioning *keeping secrets* from the patient and/or the family:

> This woman is 77 years old and has a history of multiple medical problems. She was in the ER in early December for a mild stroke, after which she went home and was cared for by her husband. Just before Christmas, she came back into the ER and was diagnosed with an acute MI. Last week she was admitted for what the doctor wrote was "mild CHF." I'm very concerned how he was using a morphine drip with this patient....my concern is, see she was a Medicare HMO patient, and I wonder about whether we used morphine appropriately....I wonder if she was not dying fast enough and that's why he used morphine so aggressively....I wondered if we were going beyond making the patient comfortable, and I started being worried that this patient wasn't dying fast enough, so he was trying to speed up the process. So I went to my Department Director, but she didn't act like she thought it was any big deal. So then I went to the Director of Nurses and, boy, did she get things going fast. After she talked to the chairman of the Ethics Committee, she asked me if I'd be all right with

> coming to a meeting to hear and to maybe participate in the discussion with the committee and the family and the doctor. I was actually amazed that the process worked (Participant #011).

This nurse was reluctant to use the word euthanasia, although she did specifically bring it up, she did not wish to criticize the medical care the patient had received otherwise, but she was clear that she needed to ask questions about this particular course of treatment as part of her role as a patient advocate. She was also clearly surprised that there was an effective system for dealing with such difficult issues in her hospital.

Another aspect of protecting patients included questioning the *morality of practicing on patients*:

> [My question] Do you think some of that has to do with the fact that this is a teaching facility and some procedures are done just for teaching purposes? [Participant's answer] Oh yeah, definitely. Not only me but a lot of the staffers are saying that, oh, because this is a teaching hospital they have to practice. Because they have to put in the Shiley. And I say, "Please, the wife is coming at 2:00. Can't you wait to put the Shiley for the dialysis, can't you wait?" And they say, "Oh no," and they put it in. I guess they do it because they need the learning experience (Participant #006).

Several of the participants said that part of their role was protecting the patient by asking questions about *who makes the decision*:

> I'm concerned that often the families make decisions for the patient without involving the patient (Participant #012).
>
> There are some situations where it gets to the point where the patient becomes unconscious and the family is demanding. I try and do as much as I can for the patient and what the patient wanted and what the patient desired. And there are times when that isn't enough. Because the family has the final say so (Participant #016).

The participants also indicated that in protecting their patients, they needed to make sure that decisions affecting patient outcomes were carefully considered because they know from experience that *miracles happen*:

> This one surgeon I worked with in the early 90's, he was kind of a radical type guy. He did not last long in our hospital system. But, we were talking about lung cancer. One of my co-worker's father has lung cancer and so we were talking about what's operable and what's not operable...Well, this doctor, that's one of the problems he had. He insisted on operating on this man who had lung cancer. He removed a lobe. You know what, he saved that guy's life. To this day, I still see that man walking around this medical center. They had him chopped as a death sentence...Evidently he had some mets, but this surgeon felt like he could get it, and he did. It was just that one in a million type, but he just felt so strongly about it, he fought, and they said no and he said, "You know, I'm doing this. I am going to do this." I don't know if that was one of the reasons, but it probably was a reason that he lost his job (Participant #013).
>
> Miracles happen, and I've witnessed them. I've witnessed it with Mr. G. I've witnessed it with other people. I have had ladies sit down at my desk in triage and I would say, "What is your past medical history?" And they say, "Well, I have ovarian cancer." I go, "My goodness, and it's been ten years ago? Wow, how did this happen?" This lady tells me a story that she was in an automobile accident and she had abdominal injuries, they opened her up and they found it. These people are miracles (Participant #013).

The nurse participants also felt that they needed to protect their patients by questioning the morality and efficacy of the *accumulation of treatments*:

> One other thing I feel that often makes decision making and ethical dilemmas difficult is the accumulation of treatment. You start with one little treatment, and okay, it didn't go so well. Well, let's try this or let's do this or

> there's another complication. And within the shortest time possible, tons of things are done and the actual patient is lost under all the treatments and tests. And what effect does it have on the patient? It's this accumulation of professional help and ideas that may do some good, but can actually sometimes do harm, because we all lost track of what would be the best...so I think we tend to want to do too much sometimes (Participant #001).

Knowing the patient. A fourth characterization of advocacy by the participants was *knowing the patient*. As characterized by some of the research participants, knowing the patient involves knowing something about the patient as an individual. Knowing the patient as a human being even in small ways allows the nurse to advocate for the specific needs and desires of that patient. In fact, *not* knowing the patient can put the patient at risk as others make decisions about care that may not meet that patient's needs:

> There are times when I'm sure I'm not a very good mediator. And a lot of times that there are problems between family members and the patient that we have. I'm sure that's where we can't do very well, because those are long term relationships and ongoing situations, and we only have them for a couple of days. And to try to mediate the problems when I know there are family dynamics that I don't know about, that there's nothing short of a miracle that we could fix the problem (Participant #009).

Doing for the patient. Some participants described advocacy and being "in the middle" as *doing for* the patient. Doing for the patient happens especially when the patient was unable to do for herself by virtue of physical or cognitive immaturity, dysfunction or decline:

> We get so callous about bodies and things. I know it happens, but it's in situations like that [in which a patient or family situation has been transformative for the nurse] that really brings you back to reality. I mean I joke along with other nurses. We call the gurney that we take the bodies down to the morgue with the

> Cadillac. And, um, and it's a big thing about um, I mean, you have a person who's cold, you know, and it's just a thing about not banging their head on the cold steel. It's amazing how people react to, and they still make that connection, even though they know the person is dead. You put a pillow under their head when you drag them over because you do not want to bang their head (Participant #005).

Being there. Yet another way in which some of the participants characterized their advocacy for patients was in *being there*. Many of them spoke of the importance of just sitting beside or holding the hand of a dying patient, believing that doing so was not only an important part of their job, but also that it was the right and human thing to do:

> There was this Russian family where two cousins had married each other, and I guess because of the inbreeding and passing on of bad genetics, two or three of their children had been born with a syndrome. Umm, I can't remember the name of it. Anyway, with this syndrome, the baby has a different kind of facial formation and is anacephalic, so obviously they die shortly after birth. About two or three months ago, the mom came in and delivered twins. One of the babies was healthy and perfectly formed, and the other one had this syndrome. We put the sick baby in one of the separate nursery rooms in the ICN and just kept her warm, but without IV's or a ventilator or anything. But the family was only interested in the healthy baby. They never came to see the sick one. No one in the family seemed to care. They acted like they only had one baby and gave all their attention to her. Well, I was working with this woman who is such a great nurse. I just love her. We had arranged to go out together after work, so I was ready to go and couldn't find this nurse. I looked all over the nursery, and I finally looked into the room where we had this little Russian baby. This nurse was in there holding the baby and fingering her rosary beads and talking to the baby. She sat

> there and held the baby for the longest time, so the baby wouldn't be alone (Participant #008).

Being fair. Another characterization of patient advocacy was *being fair*. To one nurse, being fair meant being respectful of and acting on the patient's specific instructions about resuscitation:

> This patient was here last month, and he specifically made himself a "no code." And when he came back in recently, I felt I was performing responsibly as a nurse who ostensibly knows the desires of the patient from his previous history. But his previous do not resuscitate orders had not been transcribed on the computer or in paper and the physician on duty does not know the patient and it becomes ambiguous because we do not have the concrete material at hand. But to me that was an oversight....and I see this gentleman and this is a situation where he didn't want to be coded. It would be battery to him, to touch him and it would be unfair. It would cause me great grief, because I like to know that I'm the one who can assist him in a graceful death (Participant #002).

Dealing with pain and other symptoms. Unfortunately, many of the participants identified a weakness in the healthcare system relating to dealing with patients' pain and other symptoms. These participants stated that they felt that pain control and treatment for other symptoms for patients was insufficient and inconsistent in many situations. They also saw themselves as playing a strong role in making sure that patients got relief from their pain and that other symptoms were adequately addressed:

> I asked her when I went in, "Are you having a lot of pain." That's my only concern with a dying patient. She goes, "No, I am not having any pain. I don't need to be here." They brought her in because they are frightened. They are afraid for her to die at home probably. So they need to be there. If it makes them feel better to let her die in the emergency room or somewhere, it doesn't bother me. I feel that is part of our role (Participant #013).

> Yeah, we do have the technology. There's no reason, you know. 90% of people with cancer pain are undermedicated. My goal is to become the "Queen of Pain Medication." And there's really no good reason why you can't mix around. This one gentleman that I was telling you about who had the sarcoma that came back, who was in the hospital for seven months. One thing his physician did that was neat was to give him methamphetamine, which we locked up in the narc drawer. And he was sort of able to mitigate the effects, the stuporous effects, he was on Dilaudid, yet not block them, but be a little peppy. You know, feel and have some comfort and not be so knocked out. And that was neat (Participant #002).

Getting for. A very difficult and challenging role that nurses play in advocating for patients in an environment of managed care, according to the participants, is *getting* appropriate and adequate resources *for* their patients:

> In the OR you utilize all of your resources up front. You do the extremely expensive cases. You have used up your DRG. Get them upstairs, get them out of here. Get them out of the hospital as fast as you can. We don't have the processes or the mechanisms in place to support those patients out there (Participant #010).

> That's what frustrates me being in this business, in general. What angers me is when people can't get the diagnostic tests and treatments that they need (Participant #013).

Mediating. The last component of advocacy discussed by some of the participants in the study was that of *mediating*. These nurses saw themselves as responsible for carrying messages, including their own messages, from one constituent of the healthcare process to another. The position of mediator in advocating for patients is related to the second of the three components of the nursing role of being "in the middle" -

communication. Mediation certainly involves communication, but the exemplars I cite here really are more about patient advocacy:

> Sometimes I make, I go back out to the desk and try to catch the doctor and say, "You know, these people really don't understand what you said, and I don't know how to explain it to them any better. You need to, you know, from what I understood of what you said, you need to come back a talk to them a little more." ...And then to get the doctor to understand that this is what they really wanted, to try to be a mediator, to bring the two together so that they can get understanding between the physician and the client and the client family (Participant #009).
>
> You get caught in the middle of a family and a dying patient. But, that's our role. I do see that as part of my role and I really don't have a problem with getting caught in the middle. I feel like if I can handle that role and juggle people and mediate and it comes out okay. And sometimes it doesn't come out okay, but I still feel like I have done my job (Participant #013).

Communication

Like advocacy, the second component of being "in the middle," *communication*, contributes to successfully enacting this important nursing role. "Actually, I see that as my role, as a registered nurse, to be in the middle. I am supposed to facilitate the communication" (Participant #010). The participants of this study identified many processes of communication that were an integral part of their being "in the middle" in clinical practice, including interpreting and translating, educating, clarifying and ensuring informed consent which I will explicate in the following sections.

Interpreting/Translating - "After the doctor has left." Several of the participants identified the frequent need to restate or interpret for the patient and family and put into understandable language what a doctor has just said to them. Often, the patients will tell the nurse that they know the doctor is busy and they don't want to bother him/her, or that the doctor spoke in medical language that they didn't understand, or that the doctor was gruff, abrupt, distant or distracted, and they therefore felt intimidated in asking more questions. These nurses felt they were put in a position of trust in being asked for clarification in these situations:

> Hopefully there's a time when you can get the family, have the doctor spend time with the patient. If you've got that kind of time. Find out directly what the patient wants and then with the doctor and the family discuss everything that's going on as briefly as possible. And I have found because we're all stressed at that time, frustrated, that there are always questions from the family after the doctor has left. Things that they didn't understand because of the language, you know, just the intensity of the situation (Participant #016).
>
> Sometimes when the doctor comes in and they talk to patients and give them their informed consent, the patients, when they walk, then their families and the patients are looking at us and going, "Now, what did he say?" And it's like they didn't want to look like completely totally incompetent people that really didn't understand what the doctor said, to the doctor. But it's like the doctors are so dashed sometimes that they are in and out of their and the patients are going, "And what was that whirlwind about? You want me to do what?" (Participant #009).

Educating. The nurse's role as an educator emerged frequently in these interviews, and is a part of the more encompassing role of communication. The participants spoke of their obligation to give patients and families the information they needed to care for themselves, and to make informed decisions:

> We don't recognize that they [many elderly patients] may have a urinary tract infection because the disease presents differently in older people. Consequently, we don't have the knowledge, number one. Number two, we don't have the continence experts. I happen to have a colleague who is an expert in the

> community on urinary incontinence. There are just so many different types of incontinence, and it's very easily correctable. When I triage an elderly person who has urinary incontinence, or their family may say, "My mother and my father have this problem." Even though I know I probably could get in trouble for doing it, I will pass along this information to them and I will give them a name of somebody that's not a person in our HMO. But we are responsible as a health care delivery system if we don't have a service. If we don't have a particular service, that we can refer it out. I also tell my patient or their family that this is something that they can request for their family member from their private medical doctor or family nurse (Participant #014).

Clarifying. Another component of the nursing role that was identified by some of the study participants and that falls within the realm of communication was providing *clarification* to and seeking clarification from patients and families. These nurses told stories both of clarifying what the patient wants or knows and clarifying what the doctor wants or knows. Again, they described the nurse as often acting as the mediator in bringing perspectives together in order to clarify various positions and seek appropriate courses of action:

> Another problem is when the doctor tells the patient something different than the nurse has told the patient - the patient gets confused and is not sure what to believe. This happens a lot when our patients are in the end stage of their cancer and the option is really pain control versus more chemo. Our oncologist basically never gives up. Sometimes he gives chemo and the patient dies with chemo dripping in. I think that's too much, and the patient never understood that the chemo wouldn't help at that stage. So when does the nurse step in and take a stand?...The nurse is not always the best person to know what will help the patient most, but they do have information that can help the doctor in working with the patient...The nurses should feel like they can reinforce what the doctor says. And

> the patients are hesitant to ask the doctor a lot of questions because they don't want to bother him. But they will ask a nurse. The nurse can link the patient to all kinds of other resources. Nurses have information that the physicians don't (Participant #012).

Ensuring informed consent. The last component within the realm of communication that was identified by the research participants was the key role of ensuring that patients are thoroughly *informed* before giving their *consent* for treatment. Many nurses identified informed consent as problematic within their institutions. They perceived their role to include actively demanding that the patient understand to what she or he was consenting:

> I think our role in the operating room is to try and protect patients to the best of our ability. In our particular OR it's the simple things that you wouldn't consider to be a dilemma, like an informed consent. This can become a dilemma for the nurse when they get a patient in the OR who is not properly consented. Maybe the surgeon hasn't talked to the patient and they have already signed the consent. Is that a valid consent? Well, not in my mind. So, I feel strongly that we as nurses in the OR need to make sure that those patients know exactly what they are coming down there for. And we hold surgery if they don't (Participant #010).

> Another issue for me was abortion. I personally don't agree with abortion, but I also won't stand in the way of another's choice. It is her choice to make, but again, the nurse needs to make sure that she has been presented with all the options and that she receives the support she needs in carrying out and living with her choice....I felt that these patients were making a big decision without much support (Participant #012).

> This is one of my pet peeves, informed consent. The doctor comes from his office to the bedside of this 70 year old man who is in ICU. Here's the

> daughter, the son-in-law, and they are all around mom or dad. The doctor says, "Your father or your mother's had an MI." Now this is a cardiac surgeon talking to them and he says, "They could die in three months with another heart attack or we could do bypass surgery on your father or mother, and put some vessels in her. Who knows what their life expectancy is. It could extend their life, depending on a lot of things." And, I kid you not, depending on their case load, will depend upon their presentation (Participant #015).

Professional Engagement

I struggled with what to name the third component of the role being "in the middle" because it was the only time during my analysis that a group of terms and themes emerged from the data, were obviously related to each other and yet were not specifically labeled by any participant. Many of the nurses in this study stated that their relationships with patients were interdependent and that part of their professional duty was to care, to have professional passion, to trust one's own judgment, to reach out to others in collaboration and partnership, and, at times, to engage in responsible subversion - all of which I described in more detail in the following section. I chose to give this group of themes and characteristics the title of *professional engagement*, because it seemed to me that nurses cannot engage in any of those activities or feel those feelings without being professionally engaged. After I proposed that terminology, I went back to four of the participants and asked them for feedback about it. Each of the nurses agreed that it described what they meant in their narratives about these themes.

Caring. With the wealth of interest and scholarship in nursing around the topic of *caring* in nursing, it was interesting to me that this concept was not cited very frequently in these interviews. However, it was briefly discussed a few times, and, for these participants, it clearly falls within the domain of professional engagement:

> I had this cute elderly couple. I don't know how these people drove in here. I don't know how a lot of these elderly people drive in. She was in the bed

> and he was next to the bed, and it was 2:00 and they hadn't eaten. She is saying, "You got to go eat." And he is saying, "You got to eat." So I just went in the refrigerator. I got an order from the doctor for the patient, and I set them up. I said, "Come on, you guys. We are going to have a picnic right here." I just set them all up and they go, "Yeah, we are having a picnic honey." They were eating their little sandwiches and they are just having a ball. I am thinking, this is what makes me shine, is to do something that shows that I care (Participant #013).

Professional passion. *Passion* for the practice of nursing and passion in advocating for their patients' needs was apparent in the narratives of many of the participants. In spite of fear of retaliation, loss of a job or the wrath of supervisors, the participants spoke of aggressively seeking out treatments and additional diagnostics, and aggressively advocating for moral decision-making in partnership with or on behalf of their patients:

> We got a guy in right at midnight. Change of shift, code three ambulance. This guy who was obtunded, almost not breathing from bronchospasm. It was one where he was definitely pretty close to being intubated. He was turned around with a bypass instead, and bronchodilators, and that sort of thing. Then he was turned over to Medicine about two hours later, and Medicine came down and looked at him and said, "He can go home. Take off the bypass and he can go home. We will write discharge orders." Because that's the way it works here. ER turns people over to Medicine to admit, and Medicine wasn't interested in admitting him. The ER doc says, "Well, I guess if he thinks so." I said, "I don't think so." I said, "He looks a lot better now than he did two hours ago, but I don't feel very comfortable with him going home." I talked the ER doc into keeping him. We kept him until 8:00 in the morning which was six hours beyond when the Medicine doc wanted to discharge him. He didn't go bad, but I thought it was

> a pretty risky thing to send somebody home who was that sick, two hours later (Participant #017).

Trusting one's own judgment. Professional engagement also encompassed *trusting one's own professional judgment* and seeking to have one's professional judgment trusted by others. For the participants of this study, this meant allowing one's judgment to overrule policies and procedures, the directions or inattention of others and the fear of retribution if it meant getting what their patient needed:

> Sometimes you feel like you need to put a fire underneath the doctor. Because you know you have a situation going on that could turn out to be very bad and you need that doctor now. They've looked up, maybe they've looked up at the EKG, and the history that you've given isn't terribly significant. But from your experience and from trusting your inner voice, you know that there's a crisis here. And you can't get that person to respond the way you want them to. I get to be a little bugger. I am a little pesky bug that won't go away. What is good about that is that you know you are doing the right thing. And I don't care how angry or what goes on with that doctor (Participant #016).

Collaboration and partnering. Many of the participants of the study recognized how powerful a *collaborative team* can be in addressing patient's needs. They identified how every member of a team brings different skills, perspective and attitudes. They acknowledged the many ways in which patient care benefits from a partnering model:

> Something happened where a couple times a week, we had two doctors that were working. One doctor was working two nights a week with us, and the other doctor was working one night. So every week you know you were going to have those two doctors on specific nights. Since I work the last end of the week, Wednesday, Thursday, Friday, it worked out great. Because one doctor, he worked Wednesday, Friday and the other doctor worked on Thursday. We had like the "A Team." That was really good because you knew what you could do

> ahead of time. What they wanted. You could go ahead and order the x-rays. And what labs you could go ahead and order that weren't your routine. You knew you would get their support. Yeah, and you just worked together. It was just a fabulous feeling, like a fine-tuned machine. Just really, really good (Participant #016).

Rule-bending. Sally Hutchinson (1990) described the construct of responsible subversion among nurses which was called bending the rules by the participants of this research. She observed rule-bending in clinical practice as a response to conflict about care of the patient, as an option utilized by nurses with knowledge, ideology and experience. The narratives of the participants in this study indicated that they sometimes practiced rule-bending when it meant that a patient would get care that they might not otherwise get. Their willingness to bend the rules for their patients emerged from their professional engagement:

> Since I've been in school, some of the cardiovascular nurse specialists have taught me a tremendous amount. I now know that a 12-lead EKG is not anywhere near the standard diagnostic treatment for women presenting with chest pain. Oftentimes a woman will come in with what sounds like ischemic chest pain or angina. They will have a 12-lead EKG and they'll be sent home with, "Well, it's probably stress or you probably have so many things going on in your life that are contributing to this." And yet, I as a nurse know that the doctor did not order CPK-isoemzymes, which is the serum blood test that will tell us if there are elevations caused by the patient having cardiac ischemia. I also know that the best diagnostic test for a female, not a male, but a female, is not a stress treadmill, but a stress echocardiogram. That is the definitive diagnostic test. And we never do it. It's not hard for me anymore, I just tell the patient, "Look, if you continue to have chest pain, you need to come back in. You need to ask for this and this and this and this." [This nurse tells patients specifically which tests to ask for].

Because it's different in women. Cardiac chest pain is different in women, how it's diagnosed. You might in fact be having an ischemic assault to your heart, but it may not show on an EKG. How does a nurse tell a patient that they didn't draw the appropriate blood work? We automatically draw blood in triage, but we don't draw the CPK with isoemzymes. That's where the physicians decide. If they make that, base that decision on the EKG findings, you could have elevations and not even know it. And yet, the patient thinks that they've had all the bloodwork. But you know that they haven't had that (Participant #014).

I think it does impact patient care when you don't respect the physician that has that patient. Because you're constantly shielding that patient from the fact that this guy's a dumb butt. And even if I don't like the physician, if he's good, that's okay. But if he's not good and you constantly have to shield the patient...a lady came in, was just brought to our hospital, although she normally goes to a different hospital. She came here because she had chest pain. He did a heart cath on her, and she had lots of diseased vessels. She should have immediately had a PTCA or been bypassed. But her doctor, who's a ding-dong, said, "Well, we're gonna just treat this medically." Nobody else would have treated it that way with her LAD occluded. So I thought, now how can I tell this lady really she should go see somebody else? So I said to her, "Your primary is over at the other hospital. What you need to do is before you leave the hospital, I'll get you a form to use to request all your records be sent over to him so he can review everything. So he can get a good firm view of how your total health picture is since you were here in the hospital." I thought, God willing, her primary is going to send her on to a different cardiologist who will be a little more aggressive with this 52 year old lady. Incidentally, I asked my friend Dr. B [a cardiologist] about what he would have done with a lady with her findings. He

> said, "God, I'd take her to the operating room. What else would you do?" (Participant #007).

The role of being "in the middle" - Effective use in practice

The participants in this study not only spoke about the role of being "in the middle" and it characteristics of advocacy, communication and professional engagement, but they also spoke of the outcomes when this role was effectively used. They believe that when this role is understood and implemented by competent nurses and when it is recognized and received by the various constituencies of nurses, there is positive impact both to nurses and to those constituents.

Impact on patients. The study participants spoke of many instances when the nursing role of *being* "in the middle" was successfully carried out. The impact on patients and their families in such cases was positive and included such benefits as integrated patient care, appropriate utilization of expertise and technologies, patient-centered care, and mutual respect:

> I felt effective because I did the right thing to call the doctor. To assume he [the patient with end-stage AIDS, seizures and respiratory distress] was a full code, I gave what was ordered. But I was on the ball, trying to get somebody else to take responsibility that I couldn't take responsibility for [clarifying the code status]. You know, I skipped over the intern and called the chief resident. I found the attending's phone number, gave it to him over the phone and said, "I think you should call him right now." He said, "Well, I don't know." "You should call him right now." You know, I just did that. And so that felt good, that he respected my opinion that this was a stat situation. I'm glad that it worked out that quickly because if he had died in twenty minutes anyway and we still didn't know his code status because we were tip-toeing around not wanted to bug a doctor. It would have been a horrible intubation. It would have been a messy code. And because we could have probably revived him with intubation, I think it would

> have been possible, and maybe he would have come around. But you know, it was one of the few times that I did call the lover myself. The doctor said, "Do you want me to call?" I'm surprised he even asked. And I said, "I'll call," because I knew the lover from earlier that week. And I called him, and the first thing he said was, "Thank God." And that clarified for me, not clarified, but made me feel better that not only did we follow through on the wishes of the patient and got the attending involved, but that his partner felt that we did the right thing (Participant #002).

Sometimes the research participants felt that successfully carrying out their role of being "in the middle" wasn't necessarily perceived as positive by their patients:

> I was stationed out at the triage, screening desk...This woman, she was forty, forty-two, and she had a hand injury. When I asked her how it happened, she said her husband had thrown a toy at her. Upon further assessment, it sounded like, well, she had revealed to me that he was angry with her and threw this plastic toy toward her head and she blocked it with her hand. She had a big contusion to her hand. So I asked her if this happened regularly, and she said, "Usually it's just verbal." She said, "But it's okay." We are mandated to fill out the Violent Act Reporting Form. When I started asking her if it happened at home and what's his name, she suddenly got the idea that I was going to report it. And she said, "I don't want it reported. I am not going to do anything. I have my children, I have my family." I said, "In this country, this is against the law." I said, "What country are you from? What nationality is your husband?" She said, "Korean." She said, "This is okay in Korea. This is acceptable in Korea." I said, "In this country it is against the law, and it's not really up to you whether he gets prosecuted or not. It's up to the district attorney." Suddenly she realized the seriousness of this issue. She got real quiet. She was quiet to begin with. She was a timid Asian. Nice looking woman. It just didn't fit this typical scenario for

a battered wife. But she was. She didn't have a huge injury. It wasn't like she lost an eye or had a concussion. You could tell this had been going on at home. Whether or not to report. She suddenly had tears running down her face and was begging me not to report. She said, "What will happen if the police call me and talk to me? Or show up and talk to me? He'll kill me. He'll kill me." And that's what upset me even more. Because I am thinking, I am mandated. I could lose my license for not reporting this. And here, what if the police show up at her house tonight and he gets a warrant and doesn't go to jail. It's a minor injury. She is going to put up with his wrath for the next several weeks. I was torn. I asked her, you get a feel for their support system, "Do you have somewhere you could go? Do you have family in the area?" "Yes, I have family in the area, but they will in no way stand up to this man. He's got control over them too." She had no support from her family. Social Services says this is the time to talk to people. When they are away from the batterer. Once they go home, it's hard to get a hold of them and counsel them. I said, "Well, you have sons at home. They see this happening to you. They are going to grow up and probably model their father in thinking that it's acceptable and that's the way it should be." "No, I already train them." I said, "Actions speak louder than words." I get chills just talking about it still. "They are going to grow up and do that to their wives. It's a cycle that you can change, you need to do something."...I thought, this isn't going to go anywhere, except get worse. By me not reporting it, I was making her life worse. It just suddenly stopped me dead in my track with the flow of triage trying to keep people moving and here I was thinking, "Gosh." So what I did is, I told her, "You can keep this form right now. And you could tear up this form. I am going to talk to my charge nurse. I probably will end up filling out another form and reporting it. But for the time being, you can go to your appointment knowing I..." It was just something I could give her at the moment. I did end up calling the police a

> half hour, an hour later. I told them the situation. I said, "She is very upset. She said he would kill her." Sometimes the police can look at the records and say they have had several calls for that house. One more piece of evidence. But that really struck me, for some reason. Maybe it was her demeanor. This timid woman who didn't fit the typical scenario for the battered wife...Later, I went around the department. I left my station. I asked, "This is what I have. What would you do?" I talked to an LVN and asked her. She said, "I really wish somebody would have reported it for me, it would have made a difference in my life." That helped me (Participant #018).

Impact on nurses. Likewise, the study participants talked about the positive impact of the nursing role of being "in the middle" on nurses themselves. When nurses successfully carry out this role, the benefits to them include self-respect, job satisfaction, utilization of their valuable expertise, working as part of a team and empowerment. An example of the positive impact of teamwork was given by one of the participants:

> [Speaking about a father who had brought his young daughter into the ER with a badly lacerated nose, and who proceeded to yell, scream and insult every nurse and doctor he encountered] When I came into the room, my co-worker who is also one our charge nurses and a leader in our department, was asking him, "Sir, I would appreciate it if you would step out in the waiting room, because you are making it very difficult for us to work in her." That was what blew him up. Then a doctor comes in and just melts for this guy. Just treats him like gold. And he goes, "What kind of a doctor are you? Do you treat humans or animals?" He was just obnoxious. The doctor approached me to start the IV and get things going. He is one of our ER docs. He had called a head and neck specialist to sew this nose. He could see how out of control we were here. This guy, I don't know if he was a drill sergeant or what. He was quite elderly. His wife was young, and his daughter was very young. We also had to do pregnancy tests and stuff on this

> little girl. Supposedly she fainted and that's how this happened. So we were thinking she was pregnant. We thought, "Oh, please don't let her be pregnant. How were we ever going to tell the family. They are going to blame us. We know they are." So they were just so out of control, they never settled down. As soon as we had her stitched and stable, we let her go, before her pregnancy test was back. We figured we could deal with that later that day or the next day. By the next morning when the ER doctor comes back in, he goes, "I'm going to check the pregnancy test right now." I said, "You know what, I didn't even ask them about the tetanus." He said, "No, I covered that, that was all good." I go, "Thank goodness." The pregnancy test was negative, but then we were just critiquing it and this doctor came up to me and the other nurse and he apologized to both of us. He goes, "You know what I have learned from this? I will never let any patient take over my ER like I let that gentleman. I was so out of line, because I should have called him on his behavior from the very beginning. Look how disruptive he was. I will never, ever, let someone abuse me or the nurses." This particular doctor is one of our favorites. He is a very hard worker and he works hard with us. He's a good team member, team player (Participant #013).

Feeling "in the Middle" - A Breakdown in the Nursing Role

To this point, I have discussed the many components of the complex phenomenon of *being* "in the middle." In the following sections, I will discuss a separate, but equally complex phenomenon that occurs when the effectiveness of the nursing role breaks down for any of a variety of reasons. This different and distinct phenomenon is called *feeling* "in the middle."

Causes of Feeling "in the Middle"

As mentioned previously, when the nursing role of *being* "in the middle" breaks down, *feeling* "in the middle," which was also called getting "in the middle," caught "in the middle" or put "in the middle," occurs. This is a phenomenon that specifically occurs in instances of breakdown and results from nurses not being able to fulfill what they believe to be one of their primary professional roles. According to the participants, this breakdown may occur because of lack of knowledge about or acknowledgment of the nursing role, failure of the system to provide staffing and other resources, failure to address legal and ethical issues, unresolved conflict, the primacy of technology, and sexism, classism and power differentials. Not surprisingly, this breakdown and subsequently feeling caught "in the middle" is not perceived positively by nurses.

The participants told numerous stories of incidents in which they felt helpless, powerless or marginalized and which they equated with *feeling* "in the middle." These incidents included interactions with patients, with families, with physicians, with supervisors and with other nurses. Many of the incidents were perceived as having some impact on the provision of patient care, such as giving unsafe or incomplete care, segmentation of care, piling on of treatments and betrayal of patient trust.

The narratives of the participants described breakdowns in the nursing role and the subsequent impact on nurses, in particular, how they feel about their profession, how they feel about the healthcare system, and how they feel about themselves. The ramifications of the breakdown of the nursing role of being "in the middle" has exacted a significant toll on the participants of this study and their colleagues, including burn-out, stress, anger, physical problems, grief, and fear and intimidation. The following sections delineate the many components of feeling "in the middle."

Lack of knowledge about and acknowledgment of the nurse's role. The narratives of the participants told many stories of breakdown in their nursing role in advocating, communicating and being professionally engaged in patient care. They identified several circumstances that contributed to the breakdown of their role including *lack of knowledge* by patients and non-nursing caregivers about what this nursing role, and/or *lack of acknowledgment* that this role is taken by nursing:

> In general, success in discussing a difference of opinion in an ethical situation with a doctor depends on the nurse's approach. Part of the nurse's role is learning the best approach. Confrontational approaches don't work. It's better to use a non-threatening manner. And a lot of times, you have to build a trusting relationship beforehand. Think about our ICU shift manager - she is very soft spoken. She has been a nurse forever, and all the docs trust her clinical judgment. When she wants something for her patient, she always presents it in such a way that the doctor gets the credit for thinking of it. She almost always gets what she wants (Participant #012).
>
> I think as nurses we often have no voice. We feel like we have no voice or a very small voice in contributing to the planning for the care of the patient (Participant #023).

Failure of the system to provide staffing or other resources. ***Insufficient staffing and other resources*** for providing appropriate patient care were cited by many of the participants as prevalent in most of their facilities. This varied from specialty to specialty, but all of the participants were worried about how decreasing funding was stressing the system and making it more and more difficult for them to perform their roles:

> The last time that I worked it was in the trauma area of the emergency department. I was the only experienced RN who was on that day because of ill calls. There was another RN who called in ill. Recently we have had a lot of our RN staff replaced by PCAs, patient care assistants, who are not licensed and are not certified. They have not taken any advance cardiac life support classes to have even any baseline knowledge of critical patients and their care. Because I was the only experienced RN on, I was assigned a patient who was having an anterior wall MI...what this means is that the nurse starts three intravenous lines and orders a portable chest x-ray, orders all the lab work, administers

> nitroglycerin, administers a nitro drip, if that is indicated. If the patient is having severe chest pain. After the portable chest x-ray is done, then you infuse the streptokinase, which is the clot busting agent that will reduce the ischemic injury to the heart. Less than half an hour after I started the infusion of the streptokinase on patient number one, another patient came in, also having an MI and I had to administer streptokinase on that patient. In the unit each one of those patients would have been a one to one - one nurse to one critical patient, because the side effects of administering streptokinase are hemorrhaging or ventricular arrhythmias, which are life threatening. Here I am in a room [meant for] one patient who is coding, with two patients that I am administering streptokinase to. And when I asked for help, they sent me a PCA, a patient care assistant, who could do nothing for me. He was willing, but he did not have the knowledge. I felt like I was lucky that neither one of those patients had ventricular arrhythmias that would require me to cardiovert, to defibrillate. The patients were lucky that they survived that potentially very dangerous time of about forty-five minutes from when the medication was being infused. I continued to monitor those patients because we did not have any unit beds. No unit beds available, no place to transfer those patients because they were critical and they couldn't be moved. Here I am, one RN....One of the Medical doctors was so blown away by what he was watching me do. He set up sterile fields, which I didn't need. What I needed was another hand. I needed another person who was knowledgeable about the potential side effects that could happen here and could monitor the rhythms on the monitor. His comment to me [in reflecting on this nurse's very difficult patient load and her responsibilities] was, "I'm so glad I'm a doctor and not a nurse" (Participant #014).

<u>Failure of the system to address legal and ethical issues</u>. The *failure of the system to address some serious legal and ethical issues* within their facilities was of great

concern to many of the participants of the study, and contributed to their feeling "in the middle." In general, these nurses felt that there were written policies and a chain of command for seeking assistance, but that there were also unwritten rules for how some difficult issues which resulted in either no action or inappropriate actions:

> Well, you know about no codes and slow codes and curtain codes. You rarely see them. But there is something that goes on that is this great ethical concern. It's just euthanizing them with PCA, with the morphine. When the doctors says, "Go out. Call me when the respirations are eight [per minute]. You call." And there are no codes that you're giving the morphine just to depress respirations. And that's really hard for me because I want to do it, but it's my license. I also think that it's not appropriate for every patient to be completely sedated when they die. Once in a while there's this huge amount that we're giving, and we keep upping the dose or the frequency of the morphine. They're on a PCA and they're obtunded and, you know, the PCA has a basal rate, and then you go in and bolus it, and keep hitting at the PCA when they can't. And that's happened [to me] about three times. And two of the times, um, it's happened more than that. But when it's truly been like that, um two of the times I felt fine about it. One, I didn't um feel fine about it, because the family wasn't there. I didn't know the patient at all, and I didn't know the doctor. The other two times I knew the doctor very well and the family was there, and it happened after the family and the doctor met together. But it's happening and it's just not legal. It's just not. And, and nobody will ever find out. And the two times I felt they needed it, and my colleagues did too - with a united front. And they came in for it, essentially. This doctor told them, you know. And they kind of, they were so gravely ill, and it was like a respiratory kind of them, um, even apneic respirations. But they came in somewhat conscious and died. And it's just kind of scary. It's not legal. Yeah, and I'm following orders. But I'm being asked to

do something that's not legal. But it's scary. I think I'm hypersensitive about it now, because I do kind of agree that people should have the right to manage their death. But I have to be covert in documenting it too. You fib on the respirations, you know. It kind of makes it, I mean, it's a bit of untruthful charting (Participant #002).

I have an anesthesiologist who I don't know if he is impaired at this point or not. He has a history of very erratic behavior and he is very strange in cases and actually unable to function. He was in the impaired physicians program for drug abuse several years before he came here. I have two nurses on the evening shift who refuse to work with him. I don't have very many nurses on the evening shift, so somebody has to work with him. But they did not feel that they could say to the patient, "We will take good care of you in the operating room," when they couldn't count on the anesthesiologist to take care of them all. The surgeons who were involved in the cases in which he was non-functional, of course, were very concerned. But when it came down to actually acting on it, they would not. The nursing staff is out there and the physicians are hemming and hawing about the whole thing. And Administration is not willing to do anything at this point. They said they did not have enough concrete information to be able to act on any disciplinary action with this guy, that there were restraint of trade issues that needed to be taken into consideration. They said we could not limit his income, not allow him to make an income. So my response back was, "So we will allow him to possibly harm a patient?" They said, "Well, no. What you need to do is if he acts weird, then you call Dr. B [the chief of anesthesia] at home, or you call one of the administrators at home." And I said, "Then the time it takes for someone to respond and get in here, what is going to happen to that patient?" "Well, you wing it." Winging it doesn't cut it in my book (Participant #010).

> I was thinking about this doctor several months ago. He asked me about a baby in the ICN who had just been born and was intubated. He said, "How much does this baby weigh? Oh, 234 [grams] and 24 weeks gestation. Well then, I'll just pull out the tube." This baby weighed 234 grams and the policy is 250 grams, so he just extubated the baby and the baby died. But he didn't discuss it with anyone, and the parents didn't know what was happening. He just did it. I really felt like I wanted to do something or say something, but there was not a chance. He just did it (Participant #008).

Unresolved conflict. *Conflict* is not uncommon in all types of workplace settings. Human beings, by their very nature, do not always agree with each other. Conflict may occur when people with differing viewpoints confront the issues aggressively. The participants identified that sometimes each party's ability to make oneself heard and to negotiate for a mutually acceptable resolution did not occur and that, in those instances, conflicts lingered and be unresolved long after the incident occurred. They told me that they sometimes felt silenced or devalued in discussions about patient care even though they had information or perspective that was crucial to the care of their patients:

> This patient, he was 24, and had been in the hospital many times. He was in the hospital for seven months and very acutely ill with Ewings sarcoma. He had had chemo, radiation and actually became independently functioning for a long period of time. Then he developed a metastasis in his spine. This caused major spinal cord compression, inability to walk. And then he had other things associated with his immobility and immunocompromised state. One of the hardest things was, he was in for a long time. And the nurses, a lot of us, felt, whether we said it or not, we had issues. We knew this guy, knew him like the back of our hands. And knew his family, knew his sister, when she got married, it was part of our lives. But we never had a care conference where the nurses were included. The nurses were never invited to the care conference...we felt like we

didn't have a voice, really. And many of the nurses who had the biggest issue with this, knew him [the patient] really well. And the reason that the nurses weren't at any of the conferences, the initial primary reason was because the patient and family were there and this physician did not want to tell the patient and his family his diagnosis because it would make him give up hope (Participant #002).

So she [the patient's wife] knows that he's not getting better, so she wants to make sure that he will not be suffering any more, so she doesn't want him to be shocked. Well, he was in SVT three days ago and we had to shock him, and then I had to tell her that we shocked him. And she said, "No. I didn't want that to be done to him. He has suffered already." And then Dr. S. talked to her and said that we have to try dialysis, hoping that will improve his lungs...the doctor has kind of persuaded her, and so she said okay. But the dialysis nurse said to me, "This is hopeless. You can see it's multi-organ failure already. The family knows it and we know it." I feel like I sympathize with her and want to help her. So I helped her look at her husband's medical chart. And the doctor talked to me and wanted to know was the one who showed the chart to the wife. And I said that I did because it says in the chart that the patient is unlikely to benefit from aggressive treatment. I told him, "You know the wife is so torn up and we cannot see any reason for this to go on. She said goodbye already to him." So this doctor said, "We're having mixed signals here. I'm telling the wife that the prognosis is poor, but we have to try the dialysis. And here you are, you're telling her to stop. So we have to get together." So the other nurse and I went to the wife again and explained the doctor's point of view, even though the blood pressure was going down and up, and the patient's extremities and nail beds and toes were all black already....the rest of the doctors, the renal, the pulmonary, were saying the chances

> are only one percent, but he was saying to the wife that it's 50 percent after dialysis (Participant #006).

Primacy of technology. Several of the participants identified the *primacy of technology*, putting technology over the needs of patients, as contributing to the breakdown in their nursing role:

> We assume an awful lot, and we don't discuss it with the patients. And we assume that. It is part of our ethos and our mythology that we put around technology, and about our ability to do all sorts of things that maybe we really can or cannot do" (Participant #005).

> You have physicians that come in and put thermodilution lines in. And you go, I have a bleeding little old lady that they are going to put thermodilution in. Okay, fine. "What do you want me to do with the wedge?" "Nothing." "Oh, why did you put the line in?" "Because I want it there." "Got ya," I said. So I have trouble with hours of IV lines and having invasive therapies for patients that nothing is done with them. I said, "Why do you put a thermodilution in? Are we going to do a PA?" "No." "Are we going to record pressures?" We do that because that is a CCU standard, but not because you do anything other than write them on a paper. [The doctor told her] "I'm not a cardiologist who comes to see this patient to get a gimmick." [So the participant asks herself], "Oh, why are you still coming in the morning?" Every time he comes in he makes them note it. "Yup, she's still there. Oh, I guess I should sign off the case." I said, "Yeah, you probably could have signed off a week ago." (Participant #015).

> So, I'm saying that people are getting cardiac surgery that are too high risk, if they [the cardiac surgeons] don't have enough patients to do (Participant #015).

Sexism/classism/power differentials. Unfortunately, the participants identified many instances of *sexism, classism* or invocation of *power differentials* which contributed to the breakdown of the nursing role and left them feeling "in the middle." Their narratives included stories of oppression by physicians and administrators:

> Our renal docs are known for their lack of communication with their patients. For their superior attitude towards nurses, they are known for that. They are pretty irritating. Nobody even wants to talk to them unless absolutely necessary to get an order. Which is another thing that is really bad, because we need to take care of these people and they are bothered by you calling. So this particular patient was a man who was very seriously ill and on renal dialysis and had diabetes. He had multiple problems, multiple other problems...And the man started bleeding. So I called the doctor, the renal physician and told him that he was bleeding. He said, "That's not my problem, you should call the surgeon." By the time I got back, he had soaked three towels that I had put on the bed, under his belly, between his legs. They were already soaked with blood. So I called him within fifteen minutes and the surgeon then decided to come in. And I notified the renal doc, also. And so, the surgeon decided to sew the man up more at the bedside. So I assisted him to sew him up at the bedside. The patient is totally conscious, when this is happening. And then the friendly renal doc comes in and starts yelling at the surgeon, and blaming him. And saying that it's all his fault that the patient's bleeding. Probably the patient hears all this, and I'm assisting there, and he starts yelling at me for telling all these lies, that I didn't warn him enough that the patient was bleeding so much. And then he starts, the doctors start fighting about this verbally about this patient's bleeding. And I said, "Would you gentlemen care to discuss this matter outside so I can put a bandage on the patient?" And the surgeon was just finished ad he left. And the doctor, the renal doc walked right out behind him and pulled up his shoulders and yelled, "Oh, that German, what call, how do you say? That Hitler nurse." He called me a Hitler

> nurse, he said, “She thinks that she knows it all, could tell us what to do.” And then in the hallway he went on to insult me some more (Participant #001).

Power differentials between physicians and nurses were identified as a key blocker in the resolution of some of the ethical issues encountered by these research participants, including the nurse cited previously who was told to give her dying patient extraordinary doses of morphine, and who did so even as she was concerned about the legality of doing so. Another participant was very aware of how power differentials influenced her colleagues, as well:

> A lot of times the nurse’s willingness to get involved is influenced by the particular doctor they are dealing with. A powerful doctor, they wouldn’t approach with an ethical concern, because they know he would have the upper hand in any difference of opinion (Participant #012).

Both the female and the male nurses in the study stated that they observed differences between how physicians interacted with the male nurses, and in the male nurses’ ability to get physicians to consistently listen and act on their point of view:

> [My question] Do you feel that as a male your relationship with physicians is different than the female nurses? [Participant’s answer] Yes, definitely. Number one, they relate to you differently, and there isn’t that subservient thing going. They know that I have no problem getting in their face, and they know they can come to me and get the straight scoop. And I don’t know whether it’s because of their upbringing or it’s their nature, but there are certain nurses that they’ve been enculturated in that passive role, and that’s how they act, and that’s how they’re most comfortable. But there are also female nurses that have worked on becoming assertive but not aggressive. And the physicians do respond differently and they go to them, as well. But there is a kind of proving process for the females that doesn’t occur for the males, where you have to prove yourself as being assertive. That is sort of a double bind for the females, because if you’re

> too assertive you're a bitch, but if you're too passive then they just run all over you. And you know, it's funny, the worst ones, that treat the nurses like crap, are the female docs who have an edge to them (Participant #005).
>
> The head doctor on our unit is a very difficult person to get along with. A lot of people feel he is kind of intimidating. If you stand up to him, he backs down. A lot of women don't. There are big differences in how men and women deal with people in the work environment. I think men are a lot more confrontational and women get angry and go to a supervisor (Participant #017).

The experience of feeling "in the middle"

The experience of feeling "in the middle," according these participants, is complex, emotional and has profound bearing upon how well they are able to do their jobs. Some of the participants spoke of feeling "in the middle" when working with some physicians or administrators, but not with others. They experienced feelings of disempowerment in some situations and not in others. They sometimes felt fear at being yelled at, at being humiliated, and at losing their jobs. They talked about learning to choose their battles carefully, fighting only the battles that were truly important, because they didn't have the energy to fight every battle. They didn't have enough trust in the system to believe that they would be consistently be supported in advocating for all of their patients' needs. They sometimes felt that a steep price was paid for upsetting harmonious relationships for the sake of their professional principles. Many of them said that they had learned not to complain, that there was nothing to be gained and much to be lost by doing so:

> And then you get the nurse that's crossed over from being the advocate, taking the stand, who all of a sudden becomes apathetic. I have been fighting this style for 25 years, it ain't going to change (Participant #010).
>
> [My question] Do you think that there is sometimes a hesitancy among nurses to get involved in difficult ethical situations? [Participant's answer]

> Absolutely. Those kind of situations take up a lot of time and energy, often with no effect. Nurses need the time and energy to do all the other things they are asked to do every day. There's also an attitude that it's not my business, and there is nothing I can do about it anyway (Participant #012).
>
> And what I have found out is that most administrators now, since they are really not the middle management, are very remote, very remote from what's happening. They do not really understand what kinds of conflicts are coming up. How all these little tiny conflicts add up to more frustration and more sick time and more unhappiness with nurses' work. I mean everybody's on the verge of being burned out. It's happening more and more. So I don't really know any good solution because the problems are so massive. I think if the managers would be able to establish better rapport with the nurses, give them time to talk about the issues (Participant #001).
>
> And when you start to see, when you start to be giving your all, when you come to do this job. And you do make the attachments a lot. You're giving a piece of yourself when you're taking care of these people. You realize right off the bat, when you come to that assessment [of a terminally ill ICU patient] that this is for naught. That this is a futile endeavor. There is a price to be paid by each individual [nurse] and collectively as a unit. I have seen, I've seen units just go into literal deep depressions because of the onslaught of bad outcome after bad outcome. There is a price to be paid. There is a price to be paid individually, there's a price to be paid by the institution, there is a price to be paid in the quality of care that's given. Because people cannot sustain that kind of onslaught over time. The toll on the staff is just incredible, unbelievable. They begin to wonder what it is that they're doing here. What am I here for? (Participant #005).

Consequences of the breakdown of the nursing role on patients. Not surprisingly, narratives of the study participants contained many examples of the negative impact that the breakdown of the nursing role had on patients. They identified such concerns as the delivery of unsafe or incomplete care, the segmentation of care, the piling on of treatments, the betrayal of trust by caregivers and the focus on process rather than on the patient:

> One of our nurses who just recently retired came into our Emergency Department, and I triaged her. She was having some difficulty speaking, she was having some paresthesia of her extremities that suggested to me that she was at least having a transischemic attack, and possibly a CVA. And she, like all of us, we don't go until we get frightened. She had been having these symptoms for probably several weeks before she came to the Emergency Department. And because in our ER we have this policy, there is a window before you can administer medication [TPA]. Now here she is, she's dragging one foot, she's very weak on one side of her body. She had a headache, she's had blurred vision, her speech is somewhat garbled. They kept her, they observed her. They did not TPA her because she admitted that her symptoms began several weeks ago and she kept thinking she would get better. So they sent her home. The next day she came in, same thing only more pronounced. Now this is a nurse who worked in this department for 30 years. They kept her overnight in the observation unit, but they didn't TPA her. They felt her symptoms were going to resolve. She still was hypertensive, but her blood pressure was coming down a little bit. Sent her home, and two days later she came back, a complete CVA. She is in a con home. She'll be in a con home the rest of her life. She is only 60 years old. She took early retirement after her husband died. We asked about the standard in a teaching hospital, because we were so upset, the staff, that she wasn't given TPA. We called the trauma centers in the area and we called the stroke centers. The neurologist said they would have given her the TPA because they could have prevented an extension [of the CVA]...she had three daughters. Two of them are

nurses. They begged to have the TPA, but they didn't TPA her. I know that they must know that she should have received this. It's pointless for me to say, "There's not anything that can be done for my friend." She'll be like this, she's laying in that bed. With her one hand she's able to write, "I want to die." (Participant #014).

I sometimes feel that our focus isn't always on the patient, its on the process. I think at times decisions are made that may not necessarily be in the best interests of the patient, because physicians are reticent to talk about issues. Opening up issues with families and patients. And they are also very worried about legal ramifications. So there are times, I think, when we don't have control over the decisions that are made, whether we agree or we disagree (Participant #010).

One other thing I feel that often makes decision making and ethical dilemmas difficult is the accumulation of treatment. You start with one little treatment, and okay, it didn't go so well. Let's try this or let's do this and there's another complication. And within the shortest time possible, tons of things are done and the actual patient is lost under all the treatments and tests. We all lose track of what would be the best. The patients get buried in our zeal to do what we know how to do (Participant #001).

One of his patients, this nephrologist, was a dialysis patient who had been in the hospital for a month in our TCU and was transferred back to the intensive care unit. And the wife and the daughter decided this was enough, was enough, and they wanted no more. They wanted him to die in peace and dignity. Stop dialysis, just let this, their family member die. Well this doctor, they were in the room crying, and this doctor walks in. And the daughter says to him, "We don't want dialysis anymore." This physician turns around and yells out the door, "Get him out of here and transfer him to the floor." In just that kind of tone of voice. I

> mean just absolutely, totally without any feeling. I mean, I don't know if he was talking about a piece of hamburger meat. It certainly couldn't have been another human being (Participant #007).
>
> This one doctor, his patients leave him often because of his crudeness in saying things. Like a patient said to how constipated she was. She was so uncomfortable. He said, "Well, you've got ten fingers haven't you. Get busy" (Participant #007).

Consequences of the breakdown of the nursing role on nurses. Feeling "in the middle" clearly exacts a personal and professional toll from clinical nurses, as well. The narratives of these research participants described humiliation, stress, anger, physical problems, feelings of grief, fear and intimidation, and a decreased willingness to get involved in advocating for their patients. One participant told about how her colleagues are burning out but need to stay in their jobs for financial reasons:

> For my colleagues, for my peers who work forty hours a week, you can imagine what that's like. The morale is very low because nurses feel like they truly are caught in the middle. They have to work. Many of them are single parents and they are supporting families, and it's their livelihood that is putting bread and butter on the table and paying the rent. But on the other hand, there's certainly the professional component where you, as a nurse, want to give competent care and you feel like part of your role is to advocate for your patients. But there's also the professional component where rocking the boat or refusing an assignment could impact your livelihood (Participant #014).

One participant who cared for a child who had subsequently died talked about his own feelings:

> This incident was probably the worst day I ever had in my nursing career. And I mean, I just never felt like such, I was completely, I was so emotionally ripped apart. So the coroner arrives, and now I have to negotiate getting this body

> out and I have, the only way I can get it out is to go past these two waiting rooms full of parents. So I wrapped this body up in blankets and I had to carry it down the back elevator to the coroner's truck, because I didn't want to run the risk, because it was getting early enough in the morning that some of the parents would have been awake. It was the quickest, the easiest, the most expedient way to avoid putting them [the other parents] through seeing this...it was devastating for me. And then I get it down, get him down there, and the typical good old government official, civil servant got his paperwork, got his body and then started yelling at me (Participant #005).

Another participant talked about her lingering grief over a patient whom she had to fight against the wishes of the physician in order to get her home to die:

> I managed to arrange a situation where I saw the husband alone. And I talked to him, and I said, "Mr. E., this is what's happening, and I really think that you and your children need some help from the hospice nurse. And do you want her to be in the hospital, or do you want her to be at home?" And so we got through this whole talk and he said, "You know, this has taken so long, I kind of forgot that it was really going to happen." [the participant was sobbing] And I got her home and she died. She was exactly the same age as I (Participant #001).

Another nurse participant spoke of frequently second guessing her nursing actions:

> I had a very critical patient who was a young asthmatic with an exacerbation of her asthma. She was really struggling, and had been in our department all night. In our observation area on continuous nebulizer treatments. And when I came on duty at 8:00, this little girl, I say little girl because she was in her 20's, was like desaturating every time she would literally change position in bed. Then she got up to the bedside commode, and it really desaturated to like 87. Her breath sounds were decreased, but I could hear air exchange and stuff. It just concerned me that this was a patient, at her age, that had been there all night and

> nothing was happening with her. It was obvious to me. So she was my first patient when I got report on, out of the five I had. I was kind of concerned about her. When I went to her bedside and saw that she was wet and she was labored and she had just literally been here to the toilet and back. I immediately went out and said, "I don't want this patient back in observation. This little girl needs to be on a monitor." In checking her chart, I didn't feel that the proper tests had been done. So I went to the OD and he just downplayed it. And he comes back and checks her and says, "Oh, she's fine." He ordered a larger dose of prednisone. So I just kind of kept my eye on her. And as the morning went on, I went out there twice more. My last time out there, his comment to me was, "Well Dr. D. is going to be coming on in a little while." This is a doctor that I really admire though. As soon as the other doctor came on, I went to him with my concerns like I had gone to this other doctor. I said, "I really need ABG's on this patient. I need a chest x-ray." And he goes, "Well, certainly, certainly." Well her ABG's came back horrible. She would desaturate when she was laying still. The desaturation is what we are looking at and then the ABG's should have been drawn hours earlier. I really do feel, I don't know where that doctor was coming from. If he had a bad night or whatever. But it really frustrates me. Then I am frustrated with myself that I just did not say, "Look, I am not going to take care of this patient unless we do this and this." That's kind of where I am at now. Beating myself up, saying why didn't you do this three hours earlier. The patient was admitted to CCU by 3:00 that afternoon (Participant #013).

In one group interview two nurses agreed that they often felt like failures when patient outcomes were compromised:

> [First speaker] I feel like such a failure when I don't do as much as I can.
>
> [Second speaker] Yeah, me too. Even when I know I had six other patients who

> needed me just as much. I think I should have been able to do more. I feel so guilty. (Participants #025 & 026).

Another toll upon nurses was described as a loss of trust in the system to provide them with the medical care they needed for themselves:

> Because many of us, as nurses, think that we will be protected from this kind of harm happening to us because we are professionals and we are known at the facilities in which we work. And you think you will get special care, probably. Last summer, I had an ultrasound due to abdominal pain. The ultrasound showed a large, invasive ovarian mass which my physician diagnosed as Stage IV ovarian cancer. I had a series of chemotherapy and basically began preparing to die. I didn't tell my husband that this was going on, because I didn't want to upset him. I had always wanted to own a Jaguar automobile, so I got a friend to help me buy one. I figured, why am I saving all this money now? In the Fall, I went to lunch with my doctor, who is a personal friend of mine. She asked me about my pain, and I said, "I'm not having any pain." She couldn't believe that I was having no pain with such an advanced stage of cancer. This didn't make sense to her since this type of cancer was so invasive and fast growing. So my doctor arranged to have another ultrasound done, which she observed herself. We did the ultrasound at another hospital [not this nurse's own facility]. The ultrasound turned out to be normal. I had gone through all this emotional anguish and physical trauma because my ultrasound had been mixed up with someone else's. And I was worried about the other patient. Did she know she was so ill? Had she been misdiagnosed, as well? It turned out that shortly after I found all this out, I cared for the other patient. This patient was very ill, and came in with her two teenaged children because she was having so much pain. They had just learned about her terminal diagnosis about two weeks earlier. She died about a week after I cared for her (Participant #014).

Another impact on nurses which was described by several of the participants was a tendency to second-guess themselves and whether they had done all they could do to care for the patient. Some participants still thought about and had doubt about their own actions towards patients for whom they had cared several years ago. They struggled with what their role was and how far they should intrude into a doctors role.

> I think of times when what I think is in the best interest of the patient and what the physician is doing are in conflict. Like when the doctor is insisting that the patient have chemo but the patient is going to die soon anyway. Why not just leave the patient alone and let them die with some dignity. There is a fine line for nurses - do we step in and practice medicine when we think something different should be done clinically? Does the doctor know something that I don't know, or is he just feeding his own ego - sometimes I just don't know (Participant #20).

Conclusion

In this chapter, I presented an analysis of the findings of my research. Two distinct phenomena emerged from exploring the narratives of the twenty-six nurses in this study - *being* "in the middle" and *feeling* "in the middle." In general, the organization and categories used to describe these findings came directly from the narratives of the participants. Clearly, the terms, definitions, contexts and meanings contained in the narratives emerged as patterns which described one role in clinical nursing, *being* "in the middle," and also described instances when that role broke down. The breakdown of the role is a separate and distinct phenomenon which the participants called *feeling* "in the middle." Additionally, the narratives of these participants illustrated the consequences that both the effective practice of being "in the middle" and the breakdown of that role had upon their patients and upon themselves as human beings. Both phenomena are complex and powerful in their influence and impact upon the practice of nursing. The participants take their roles very seriously and strive to understand how they can be better nurses.

CHAPTER 5

Discussion of the Findings

Results from this study indicate that being “in the middle” and feeling “in the middle” are both significant phenomena in the professional and personal lives of hospital-based nurses. The participants articulated that each phenomenon exists independently from the other, and that feeling “in the middle” only exists when being “in the middle” is not occurring. However, a careful examination of the data also reveals that although the participants believed the two phenomena to exist under separate and distinct circumstances, their narratives actually described circumstances where feeling “in the middle” co-existed with being “in the middle.” Their narratives contained examples of nurses carrying out the role of being “in the middle” as professionally engaged advocates and communicators, while being situated in marginalized, gendered spaces. This reveals that being “in the middle” is a paradoxical position in nursing and feeling “in the middle” is pervasive in spite of the successful implementation of the nursing role.

This chapter includes a discussion about how and why these two phenomena might co-exist, and what implications that has for nursing. In doing so, I examine how the findings of this study answer the initial research questions: 1. What are nurses’ experiences of being “in the middle?”; 2. What does being “in the middle” mean to clinical nurses?; 3. What is the nature of “betweenness” or “middleness” in nursing?; 4. Are there patterns of dealing with or responding to being “in the middle?”; 5. And, what consequences does being “in the middle” have for clinical nurses and others? I frame the discussion of this research in terms of relationships and social structures which emerged from some of the nursing ethics literature, and in terms of support which is found in the nursing and the feminist literature. Additionally, I consider how the research contributes to the feminist goals outlines in Chapter 2. Finally, I evaluate whether the research supported the feminist goals of this research.

The Research Questions

Experiences of Being and Feeling "in the Middle"

> Experience is the process by which, for all social beings, subjectivity is constructed. Through that process one places oneself or is placed in social reality and so perceives and comprehends as subjective (referring to, originating in oneself) those relations - material, economic, and interpersonal - which are in fact social, and, in a larger perspective, historical (de Lauretis, 1984, p. 159).

The participants' narratives about being and feeling "in the middle" included experiences that they often defined as either professional or personal. However, as a neomodern feminist researcher, I find it somewhat artificial to view experiences as *either* professional *or* personal. Instead, I believe that "the personal is what all of us spend most of our lives engaged in, and what people spend most of their lives engaged in should be seen as both important and political" (Stanley, 1984, p. 321).

Nonetheless, the participants' experiences were varied and complex. These experiences were embedded in their narratives, both as specifically remembered encounters, interactions and responses, and as more general ideas, feelings and opinions about a variety of subjects. The participants talked about experiences that had occurred twenty years ago and were still vivid to them, and about experiences that happened within the very recent past. Narratives about *professional* experiences involved a colleague or the participant herself in interaction with patients, doctors, families or other hospital staff, and were framed in terms of the performance of her professional role.

In general, the experiences of *being* "in the middle" were more positive and more descriptive of the professional role and its component parts - advocacy, communication and professional engagement - than were experiences of feeling "in the middle." Professional experiences of being "in the middle" were the lived experiences associated with carrying out the roles of clinical nursing. The narrative about the nurse who aggressively advocated for her cancer patient who wanted to stop treatment and go home to die is an exemplar that illustrates the professional experience of being "in the middle."

The experiences of *feeling* "in the middle" were generally more negative, more regretful and more apt to result in second-guessing one's actions than those of *being* "in the middle." For the participants, the lived experiences of feeling "in the middle" exemplified the breakdown in the professional role for reasons such as lack of knowledge about or acknowledgment of the nursing role; failure of the system to provide staffing and other resources; failure of the system to address legal and ethical issues; unresolved conflict; the primacy of technology; and, sexism, racism, classism and other power differentials. A majority of the participants told at least one story about professional experiences of feeling "in the middle."

The *personal* experiences of being and feeling "in the middle" also involved either the participant or a colleague and focused either on experiences in which she or a family member was a patient, or where she identified her personal values or beliefs as influencing an experience. Likewise, personal experiences included those in which the participants spoke about the personal impact or the personal implications of performing their professional roles. For example, the nurse's narrative about her struggle to care for the child with cancer whose parents made different treatment decisions than she had with her own child is illustrative of a personal experience within the professional domain. Another example is the narrative about the nurse's anguish about standing by as a patient and his parents decided to refuse life-saving blood transfusions because of their beliefs as Jehovah's Witnesses.

Being "in the Middle" - The Paradox

Although the participants most frequently differentiated between their experiences of the two phenomena, it is striking that a substantial number of the narratives about *being* "in the middle" were framed in terms of overcoming or dealing with some aspect of *feeling* "in the middle." This leads me to believe that being "in the middle" is a paradoxical position in nursing. In examining the research data at a level deeper than merely understanding and reporting the participants' insights, I found that many of the exemplars about being "in the middle" ended with or were couched in the words "but" or "in spite of." For example, [*in spite of*] one doctor's reluctance to hospitalize the patient who had been in status asthmaticus two hours earlier, "I talked the ER doc into keeping him" [in the ER for observation for six additional hours] (Participant 017); or, the nurse gave the nursing mother who was visiting her ill husband a light meal because she hadn't eaten all day [*but*], "my charge nurse had a fit that I was feeding a family member" (Participant 013); or, a nurse took her concern about overmedicating the terminal patient to her Department Director, "*but* she didn't act like it was any big deal" (Participant 011); or, the participant told a patient where to seek education and treatment about urinary incontinence that wasn't available within her HMO, [*but*] "I know I probably could get in trouble for doing it" (Participant 014); or, a nurse advised a patient to get a second opinion, [*but*] "I thought, God willing, her primary is going to send her on to a different cardiologist who will be a little more aggressive with this 52 year old lady" (Participant 007).

These examples are powerful testimony to the paradox of the position of being "in the middle" while, at the same time, feeling "in the middle." They support the case for the existence of two distinct phenomena, as was articulated by the participants, but also make us question why and how this paradox exists, as well. The two phenomena are unquestionably closely related, and, no doubt, exist as a result of the social spaces that nurses occupy and the types of relationships in which they are engaged.

Liaschenko's (1997) work that addresses the ethical concerns emerging from the structural aspects of nurse-patients relationships is illuminating here. Clearly, the narratives of these participants indicate that nurses work in a gendered space of invisibility where their actions are neither acknowledged nor seen, of instrumentality where they carry out physicians' orders and make the work of medicine possible, and of oppressive practices towards nurses by physicians, administrators and other nurses. In examining the participants' narratives in terms of the cultural ethos of healthcare, it is apparent that the social organization and ideologies of the workplaces of nurses influences how they respond to and interact with patients.

The participants cited examples of how power differentials among staff in hospitals are both condoned and encouraged. One example is the nurse who had educated a family about a variety of treatment options and then was asked by a physician to go emphasize the his treatment plan. In spite of her belief that it was not in the patient's best interests, she did as he asked. Likewise, the participants found that oppression of nurses and patients frequently went unexamined in hospital settings, often because administrators needed to support the teaching goals of the hospital or to maintain good relationships with physicians in order to profit from their referrals. The narratives contained many examples of these oppressive practices such as the physician who humiliated the nurse in front of a colleague by calling her a "Hitler nurse," or the resident who encouraged his intern to practice an invasive procedure, the insertion of a chest tube, on his patient even though the patient didn't need or want the procedure, or the undermedication of patients in pain.

Meanings of Being "in the Middle"

From the participants' experiences of being and feeling "in the middle" emerged the meanings of the two phenomena as lived and articulated by the participants themselves. Like their experiences, meanings were integrated into both the personal, and professional domains, and were connected both to role identity and to personal identity. Again, as a neomodern feminist researcher, I present these meanings as deconstructions of much more complex experiences and meanings.

The formation of role identity is a complex process, and an important finding of this study is that nurses identify themselves with the role of being "in the middle." This role has considerable meaning to the study participants as a part of their professional selves. Nurses are trained to perform certain functions and to think in specific professional ways that are unique to nursing. This distinguishes nurses' spheres of influence and action. Being "in the middle" is included, if not featured, in this sphere.

As discussed earlier, the performance of the role of being "in the middle" is impacted by the organizational structures of the profession, the norms of other professions, the ideologies and structures of the society in which the nurse is practicing, and the norms of their individual institutions. The meanings attached to being "in the middle" were connected to a positive, centered and effective professional role and included job satisfaction, feeling professionally challenged and being able to do what's best for the patient.

Being "in the middle" has meanings within the personal realm, as well, especially because of the interrelatedness of the participants' professional and personal identities. Retained employment and the resultant ability to support themselves and their families, self-fulfillment, mental challenge and growth, and pride all emerged as personal meanings for the participants. One participant, for example, told me about her sense of personal fulfillment in using her knowledge to advocate for a patient who was having an MI but was not getting appropriate treatment from the ER physician, but for whom the nurse was able to go to another doctor and insist on aggressive action. Another participant told me about how she had grown up in poverty and, as a young, single mother, was able to put herself through nursing school. She identified that she was now making a difference in both the lives of her patients and her children because she was a strong and articulate nurse.

Again, however, it appears that the meanings attached to being "in the middle" were often colored by the ethical concerns that are inherent in the marginalized, gendered spaces in which nurses must work. Gordon, Benner and Noddings (1996) wrote that "because of gender idology, traditional stereotypes and the formal identification of men with public life and economic activity, ...caring practices are overlooked and understudied" (p.ix). Meanings about being "in the middle" were described as positive and empowering although often there was a "but" or an "in spite of" attached to the narrative. For example, participants spoke of being proud of their professionalism *in spite of* the many blockers that impeded them in doing their jobs. One participant spoke of finding job security when she became a nurse, *but* feared losing her current job due to her outspokenness. Another nurse found satisfaction in being an empathetic caregiver *in spite of* her family's irritation with her long hours at work. These paradoxical meanings begin to blur into the meanings of feeling "in the middle," even though the participants expressed them as distinct and different from each other.

Meanings of Feeling "in the Middle"

When the nurse cannot effectively carry out the role of being "in the middle," the role breaks down and feeling "in the middle" results. The participants in this study were clear that the breakdown of the role existed in their lived experiences, and that they were distinct from those of being "in the middle." The professional meanings of feeling "in the middle" were negative and marginalizing, and included such meanings as being asked or forced to violate one's professional duty and losing one's professional passion and energy.

Personal meanings associated with *feeling* "in the middle" fit squarely into the emotional dimension of professional nursing. These are part of the affective component of this research and underscore the notion that emotions can serve as a source of insight or a signal of rupture in social reality (Cook, 1988). In general, the meanings the participants attached to *feeling* "in the middle" revolved around the aspect of breakdown or ineffectiveness in their professional role.

The breakdown in role identity leads to role stress, according to Hardy & Conway (1988). Role stress was a reality for many of the study participants. In particular, personal meanings revolved around fear of loss of employment and resultant inability to support herself and her children, devaluation, loss of dignity and self esteem, and physical and emotional problems resulting in pain, stress, distress, drug dependence, burn-out and/or loss of energy. Several participants said that they knew nurses who had burned out and left the profession because of these stressors. Some of the participants said that they themselves often felt very stressed in their work because of various factors that led them to feel "in the middle."

On both personal and professional levels, the participants had moral questions that pervaded their narratives and were tied to meanings, as well. Implicit and, less frequently, explicit, in their narratives were questions about whether they and their nurse and physician colleagues were "doing the right thing" for their patients or for themselves. One example of such meaning was found in the narrative of the oncology nurse who was conflicted about the doctor leading the patient to believe that chemotherapy would help even when the patient was clearly days away from death. Another nurse told a story about struggling with whether to do what a physician told her to do and risk losing her license, or to refuse and risk losing her job.

The Nature of "Betweenness" and "Middleness" in Nursing

"Betweenness" and "middleness" in nursing, which I define as equivalent and interchangeable terms, take their meanings from the two phenomena, *being* "in the middle" and *feeling* "in the middle." That is, the quality of middleness or betweenness occurs when one is "in the middle" either in the sense of being "in the middle" or feeling "in the middle." Just as the nursing literature addresses the two phenomena as part of the domain of nursing ethics (Astrom et al., 1993a; Bishop & Scudder, 1987; Broom, 1991; Cooper, 1988; Erlen & Frost, 1991; Fry, 1985; Huggins & Scalzi, 1988; Hutchinson, 1990; Jameton, 1977; Johnstone, 1988; Ketefian, 1987; Mayberry, 1986; Pike, 1991; Soderberg & Norberg, 1993; Stenberg, 1988; Wilkinson, 1987/88; Yarling & McElmurry, 1986; Youngner et al., 1979; Zorb & Stevens, 1990), the language of middleness was, for most of the participants in this research, the *moral* language of everyday practice and the ethical concerns that arise from their practice. Ethics and middleness were consistently tied together by the participants in this study, and ethical situations gave rise to many instances of feeling “in the middle.” Understanding the conceptual frameworks and philosophical influences that have shaped the ethical assumptions of the nursing profession helps to situate being “in the middle” in nursing. However, like Liaschenko (1994), I found that the ethical narratives of my participants, although they periodically used the words “rights” and “care,” were neither framed by the ethic of rights nor by the ethic of care. This suggests that neither of these conceptualizations quite articulates nurses’ ethical stance as well as would an ethic of principles that links just institutions and virtuous lives.

It is here that I return to the concept of marginalization, as described by Hall, Stevens & Meleis (1994), and utilize several of its characteristics to describe betweenness or middleness in nursing. The nature of betweenness is, on the one hand, a position of power and centeredness when used in the context of being “in the middle,” and on the other hand, a position of disempowerment and peripheralization when used in the context of feeling “in the middle.” The paradox of feeling “in the middle” while carrying out the role of being “in the middle” is part of the nature of betweenness, as well.

For some of the participants, betweenness and middleness were not conceptual “positions,” but were more ways of thinking of themselves and being in the world, or ways of being perceived by others. These participants were clear that being in an empowered and centered position of middleness meant being in that position with all the other people who needed to be there - physicians, patients, families and other health care professionals. None of the participants described the successful implementation of their role as occurring in a vacuum. In fact, working as a team, with each person bringing their perspective and expertise to the table, was described as crucial to the success of the nursing role. Nevertheless, even when nurses described being part of an effective team, they didn’t necessarily have equal voting membership. An example is the nurse who was asked to continue to work with the impaired anesthesiologist and trust that administration would step in when things "got really bad." The nurse's assessment that his actions potentially endangered patient care was not acted upon; a physician's comparable assessment got the anesthesiologist fired.

The participants said that when cooperation and integration failed to occur, the nursing role of *being* "in the middle" deteriorated to breakdown and *feeling* "in the middle." In such cases, the nature of "betweenness" or "middleness" becomes a marginalized position, and we observe one or more of the characteristics of the phenomenon of marginalization: *intermediacy*, *lack of power and control*, *reflectiveness*, *voice* or *liminality* (Hall, Stevens & Meleis, 1994). *Intermediacy* is "the tendency of human boundaries to act both as barriers and as connections" (Hall, Stevens & Meleis, p. 25). These boundaries mediate physical and emotional safety in marginalized circumstances, and they allow for social connection and openness in safer circumstances. When role breakdown occurs for nurses, barriers are often thrown up in the guise of loss of professional engagement, physical symptoms and anger.

The participants relayed many stories in which *power* was withheld, taken away or used against them and resulted in role breakdown. Likewise, some of them talked about taking power back by subversively finding ways to meet their own and their patients' needs. I used the following quote from one of the participants earlier. It is a good example of the paradox of being "in the middle" using a subversive strategy when the nurse believed that directly confronting an issue would not work:

> In general, success in discussing a difference of opinion in an ethical situation with a doctor depends on the nurses' approach. Part of the nurse's role is learning the best approach. Confrontational approaches don't work. It's better to use a non-threatening manner. And a lot of times, you have to build a trusting relationship beforehand. Think about the ICU shift manager. She is very soft spoken. She has been a nurse forever, and all the docs trust her clinical judgment. When she wants something for her patient, she always presents it in such a way

> that the doctor gets the credit for thinking of it. She almost always gets what she wants (Participant #012).

Reflectiveness is related to the breakdown in the nursing role in that it involves the fragmenting and conflicting effects that result from that breakdown, and the introspection that is required to understand and deal with those effects. The participants spoke of "feeling silenced," having a "small voice," being "discounted," and being "peons." Hall, Stevens and Meleis (1994) proposed that

> the capacity for reflecting on one's marginality is empowering in the sense that one can strategize more effectively with increased awareness of specific conditions of discrimination, isolation, privatization and oppression....the political consciousness it engenders increases the chances of survival and success. Yet those who have the ability to be reflective, but who lack sufficient social support and resources for addressing the fragmentation and isolation that they discover, may feel their marginalization even more intensely (p. 31).

I have spoken of *voice*, or the "small voice of nurses," previously. Being silenced within the dominant stream of communication, in this case, within discussions about patient care and in policy-making arenas, is a powerful force in and consequence of the breakdown of the nursing role, and occurs even as nurses are successfully carrying out their role of being "in the middle."

Lastly, the property of *liminality*, another component of marginalization, occurs when the role of nursing breaks down. Defined as "altered and intensified perceptions of time, worldview, and self-image that characterize and result from marginalizing experiences" (Hall, et al., 1994, p. 33), liminality especially emerged in the cloak of self-doubt, second-guessing oneself and repetitive reliving of bad patient outcomes among the participants of this study. It was disturbing to me that several of the participants continued to have bad dreams and feel personally responsible for months and sometimes years after situations where poor patient outcomes occurred and where their crucial professional observations and assessments had been ignored or discounted. However, it may be these anguished events that help some nurses to remain "in the middle," and to advocate more assertively on behalf of patients.

In summary, "betweenness" and "middleness" in nursing are equivalent terms and are descriptors of being "in the middle" and feeling "in the middle." They refer to literal and figurative positions and to ways of being and feeling and can be conceptualized utilizing components of the concept of marginalization. Tying being "in the middle" and feeling "in the middle" to marginalization underscores both the feminist concerns about oppression and androcentrism, and the feminist vision of "collegiality, non-hierarchy, mutual dialogue and recognition that all consumers of knowledge have valuable insights" (DeMarco, Campbell & Wuest, 1993, p. 32). It helps us to understand the paradox of being "in the middle" as a successful role that co-exists with feeling "in the middle."

Patterns of Dealing with or Responding to Being and Feeling "in the Middle"

Nurses manage patient care within societal and facility-specific systems that have both strengths and weakness that impact the patient care process. Patterns of dealing with and responding to being and feeling "in the middle" result from interactions within these systems. According to Hardy & Conway (1988), social action, as expressed in roles, includes both learned responses and the organization and interpretation of cues in one's environment. As the nurse participants examined and defined their situations, they identified strategies for dealing with a specific situation based on societal and facility systems and ideologies, past experiences, perception of current realities and underlying professional and personal beliefs.

The concept of social support developed in the nursing literature is relevant to the discussion about patterns of dealing with being and feeling "in the middle" (Diamond & Jones, 1983; Frey, 1989; Norbeck, 1984; Norbeck, Lindsey & Carrieri, 1983). Just as prior nursing research (Frey, 1989) has supported the hypothesis that parents' social support has direct and positive effects on family health, the participants of this study indicated that social support was an important factor in carrying out their nursing roles. Likewise, lack of support or weak support were factors in feeling "in the middle." Because there is little social support for caregiving activities (Benner, 1998), nurses are being asked to fulfill their roles under difficult circumstances that, no doubt, contribute to feeling "in the middle."

The participants' patterns of dealing with the professional role of being "in the middle" incorporated ways of being patient advocates, ways of communicating, and ways of being professionally engaged in environments that were not always supportive. These patterns of professional action were described, in their own words, as speaking for the patient; providing support for the patient; protecting the patient; knowing the patient; doing for the patient; being there; being fair; dealing with pain and other symptoms; getting for; mediating; interpreting and translating; educating; clarifying; ensuring informed consent; caring; being professionally passionate; trusting one's own judgment; collaborating; and, bending the rules. When the participants felt supported by their colleagues, by the attending physician, by an administrator, or by their department director, the paradox of being "in the middle" co-existing with feeling "in the middle" was less likely to occur. In environments of social support, nurses were more likely to carry out their roles in effective and professionally satisfying ways. Therefore, one pattern of being "in the middle" was to seek out and clarify social support.

A less professionally satisfying way to be "in the middle" involved going around systems or disregarding orders. Carol Gilligan's more recent works (1987; 1988; 1993) have explored ways in which women can individually ignore dominant discourses and paradigms and listen to their own inner voice. The participants of this study told stories of how ignoring dominant discourses and listening to their inner voices sometimes led to action in advocating and communicating with patients and sometimes led to frustration and breakdown in their profession role and subsequent inaction. Thus, patterns of action were closely tied to whether the nurses were effectively carrying out the role of being "in the middle" or unable to carry out the role due to breakdown.

In general, patterns of being "in the middle" are collegial, communicative, professionally energized and interactive. However, being "in the middle" sometimes occurs subversively if individuals or systems interfere with role performance. This once again points to the paradox of being "in the middle." In such cases, the participants determined what, from their perspective, was "best for the patient," and then sought ways to achieve their goals. Strategies for action included rule-bending (Hutchinson, 1990), trusting one's own judgment, persisting in demands for action from others, and going behind the back of the physician or the system.

Patterns of responding to feeling "in the middle" emerged from the marginalized and oppressed character of this role breakdown. Knowing "what was right" or knowing "what should be done," and being unable to act upon their inner voice in carrying out their professional role was difficult for these nurses. They described their responses to feeling "in the middle" in a variety of ways including acting fearful or intimidated, choosing one's battles carefully, being distrustful of the system, being more hesitant to take a stand, shutting one's eyes to issues ("I come to work, do my job and go home. I don't get involved."), burning out, expressing inappropriate anger, and developing physical symptoms.

The Consequences of Being and Feeling "in the Middle"

In Chapter 4, I reported about the impact that being and feeling "in the middle" had on patients and nurses, as described by the participants of this research. In general, when the professional role of being "in the middle" is understood and implemented by competent nurses in an environment of integrated, respectful health care, the consequences both to patients and to nurses are very positive. Although this is not a role that is consistently understood, carried out or allowed in all situations, it is one that nurses see as crucial to the provision of excellent patient care. This means that nurses can go beyond following physician's treatment plans and establish patient care plans of their own; educate patients on how to deal with their healthcare needs; ensure informed consent; and, ensure appropriate post-discharge care.

In addition, the successful execution of the role of being "in the middle" has ramifications that go beyond an individual patient or nurse. There is potentially a great deal of positive impact to society if nursing's role is consistently understood by all and carried out by all registered nurses: A health care system that is more balanced in its focus both on fighting against disease and fighting for wellness; a health care system that encourages dialogue about what patients need; a health care system that encourages dialogue about ethical and legal issues; a health care system that recognizes and utilizes the expertise that each player, including the patient, brings to the table; and, a health care system that focuses both on the short term and the long term impact of its policies and interventions.

Likewise, in chapter 4, I discussed how the participants interpreted the consequences of the breakdown of the professional nursing role and feeling "in the middle" on both patients and nurses. In a word, the impact is grim. I feel certain that feeling "in the middle" is related to the disillusionment that nurses frequently describe and was cited by many of the study participants, as well. This is where nurses become disenchanted with their roles, and where they begin to disengage from the needs of their patients. But obviously, the consequences reach further than the individual nurse and is only one symptom in the larger breakdown of the health care delivery system in the United States. The impact of the breakdown includes disrespect for and minimization of the role of nursing; dissonance between what patients need and what the system needs; the commodification of health care; distrust of the system and health care providers; lack of continuity of care; lack of access to care; and failure to deal with life-changing ethical and legal issues.

These are issues that concern nurses and impact their practice. But what nurses contribute to the effectiveness of health care delivery as a whole cannot be underestimated either. Understanding how nurses contribute and what the consequences are when those contributions are thwarted is crucial in the quest to fix our broken health care system.

The Feminist Metanarrative

The feminist metanarrative provides the critical, reflexive and analytical approach to this neomodern research, especially as the "'narrative foil against which scientists critique their work to form and reform knowledge" (Reed, 1995, p. 76). Using the feminist metanarrative as impetus, I return here to the feminist goals of the research and evaluate how they inform the findings. Specifically, I ask whether (and how) the research challenged prevailing assumptions, exposed oppressive practices, attended to social context, and attended to the particularity of lived experiences and differences among individuals (Sherwin, 1992).

Challenging prevailing assumptions. The narratives of the research participants made explicit and revealed the impact of several important prevailing assumptions in their professional lives: the primacy of technology and the medical model; the hierarchical social structures in hospitals; the unequal power distribution between physicians and other care providers; and, the tendency to understand disease apart from its contextualizing factors. These assumptions all fall into the domain of cultural ethos. Identifying them as concerns of the research participants underscores Warren's (1989) contention that the most important ethical issues in healthcare are infrequently addressed. This research also supports Yarling and McElmurry's (1986) contention that the nature of hospital systems undermines the nurse/patient relationship, and Roberts (1996) claim that the current structure of the health care delivery system reinforces the oppression of those who are not at the top of the hierarchy. The ramifications of those prevailing assumptions have impact on patients, families, nurses and other health care providers. Clearly, these are all ethical issues that have consequences for the provision of nursing care.

Exposing oppressive practices. This research reaffirms that oppression of both patients and nurses continues to occur. The narratives of the study participants exposed several oppressive practices including belittling, humiliation, devaluing, ignoring, assuming one's own superiority and other's inferiority, and exclusion from professional discussions. These findings support the vast feminist literature about the role of medicine in the oppression of women (Apple, 1990; Mitchinson, 1991; Sherwin, 1996).

In addition to exposing oppressive practices, the goal is to find ways to eliminate oppression. This research contributes to understanding and uncovering these practices as part of cultural ethos, and then moving to empower women to address oppression. Incorporating the notion of cultural ethos into the evaluation of the findings gives us a framework for building knowledge. Specifically, it focuses on the aspects of the participants' experiences that "reflect ethical concerns with structural or organizational elements" (Liaschenko, 1994, p. 48). This links an important component of ethical thought to feminist critiques - about oppressive practices within societies both in the larger and in the more local sense, and about recognizing that social context impacts behaviors and norms - and finally to the findings of this research. At the societal level, policies that allow HMOs to deny payment for life-saving or health-promoting treatments emerge from the cultural ethos of capitalism, but provoke ethical concern among nurses and others. At the hospital level, policies that encourage deferential and preferential treatment towards physicians, such as separate parking lots and dining rooms, free food, and the deciding vote in most clinical differences of opinion, are examples of oppressive ideologies. At the most local level, the hospital unit, managers who act of doctors complaints about staff without hearing the staff member's side of the story, or nurses who believe they must follow a doctor's orders in spite of the risk to the patient or to her license, are both examples of ethical concerns emerging from cultural ethos.

The notion of cultural ethos helps us especially to understand the phenomenon of *feeling* "in the middle" as a breakdown in the role of nursing within the context of oppression, hierarchical systems and power differentials. But it also helps us to understand the phenomenon of *being* "in the middle" as a role that has successfully, albeit inconsistently, been integrated into the social and political fabric of healthcare. There is no doubt that the role of *being* "in the middle" does not exist universally or unquestionably, although philosophically it is a goal towards which to strive.

Attending to social context. In seeking to articulate the findings of this research at the intermediate level of significance, in particular the level of nurses practicing in hospitals, understanding the impact of social context on nursing practice is critical. The findings point out some of the ethical problems that are inherent in nursing practice and that impact the role of being "in the middle" and the breakdown of that role. Those ethical problems stem from our cultural ethos in how we structure our social and political systems, such as not allowing nurses to be part of their patients' care conferences or having ethics committee meetings closed to nursing input. In allowing and valorizing the primacy of medicine and technology over caregiving and patients as situated persons, ethical concerns about dehumanizing patients and devaluing nurses arise. In assuming the white, middle-class European male to be the societal and medical norm, nurses and patients in marginalized classes are left out of medical decision-making and ignored when health care policy is formulated. In such an environment, interns and residents are allowed to practice on patients and carry out surgical procedures without their consent. Nurses only quietly question the morality of hastening a patient's death in such a social context. Impaired physicians are not removed from practice if they contribute significantly to a hospital's financial base or to their colleagues' referral base.

However, many of the participants, while identifying societal weaknesses that interfered with good patient care and with professional pride, also spoke of strong local organizations that provided supportive, communicative and interactive environments.

These were organizations, sometimes hospital-based, sometimes unit-based, sometimes shift-specific, where nurses could more consistently carry out their role of being "in the middle."

Attending to the particularity of lived experience and differences between individuals. The aim of narrative inquiry is to identify both differing and invariant meanings among participants. By its nature, this methodology encourages attention to the particularity of lived experience and differences between individuals, which is, of course, highly local in its focus. Likewise, one hallmark of feminist research is to pay attention both to women in general and as differentiated individuals (Reinharz, 1992). This research focused on the predominately female profession of nursing, specifically, the narratives of twenty-six individual nurses.

While these study participants recognized social context as a highly important factor in the successful implementation of their role and the maintenance of their role identity, they differed among themselves as to what made the difference in successful implementation and role breakdown, as I have discussed elsewhere. The participants were generous in sharing narratives about their lived experiences. This has allowed me to better understand the conditions of their work lives, the delineate causes and consequences of oppression and to make their work visible. It will be especially important in the future to find ways to mitigate the negative impact of feeling "in the middle" and accentuate the positive impact of being "in the middle" in nursing.

Other Findings Within the Context of the Literature

Meanings and conceptualizations. Initially, many questions and several premises about the conceptualizations of "in the middle" in nursing emerged from my review of the literature and subsequent concept development. At the beginning of this study, I proposed two definitions about *one* nursing phenomenon and integrated the conceptualizations of being "in the middle" with some components of the concept of marginalization. The first definition was being "in the middle" as *effective advocacy*, or the nurse being located, by virtue of her training and experience, in a centered position which allowed for effective advocacy. The second meaning was being "in the middle" as *ineffective peripheralization*, or the nurse experiencing ineffectiveness in nursing actions for a variety of reasons, as I discussed earlier. Before undertaking this study, my assumption was that being "in the middle" was one, multi-faceted phenomenon.

The results of this feminist narrative inquiry provide support for two distinct but related conceptualizations, rather than the one, multi-faceted phenomenon I originally proposed: *being* "in the middle," which is a nursing role with distinct dimensions and the other, *feeling* "in the middle," which occurs when there is a breakdown in the functioning of the first. As I discussed in the previous chapter, the narratives of the study participants substantiated that being "in the middle" and feeling "in the middle" are not the same phenomenon. However, further analysis of the narratives revealed that feeling "in the middle" often co-exists in situations of being "in the middle."

My conceptualization of being "in the middle" is congruent with the assumptions of the authors who wrote about betweenness as an outcome of being obligated or having a duty (Bishop & Scudder, 1987; Cooper, 1988; Johnstone, 1988; and, Watson, 1985), and those who assumed it to be a function of being empowered (Bishop & Scudder, 1987; Engelhardt, 1985;Yarling & McElmurry, 1986). However, the participants of this study expanded on the assumptions of these authors and have told us more about this important nursing role. For example, the nursing literature had not fully discussed the centered nature of this role, nor had it discussed the impact of betweenness on nurses and patients.

The nursing literature has provided us with more in-depth conceptualizations of the phenomenon of feeling "in the middle" than of the phenomenon of being "in the middle." Several authors have discussed components of feeling "in the middle," including those who conceptualized it as a function of lack of power (Erlen & Frost, 1991; Pike, 1991), and those who described it as an outcome of conflict (Cooper, 1988; Hutchinson, 1990; Johnstone, 1988; Stenberg, 1988). Some authors assumed middleness in nursing to be a distinct perspective or position, although some were describing *being* "in the middle" as we have come to know it (Bishop & Scudder, 1987; Watson, 1985), and some were talking about *feeling* "in the middle" (Astrom, et al., 1993a; Erlen & Frost, 1991; Ketefian, 1987; Mayberry, 1986; Zorb & Stevens, 1990).

This research allows us to integrate the assumptions and meanings that have been put forward in the literature with the practice-based accounts of the study participants, giving us more complete descriptions and understanding of two phenomena that have largely been thought to be only one phenomenon. It clarifies the confusion brought about by differing definitions and assumptions in the literature.

Answering the Research Questions - The Neomodern Agenda

Conducting this research, and explicating the findings were two stages where deconstruction of knowledge and assumptions occurred. Answering each of the research questions begins to bring back together the deconstructed components of being and feeling "in the middle." Seeking personal narratives, exploring lived experiences and exploring differences helps us to understand variation diversity among *individuals*, as is proposed by the postmodernists. Looking for common themes, recurrent styles, contexts, experiences and meanings helps us understand *human* behaviors and responses. In addition, the analysis is strengthened by questioning how the nursing literature informs the findings. This is the stage where neomodernists bring together all of the knowledge that emerged from the research and *reconstructs* it based on the new insights that have emerged from the data analysis. In the process, both the deconstructed parts and the reconstructed whole contribute to the development of theory.

Conclusion

Bishop and Scudder (1987) wrote about the privileged "in-between" position of nursing that allows nurses a valuable perspective from which to advocate for cooperative decision-making that fosters patient well-being. I agree that nurses are in a privileged position, although not by virtue of power or class. Rather, because the unique training and expertise afforded to nurses that gives them the ability to articulate and advocate for what patients need, and because they are placed in environments where they interact with patients at an intimate level, and because they are given a public trust to use their knowledge and access solely for the well-being of others, nurses are in a privileged position. But there are paradoxes inherent in this privileged position: the paradox being invisible in the performance of caring work; the paradox of feeling "in the middle," although trained and capable of assuming an assertive role; the paradox of being engaged in work that is demanded but unacknowledged and unsupported by the public; and, the paradox of effectively performing the nursing role in the midst of oppressive and restrictive circumstances.

This chapter has discussed the findings of the study, including how they address the research questions, and whether they are congruent with the conceptualizations in the nursing literature. Many of the components of marginalization were integrated into new definitions of being and feeling "in the middle." In this chapter, the notion of cultural ethos informed understanding of middleness in the moral domain. The concept of support framed the discussion about patterns of being and feeling "in the middle." The feminist metanarrative framed review of the outcomes of this study in providing a critical, reflexive and analytic approach to the findings. I also evaluated the effectiveness of the research in achieving the feminist goals.

One goal of neomodern feminist research is to understand the lived realities of nursing practice by interviewing nurses, listening and hearing their words and the meanings of their words, and articulating those meanings in respectful, culturally sensitive and consciousness-raising ways. In the process, I was reminded about why I chose nursing as my life's work: Nurses have very important work to do, and they do it with a great deal of sensitivity and grace.

> They walked into the forest, thick and old...She paused at one of the National Park Service signs. It read:

> Very little light reaches the forest floor in the deep temperate rain forest. The only way young seedlings can survive until they reach the light of the upper canopy is to grow on the nutrient-rich decaying logs. These logs are called *nurse logs*.
>
> People can be nurse logs, too, she thought. Rich, generous, deeply

well-mannered (Wells, 1996).

CHAPTER 6

Conclusion

With the completion of this study, I found that what I initially understood to be one phenomenon with several competing meanings was instead two distinct phenomena. This research helps to clarify how feeling and being "in the middle" are conceptualized and how these phenomena impact nurses as they navigate through the everyday issues of clinical practice. The paradox of being "in the middle" emerged from the narratives as a significant mitigator of the nursing role. From the frequency with which these phenomena are discussed in the literature and referred to in the narratives of clinical nurses, we know that they are an integral part of the practice of nursing, and that they are commonly addressed within the moral domain and in moral language by the participants. For these reasons, this study focused on narratives about the everyday life world of nurses, because, ultimately, it is in the everyday activities that tell the stories of nursing. Narratives were used as a method of organizing and communicating nursing knowledge (Boykin & Schoenhofer, 1991).

This study illustrated the gap between the participants' perceptions of what is and what could be. "What is" incorporates the role of nursing - being "in the middle." "What could be" includes the components of the role that have been withheld or taken away, blocking nurses' ability to function effectively and leading to feeling "in the middle." The paradox of being "in the middle" is that it can co-exist with feeling "in the middle."

Significance of the Results

> Making the movement visible breaks the silence about it, challenges prevailing notions, and opens new possibilities for everyone (Scott, 1992, p. 23).

This research contributes to the feminist project of articulating women's perspectives - in this case, the perspectives of nurses. It helps us to understand women's roles and some of the differences and similarities that exist between individuals. The research tapped into nurses' collective consciousness as a source of data.

Interestingly, in addition to the twenty-four female participants, three males participated in this research. Their perspectives were equally important in this study because, like the women in the study, I assumed them to be speaking both as nurses and as products of their unique lived experiences. My feminism does not preclude me from considering all of the participants of my research as legitimate sources of knowledge. In fact, the hallmarks of feminist critique, collegiality, non-hierarchy, mutual dialogue, and a recognition that all consumers of knowledge have valuable insights, were underscored both in the design of the study and in the narratives of the study participants (DeMarco, Campbell & Wuest, 1993). In the words of Charles Taylor (1991)

> If men and women are equal, it is not because they are different, but because overriding the difference are some properties, common or complementary which are of value. They are beings capable of reason, or love, or memory, or dialogical recognition. To come together on a mutual recognition of difference - that is, of the equal value of different identities - requires that we share more than a belief in this principle; we have to share also some standards as equal. There must be some substantive agreement on value, or else the formal principle of equality will be empty and a sham. We can pay lip-service to equal recognition, but we won't really share an understanding of equality unless we share something more. Recognizing difference, like self-choosing, requires a horizon of significance, in this case a shared one (pp. 51-52).

One paradox of conducting qualitative research, identified by the postmodernists, is that everything changes, nothing changes and all experience is fleeting (DeJoseph, 1998). Neomodern feminism recognizes the transience of human experience as well, but finds human variability to be the key to understanding patterns of human behavior and allows for reconstruction and prediction at the level of mid-range theory. This research underscored the differences in perspective among the participants, while bringing those variations together into "reoccurring distinctions, theories and commonalties, and common clinical entities and issues" (Benner, et al.,1996, p. xiv). I systematically, critically and reflexively collected and analyzed the narratives of the participants, linking the empirical concepts known through the senses of the participants with the theoretical concepts that were known through thought.

This research also honors and acknowledges the affective dimensions of knowledge development. My neomodern feminist framework allowed me to attend first to "the voice of the lifeworld" (Mishler, 1984). It was the feelings and responses to the personal experiences of the participants that gave me insights about patterns of being and feeling "in the middle."

Contribution of this Research to Nursing - Implications for Nursing

> From the perspective of nursing, feminist critique inevitably becomes useful because it addresses humanistic nursing values and meanings that are at risk. These endangered values and meanings include focusing on the experiences of women from woman-identified perspectives (understanding women from their standpoint rather than from the world view of male culture), achieving power through the caring that results from intimate relationships with clients and each other, and accepting multiple ways of knowing as a legitimate basis for nursing practice (DeMarco, et al., 1993, p. 29).

This study contributed practice-based accounts about nurses and about two phenomena within clinical nursing - specifically being and feeling "in the middle" among twenty-six nurses working in hospital settings. These phenomena have been discussed at length in the literature, but there were competing meanings and no research focused on their dimensions and conceptualizations. This study addressed professional values and meanings, especially those related to caring for patients and to making the nursing process work. It sought knowledge about overlooked meanings by "examining unacknowledged assumptions and biases and by developing new ways to present inquiries that address the social contradictions found in lived experiences" (DeMarco, et al., 1993, p. 29). The study also recovered and examined unnoticed experiences of nursing practice in soliciting accounts of "what nurses know." I found being and feeling "in the middle" to be rich and complex phenomena.

Boykin and Schoenhofer (1991) suggest that story or narrative is a powerful method of organizing and communicating nursing knowledge "which assures groundedness in the ontology of nursing" (p. 245). Through the narratives of twenty-six nurses, this study helps us to understand phenomena that are embedded in practice, and whose dimensions were "taken for granted." It gives us a window into the everyday life world of nurses and the means to describe some of the realities of nursing in new ways.

In addition, this research addressed many of my questions about why the phenomena were being conceptualized differently among clinical nurses and nurse scholars. This research takes us towards understanding something that was not well articulated given the assumed nature of the phenomena and the inadequacy and impreciseness of the language. The words that have been used in the past to discuss these phenomena did not articulate the actual experiences.

Implications for Future Research

This study has been a modest attempt to describe and understand what nurses make of their roles, their positions, their power or lack thereof. One next step is to understand what patients, families, and other health care providers make of nurses' roles, perspectives, expertise and power, because they too are impacted by being and feeling "in the middle."

Other research must focus on the project of reconstruction of our knowledge about these subjects. We need to understand how nurses go from the role of being "in the middle" to the breakdown of that role. Do they go back and forth between the two, and if so, is it dependent on the situation, the expertise of the nurse, the systems within which she is working, or other factors that haven't been articulated yet? Assuming that feeling "in the middle" is episodic, does each episode result in an integration of that experience into the nurse's way of nursing? Does it strengthen it? Does it transform it? What more do we need to understand about the paradox of being "in the middle?" Clearly, these are questions for further research.

Other arenas for further research suggest themselves, as well. These include studying more diverse nursing populations to understand how ethnic, cultural and religious differences impact the role of being "in the middle"; studying nurses who work in environments other than hospitals such as home health, chronic and long term care, hospice and ambulatory care; examining how years of experience and expertise impact the role of being "in the middle"; exploring how the dimensions of the role are redefined, changed or shifted as individuals and groups mature in their expertise; and, studying what interventions are effective in supporting nurses in the performance of their roles.

Roberts (1996) exhorts us to be careful not to assume, however, that women share a common, essential identity as women (or nurses), that can be separated from other elements of their identity. Therefore, neomodern feminist research that incorporates the multiple identities of individuals and acknowledges the differences and similarities among people will continue to be relevant to nursing. Likewise, the feminist focus on patriarchal systems cannot ignore their interaction with other forms of oppression, and calls for research that focuses on the elements of the cultural ethos that impact nursing practices within hospital systems, public health systems, outpatient systems, and in public policy.

Of most interest to me is studying more about the consequences to nurses of feeling "in the middle" in professional practice. I believe that it is crucial to understand why nurses cannot carry out their roles, why those roles breakdown, and to understand what emotional, physical and professional prices they pay as a result. We cannot hope to carry forward the professional tradition of caring for patients without first caring for the caretakers. As a hospital administrator, I consider this to be one of my primary roles.

A question that must be answered both at the beginning and at the conclusion of a research project is, "Do we create meaning at all in our investigatory work if we do not consider the raising of our emancipatory potential?" (DeMarco, et al., 1993, p. 36). My answer is no, we do not create meaning without considering those important issues. Clearly, the experiences of being and feeling "in the middle" have consequences to the practices of the participants in this study, both positive and negative. Many of the participants of this study told stories of disenfranchisement and the impact of bias and oppression on self-esteem and professional engagement. I feel obligated to talk about those stories both in this dissertation and in other forums in order to raise awareness and to engage in dialogue about how to effect change. Clearly, denied recognition and acknowledgment of the role of nursing has led to oppression and feeling "in the middle" for many of the participants. Further research focusing on the disenfranchisement of nurses and the impact of bias and oppression is critical in uncovering, naming and addressing these problems. Such understanding informs leaders in making decisions aimed at supporting nursing staff in achieving their professional goals, and is another step away from oppression.

Limitations of This Research

Some of the limitations of this research are related to the inconclusive and unfinished nature of qualitative research. Since the research was limited to the participants and the researcher of this particular study, we can only know what those specific nurses had to say in answer to my questions on the particular day and under the particular circumstances in which they were interviewed. Each voice was different and was privileged, and therefore was the source of important knowledge. But there remain thousands of voices that were not heard.

Feminist research makes a powerful contribution in seeking to understand differences between people in order to know about what we have in common. However, while there were common stories and themes among the voices, there is no way to deduce how pervasive or common those themes are among other nurses, nor if there are important themes or issues that have been missed. My assumption is that there is much more to learn from nurses about this topic.

Another limitation of this research is related to the interpretation of human narrative. Qualitative research comes out of the laboratory and into real life situations which, by human nature, are each different from the next, and are either actively or passively observed, interpreted and understood by other human beings. The appropriateness and strength of interpretation depends heavily upon the insight, sensitivity, perspective, facility with both inductive and deductive reasoning, and the judgment of those doing the interviewing and interpreting. "Narrating personal experience can be done in many ways, but the listener may not 'hear' what is important to the narrator" (Riessman, 1987, p. 172). Likewise, the quality of the information conveyed by the informants is dependent upon their honesty, forthrightness, self-insight and ability to articulate. As I mentioned previously, the issue of truth in narrative inquiry is not whether participants are telling stories that are historically true. Instead, as a feminist, I am interested in whether the participant is reflexive, and is willing and able to convey what she wishes to convey about the subject.

The conduct of the interviews, the interaction between the participants and me, and my analysis of the data were all influenced by my personal reality as a white, middle-class, married woman who is a hospital administrator, long ago a clinical nurse, and a doctoral student. Other realities that no doubt colored my conduct as a researcher included working a full-time in a stressful job, often driving long distances after work to conduct interviews, sometimes conducting two or three interviews of forty-five to ninety minutes one right after the other, and not being as young as I used to be! But I also concluded that who I am as a person did not necessarily separate my from those who are different from me. It doesn't weaken the study that I was not the same ethnicity, sexual orientation, gender, religion or professional position as each of my participants - rather, those differences, like the differences among my participants, strengthened, expanded and enriched the study. But research that successfully recruits culturally and philosophically diverse participants is richer yet. One limitation of this research is shared by all research - an inability to be all-knowing, all-seeing, and all-understanding.

Another limitation of this research is that all the nurses self-selected into this study. Because participation was voluntary, it could be assumed that the participants were nurses who viewed the issue of being and feeling "in the middle" as important and relevant in nursing. We cannot assume that their views are commonly held. In general, those nurses who were referred to me by other participants were referred because the referent thought the potential participant would be interested in the study, that she had a story that she particularly wanted to be included in the research, or because, in the judgment of the referent, she was "a good nurse."

Likewise, if one of the goals of the research was to explore various conceptualizations of being and feeling "in the middle," we cannot completely understand the phenomenon by interviewing nurses only. As I mentioned in the previous section, it will be important to understand the perspectives of others who participate in caring for patients, of the patients themselves, and of others who are impacted by nursing care.

Last Thoughts

This research was more than research *about* nurses, it was research *for* nurses. I attempted to go beyond describing what nurses already know to give voice to knowledge they didn't know they had and to integrate their perceptions into new knowledge. My hope is that this collectivization of experience helps us to understand nurses and nursing in new ways, and gives us insights to effect change where it is needed. Certainly I agree with Allen, Allman and Powers (1991) who exhorted researchers to be vigilant in ensuring that feminist nursing research about women does not perpetuate problematic social categories that sort people into dichotomous groups by gender, race, sexual preference or any other category, but instead seek to understand the range of variability among humans in whatever subject is being studied.

> [The] dailiness of women's lives structures a different way of knowing and a different way of thinking. The process that comes from this way of knowing has to be at the center of a women's politics, and it has to be at the center of a women's scholarship....The point is to integrate ideas about love and healing, about balance and connection, about beauty and growing, into our everyday ways of being. We have to believe in the value of our own experiences and in the value of our ways of knowing, our ways of doing things. We have to wrap ourselves in these ways of knowing, to enact the daily ceremonies of life (Aptheker, 1989, p. 334).

As researchers whose conclusions are sometimes examined and taken to heart by those untrained in research, we must be mindful that research sometimes carries for them the "implicit promise that it can accommodate the richness and chaos of the world" (Smiley, 1999, p. 1). I make no such promises although the narratives of these participants were immensely rich and powerful. I do hope that I have fairly represented the findings of this study, given my audience food for thought, and honored the valuable and caring work of these nurses.

In the end, and in spite of the troubling aspects of their jobs, the participants of this study were committed to finding ways to carry out their professional roles. They had a real desire to do what was best for their patients and to make the best of the circumstances in which they found themselves. Many were also willing and able to make a difference in their working environments and in the lives of their patients. And they were aware of and grateful for the riches that came to them as professionals who touched the lives of many people. It has been such an honor to have worked with and been touched by these extraordinary and yet very ordinary professionals.

> I love this job. It's an honor to work with these people at a very vulnerable time of their life. You get to do the hands on stuff, the mental stuff with the chemo, a lot of teaching. You get to get involved with the family who are often just thirsty for knowledge. Or if they don't want to hear anything, you can just be there. Be nice. They really appreciate it. And I'd say, we are angels. If you can stick with this, it's very rewarding. And there's death. I've found that it's an honor to attend to somebody during their death. Because you, you really reflect on quality of life, and stopping and smelling the roses in this job. You realize that death is not a horrible thing, but it's just part of life. And we can be a good oncology nurse. In dealing with someone who's terminally ill and preparing to die, or you're packing them up to go home to die, its really a vulnerable, rich moment. It's a connect of emotions. I'd say that to her [a nurse new to the profession]. It's a blessing. It's a really nice, like giving birth, and helping women give birth. I think, what a job. And it's my experience, and I've actually said this to new nurses, you really feel the emotions. But in general, I really feel like I'm making a difference. And if somebody has to give these people chemo, and everyday there's more drugs that are making people live more healthfully and longer. And you see miracles not infrequently. It's very life affirming, whether they die or live. And when they come back and say, "Hi. Do you remember me?" And you recognize their voice, but the hair is grown back, and the skin looks healthy and the thrush is gone. It's really neat (Participant #002).

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Appendix 1

Conceptualizations of Being in the Middle

Author (chronological order)	Context	Terminology	Definition	Level of Analysis	Outcome	Future Actions
Jameton, A., 1977	Descriptive	Called "nurse in the middle problem"	Nurses assume many responsibilities but have little authority. Ideal moral behavior exists but cannot be implemented w/i the realities of the practice setting	Professional		
Youngner, S., Jackson, D., & Allen, M., 1979	Research - Study of physician and nurse attitudes re care of critically ill adults	In the middle" implied as differences in attitudes between physicians & nurses re ethical decision-making	Differences in attitudes between physicans and nurses re ethical decision-making - includes roles of communications, and emotional issues ties to ethical dilemmas	Professional		
Engelhardt, H.T., 1985	Descriptive	Called nurses as the "people in between"	Nurses are caught between the traditional authority of the physician, the rights of the patients, and the power of hospital administrators	Individual, professional, social	Team care, which is more important than individual or professional autonomy, should be the focus, and should recognize individual and professional competencies	
Watson, J., 1985	Descriptive	Called "standing between"	Nurses stand between the humanity of patients, and the potential destruction of humanity	Professional, social	Without nurses there is a danger of humanity not being preserved	
Fry, S.T., 1985	Descriptive-examination of ethical tension between obligation to benefit patient and obligation to benefit society	In the middle implied as resulting in ethical conflict, ethical tension	Being in the middle occurs with conflicting personal and professional obligations, and/or between professional ethic and prevailing ethic of public health	Individual, professional, social	Ethical tension	
Mayberry, M.A., 1986	Research - staff nurses, head nurses about levels of moral resoning using Kohlberg framework	Called "caught between"	In the middle implied as variance between values, obligations, practice requirements of the nurse, and those of pts/families; also, implied as lack of opportunity to participate in decision-making process; "caught between" defined as conflicting loyalties between MD, pt, family	Individual, professional	Inability to participate in principled reasoning; reasoned approach is hampered	
Yarling, R.R. & McElmurry, B.J., 1986	Descriptive - moral predicament of nurses because they are deprived of the free exercise of moral agency	In the middle implied as a moral situation of nurses; conflict;being deprived of free exercise of moral agency; nurses divided within themselves	Moral situation of nurses involves their commitment to the autonomy and well-being of the patient, responsibility to the hospital, their status vis a vis physician's power; conflict between obligations to both the patient and the hospital, nurses are divided within themselves when their moral instincts are repressed	Individual, professional, social (the responsible nursing ethic must be a social ethic)	Deprived of moral agency; deprived of freedom to act (versus freedom of will)	Emergence of strong sense of professional autonomy; shift in locus of accountability from the physican to the patient; development of social ethic
Wilkinson, J.M., 1987/88	Research - survey of staff nurses about moral distress and how it impacts quality of patient care	In the middle implied as internal/ external constraints to action; inability to act	Nurses are persons making moral decisions but not following through by performing moral behaviors, which leads to moral distress	Individual (psychological disequilibrium); professional (impact on quality of patient care)	Moral distress; impact on nurses' wholeness; impact on patient care	Effective coping behaviors
Bishop, A.H. & Scudder, J.R., 1987	Descriptive - response to Yarling/McElmurry model re focus of nursing ethics on autonomy and reform	Called the privileged in-between position of nurses	The privileged in-between position of nurses allows them to make moral contributions in the their everyday work as cooperative members of the health care team (all contributing from different perspectives); also, in-between involves deciding, or adding perspective, from that position (p.41).	Professional	Most professional, moral autonomy grows from within rather than from reform of bureaucracy; nurses have the authority and power that comes from control of the day-to-day care of the patient; exercising legitimate authority to foster the patient's well-being is part of the nursing role	Advocacy for communal decision-making; excellence in nursing practice from within an expending area of legitimate authority
Ketefian, S., 1987	Research - testing factors and relationships that might explain moral behavior among clinical nurses - Kohlberg model	Called the nurse in the middle problem	Nurse in the middle occurs when ideal moral behavior (as defined by the ANA Code for Nurses) might not be instituted in the realities of the practice setting.	Professional	Realistically likely moral behavior	
Huggins, E.A. & Scalzi, C.C., 1988	Descriptive-response to Ketefian model	In the middle implied as ethical problems framed in a context that is foreign to nurses	Nurses in the middle occurs as a result of an ethical base for nursing practice that is built on the ethic of justice, but where nurses' orientation is the ethic of care; this results in denial of the nurse's voice	Personal, professional	Nurses could feel lost, and helpless	Nursing, as a caring profession needs to rethink its ideas about what constitutes ethical practices, and then find the voice and strength to advocate for caring as an important value
Cooper, M.C., 1988	Descriptive - response to Yarling & McElmurry, and Bishop & Schudder models	In the middle implied as position of conflict	Nurse obligated by prima facie duty of fidelity to the patient - being in the middle occurs when internal or external forces threaten that duty	Personal, professional	The duty of fidelity helps guide the nurse in ethical decision making; the covenantal relation sets up conditions for the individual autonomy of the nurse in relation to the patient	Utilize the covenantal relationship model as a foundation for explicating an ethic that is grounded in and thereby reflects the singular experience of nursing.

Appendix 1

Conceptualizations of Being in the Middle

Author	Context	Terminology	Definition	Level of Analysis	Outcome	Future Outcomes
Stenberg, M.J., 1988	Descriptive - nurses and decisions about resuscitation	In the middle implied as moral dissonance,being torn by conflicting loyalties, the responsible powerless	Moral dissonance is the compromise of the nurse's care obligations and her personal values;the nurse being torn by conflicting loyalties includes loyalties to the patient and the physician, the responsible powerless is a position of responding to patients' needs without being involved in pt. decision-making	Personal, professional	Nurses feel powerless, unable to advocate for patients, and limited in their nursing role	Encourage nurses to expand their humane presence at the bedside to include issues of ethical substances; recognize that both physicians and nurses are in caring professions; nurses should participate on ethics committees, and other multidisciplinary committees
Johnstone, M.J., 1988	Descriptive - conflict of law, professional ethics, and personal values, and when nurse might refuse an order or refuse to care for a patient	In the middle implied as being asked to violate one's reasoned judgement, doing the "dirty work"	Being in the middle is implied as having little avenue for officially refusing to carry out lawful orders without threat of losing one's job even when the order is ethically contentious or morally objectionable	Personal, professiona, social (as spelled out in public policy and the law)l	It is intolerable that nurses are expected to obey doctors' orders on one hand, and yet are held independently accountable on the other	Draw a distinction between nurses' obligations and duties; establish criteria for 'just refusals', and uphold the view that compelling persons to act against their reasoned moral judgement carries the probability of causing intolerable moral consequences.
Zorb, S.L. & Stevens, J.B., 1990	Descriptive - contemporary bioethical issues in critical care using principle-based framework	Called caught in the middle	Being caught in the middle occurs when the nurse perceives that the physician is not pursuing treatment that is in the best interests of the patient or according to the wishes of the family	Professional	The nurse's role is to make sure that the patient's wishes and values are articulated; nurses bear the burden of resolving disputes among colleagues which otherwise impact the ICU climate and pt. care; caught in the middle is the result of a power differential between doctors and everyone else	Nurses should be involved in ethics committees, ethics rounds, and network both inside and outside the institution to gain broader perspective in dealing with ethical dilemmas
Hutchinson, S.A., 1990	Research (interviews/ participant-observer) - rule bending among hospital nurses	Being in the middle implied as conflicts between systems and/or people	Conflicts between systems and/or people prevent the nurse from doing what she believes is best for the patient	Professional	Responsible subversion, or rule-bending occurs in response to conflict/being in the middle; it is an option utilized by nurses with knowledge, ideology and experience; the other outcome of such conflict is moral distress	Further research to quantify how rule-bending occurs in the context of ambiguity, conflict, and frustration ; research should focus on consequences to patients, nurses and the system; a discussion of ethical and legal implications needs to occur
Pike, A.W., 1991	Descriptive - a model for nurse/ physician collaboration in the acute care setting	Being in the middle implied as constraints to moral action	One is in the middle when there are constraints to moral action which result in moral outrage	Personal, professional	Moral outrage results in frustration, anger, and powerlessness	A model of nurse-physician collaboration was presented which suggests a shift away from the stance of victimization to a posture of accountability by nurses
Broom, C., 1991	Descriptive - strategies for resolution of ethical conflict in critical care	Being in the middle implied as ethical conflict	Ethical conflict occurs when nurses and others involved in the patient situation have incompatible clinical goals	Personal, professional, social	Conflicts, both internal and external, evolve from ethical dilemmas due to differences in how nurses, physicians, administrators, and patients/ families assign priorities or interpret roles and responsibilities	To resolve these conflicts, the nurse must recognize how personal values affect decision-making, and work with others to develop an integrative approach to patient care; provide community education; participate in public policy formation.
Erlen, J.A., & Frost, B., 1991	Research - content analysis of interviews about nurses' perceptions of powerlessness in influencing ethical decisions	Called caught in the middle; feeling trapped; powerlessness	Caught in the middle is equated with powerlessness in interactions with others in ethical situations; ineffectiveness in exerting influence on the resolution of a dilemma	Personal, professional, social	Nurses unable to use expert, legitimate or coercive power to resolve identified ethical dilemmas; nurses did not see themselves as active participants in policy formation or in a position to influence decisions; possible role confusion	Need to study the differences in the perceptions of roles in ethical decision making between nurses and physicians, and to determine what other variables are related to the nurse's role
Soderberg, A., & Norberg, A., 1993	Research - Swedish study; phenomenoigical analysis of interviews of nurses and physicians about ethically difficult situations	Being in the middle implied as lacking influence	Nurses and physicians both see themselves as lacking in influence in ethically difficult care situations	Personal, (from the relationship ethics perspective) professional (from the action ethics perspective)	Lack of influence resulted in the patient getting "too much treatment", as well as "meaningless treatment"; professionals struggled with how to do the right and good thing	Learn to make personal values explicit and open to reflection and discussion; disclose more aspects of problematic situations, improve ability to perceive the complex patterns of care episodes
Astrom, G., Jansson, L., Norberg, A., & Hallberg, I.R., 1993	Research - Swedish study; phenomenological analysis of interviews of oncology nurses about ethically difficult situations	Called the in-between position	The in-between position dwells in the domain of ethical "situations possible to grasp" (as opposed to "overwhelming situations"), where the nurse's input was given but not followed .	Professional	Nurses experience the dynamic of loneliness, probably meaning "being alone in one's perspective", or having her input discounted; also can occur when distanced from leadership and not feeling supported.	More research to understand nurses' experiences, support of caregivers as part of a team in ethically difficult care situations

Appendix 2

COMMITTEE ON HUMAN RESEARCH
OFFICE OF RESEARCH AFFAIRS, Box 0962
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
http://www.ucsf.edu/ora

CHR APPROVAL LETTER

TO: Afaf I. Meleis, Ph.D.
Box 0608

Nicki Edwards, M.S.N.
S/N - Doctoral Lounge

RE: Registry Nurses "In the Middle" of Ethical Situations - A Feminist Narrative Analysis of Betweeness in Nursing Practice

The Committee on Human Research (CHR), the UCSF Institutional Review Board (IRB) holding Department of Health and Human Services Multiple Project Assurance #M-1169, has reviewed and approved this application to involve humans as research subjects. This included a review of all documents attached to the original copy of this letter.

APPROVAL NUMBER: H879-15857-01. This number is a UCSF CHR number and should be used on all correspondence, consent forms and patient charts as appropriate.

APPROVAL DATE: January 21, 1999. **Expedited Review**

EXPIRATION DATE: January 21, 2000. If the project is to continue, it must be renewed *by the expiration date*. See reverse side for details.

ADVERSE EVENT REPORTING: All problems having to do with subject safety must be reported to the CHR within ten working days. All deaths, whether or not they are directly related to study procedures, must be reported. Please review Appendix A of the CHR *Guidelines* for additional examples of adverse events or incidents which must be reported.

MODIFICATIONS: Prior CHR approval is required before implementing any changes in the consent documents or any changes in the protocol which affect subjects.

QUESTIONS: Please contact the office of the Committee on Human Research at (415) 476-1814 or campus mail stop, Box 0962, or by electronic mail at chr@itsa.ucsf.edu.

Sincerely,

Arthur Ablin

Arthur R. Ablin, M.D.
Chairman
Committee on Human Research

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
COMMITTEE ON HUMAN RESEARCH
APPLICATION COVER PAGE

Principal Investigator (Must be eligible faculty member):

Name and degree	University Title	Department	School:
Afaf Meleis, PhD	**Professor**	**Community Health**	**Nursing**

Campus Mailing Address	Phone Number	E-mail Address
Box 0608	**476-1775**	**nursing%afaf_meleis@ccmail.ucsf.edu**

Co-Principal Investigator:

Name and degree	University Title	Department	School:
Nicki Edwards, PhD (c)	**student**	**Community Health**	**Nursing**

Campus Mailing Address	Phone Number	E-mail Address
608 Sycamore Ave., Modesto, CA 95354	**(209) 239-8365**	**nicki.edwards@tenethealth.com**

Send correspondence to (check only one): ☐ PI only ☒ PI and Co-PI ☐ PI and person identified below:

Name	University Title	Department

Campus Mailing Address	Phone Number	E-mail Address

Study Title (may not exceed 300 characters):

Registered Nurses "In the Middle" of Ethical Situations - A Feminist Narrative Analysis of Betweeness in Nursing Practice

Application Type:

☐ New Full Committee Application

☒ New Subcommittee Application

Expedited Review Category #: ~~2~~ 11

☐ Modification ☐ Renewal

Current CHR #: ____

Expiration date: ____

Other Investigators:

Name and Degree/Department/Site

Site(s) (check all that apply):

☒ Parnassus ☐ SFGH ☐ VAMC

☐ Mt. Zion ☐ Foreign Country* ☐ Other*

*Name site: ____

Special Subject Populations (check all that apply):

☐ Minors (i.e., under 18 years of age) ☐ Those Unable to Speak or Read English ☐ Fetuses, Pregnant Women

☐ Individuals with HIV Infection ☐ Those Unable to Consent for Themselves ☐ Prisoners

How many subjects will be enrolled here? 30

Will subjects be paid? ☐ Yes ☒ No

Study Procedures:

Check below if research involves:

☐ Genetic Testing ☐ HIV Testing

☐ Tissue Banking ☐ Gene Therapy

List the other *main* procedures:

Drugs and Devices:

Investigational drugs/devices (and IND/IDE No. from FDA):

Is a Non-Significant Risk (NSR) determination requested for any devices? ☐ Yes ☐ No

Approved drugs/devices:

Funding (complete all sections even if funding is pending):

Will study be funded?

☐ Yes ☐ Pending ☒ No

If not, how will study costs be managed? **minimal costs - to be assumed by co-principal investigator**

Name of Administering Dept./ORU: ____

Funding award will be made to:

☐ UCSF ☐ Gallo ☐ Gladstone

☐ NCIRE ☐ Other: ____

Name of sponsor: ____

Award No. (if known): ____

Sponsor is:

☐ Federal Gov. ☐ Other Gov.

☐ Pharmaceutical/Device Co. ☐ Other Private

☐ Campus/UC-Wide Program ☐ Dept. Funds

Other Approvals:

Does research require review by:

☐ Biosafety Committee If so, BSC approval #: ____

☐ Radiation Safety Committee If so, RSC approval #: ____

Principal Investigator's Signature:

Signature

Date

Nov. 17, 9

1. Study Aim, Background, and Design

The phenomenon of being "in the middle" and its impact on nurses and nursing practice, especially within the domain of nursing ethics, is the focus of this dissertation research. The phenomenon has been described both by researchers and by clinical nurses using a variety of definitions and assumptions, but it has not been specifically researched. This study is meant to explore how nurses define and respond to being "in the middle" in their daily work, and to determine whether it has impact on the delivery of effective nursing care.

The research is meant to clarify the concept by eliciting narrative descriptions by nurses in individual and group interviews. Registered nurses working with adult patients in acute hospital settings will be recruited for this study. The data will be evaluated using a feminist,narrative analysis.

2. Subject Population

The subject population will be registered nurses working as staff nurses with adult patients in the acute care setting at UCSF Medical Center. This population was chosen because it is assumed that these nurses experience ethical situations in their clinical practice. and that they may be able to provide insight about this subject. Thirty participants will be interviewed. either individually or in groups of up to five people per group, utilizing open-ended questions about being "in the middle" in clinical situations. Inclusion criteria will be registered nurses who volunteer to participate. are able to consent. and practice in an acute hospital setting. There are no other inclusion criteria. No special subject populations will be utilized.

I have received permission from the appropriate nurse managers to recruit participants by distributing flyers within the hospital (Appendix A). and by discussing my research at their staff meetings. Group participants will be recruited among nurses who work together and who know each other.

3. Procedures to be Done for Purposes of the Study

After IRB approval is obtained, recruitment of the subjects will proceed. Those who volunteer will be consented (Appendix B) after which an interview, approximately one hour in length, will be conducted with the individual participant and with each group. A semi-structured interview technique will be utilized. The goal will be to explore the informant's clinical experiences of being "in the middle." (Appendix C).

Each interview will be arranged for a time and place that is convenient for the participant. The interviews will be tape recorded, and transcribed verbatim by the researchers. Both the tapes and the transcripts will then be stored in a locked cabinet accessible only to the researcher and her faculty. All identifying information will be removed from the transcript, at which time the short portions of the transcript may be used for teaching purposes. The signed consent forms will be stored separately from the tapes and transcripts.

The researcher will collect demographic data from each participant after the interview (Appendix D). The demographic information will be used to describe the sample.

4. Risks to Subjects, and Methods of Minimizing These Risks

One risk to the subjects is that there may be a loss some privacy because the subjects' words may be used in reporting the outcomes of the research. However. identifying material will be removed to eliminate the ability to tie the word back to a particular person. and no one but the researchers will be able to link any identifying data to the person. Loss of privacy will occur between the group members, but they will be informed that each member may autonomously choose to decline to disclose information and/or discontinue participation in the group without repercussions. All of the above will be explained to each subject before obtaining consent

A second risk to the subjects is the possibility that the nature of the interview may bring up painful or uncomfortable issues. Each subject will be informed that he/she may decline to answer any question, and may terminate the interview at any time without repercussions. In addition, the researcher will refer the subject to appropriate counseling services, if necessary.

5. Benefits: Direct Benefits to Subjects and General Benefits to Subject Group, Science and/or Society

There will be no direct benefits to the participants. The profession and science of nursing will potentially benefit from this study by advancing knowledge regarding the phenomenon of being "in the middle" in clinical situations.

6. Consent Process and Documentation

Each subject will be asked by the co-principal investigator to participate in a way that gives them as much information as they need to make a decision. The content of the consent form will be discussed, and they will be informed that they will be tape recorded (Appendix B). Written consent will be obtained from, and a copy of the consent provided to each subject. The signed consent form will be stored in a locked cabinet and separate from the tapes and transcripts. Once the tapes are transcribed and the transcription verified. the tapes will be destroyed.

7. Qualifications of the Investigators

Afaf Meleis, RN, PhD, is the principal investigator is an Professor in the Department of Community Health Nursing. She has conducted many qualitative studies, and is the co-principal investigator's advisor and dissertation chair.

Nicki Edwards. RN, PhD(c), Co-Principal Investigator, is a doctoral candidate at UCSF School of Nursing. She has conducted two qualitative studies previously, completed six units in a research residency at UCSF School of Nursing, Midlife Women's Health Study, and six units in UCSF's qualitative methods course (N285).

University of California, San Francisco
Consent to Participate in a Research Study

Project Title: Registered Nurses "In the Middle" in Clinical Practice

Purpose:
Nicki Edwards, RN, MSN, and Afaf Meleis, RN, PhD of the School of Nursing are conducting a study to explore how registered nurses define and experience being "in the middle" of ethical situations. They are asking me to participate in this research because I am a registered nurse who works with hospitalized patients.

Procedures:
If I agree to participate in the study, I will talk to Nicki for about one to one and a half hours in a comfortable, private place such as my own home, a quiet hospital conference room, or some other agreeable place. The interview will occur during non-work hours. The conversation will be tape-recorded, if I agree. A second interview may be arranged a few weeks later, if we both agree.

Risks/Discomforts:
Participation in the study may involve a loss of some privacy, but several precautions will be taken to avoid this. For example, the tapes will be transcribed to written form, and both the tapes and the transcriptions will be stored in a locked cabinet at all times. Only code numbers will be used to identify the tapes and the transcriptions, and my name will not be marked on any of the data. Only Nicki Edwards and her supervisor, Dr. Meleis, will have access to the data. My name will never be attached to any stories or quotations in any publications or presentations. My confidentiality will be protected as far as possible.

Talking about my experiences may be difficult or unpleasant. However, I am free to talk only about those aspects of my clinical ethical experiences that interest me. Also, I am free to decline to answer any question or to discontinue the interview at any time.

If I am injured as a result of being in this study, treatment will be available. If I am eligible for veteran's benefits, the costs of such treatment will be covered by the Department of Veterans Affairs or the University of California, depending on a number of factors. The Department of Veterans Affairs and the University do not normally provide any other form of compensation for injury. For further information about this, I may call the VA District Counsel at (415) 750-2288 or the office of the UCSF Committee on Human Research at (415) 476-1814.

Benefits:
There are no direct personal benefits to me. However, some registered nurses report that they find it helpful to talk about their experiences in ethical situations because it helps them clarify ideas or to see things in a different way. Also, the information I provide may help other nursing professionals better understand the experiences of clinical nurses in complex ethical situations.

Costs/Reimbursement:
There will be no costs to me for being in the study. There is no reimbursement for my participation in the study.

Questions:
I have talked with Nicki Edwards about this study and have had my questions answered. If I have any further questions about the study, I may contact either of the researchers:

Researcher: Nicki Edwards, RN, PhD(c), Doctoral Candidate
Department of Community Health Nursing
School of Nursing
UCSF, San Francisco, CA 94143-0843
Home Telephone (209) 521-8316

Supervisor: Afaf Meleis, RN, PhD, Professor
Department of Community Health Nursing
Box 0608
UCSF
San Francisco, CA 94143-0843
Telephone (415) 476-1775

If I have any comments or concerns about participation in this study, I should first talk with one of the researchers. If, for some reason I do not wish to do this, I may contact the Committee on Human Research, which is concerned with the protection of volunteers in research projects. I may reach the committee office between 8:00 AM and 5:00 PM, Monday through Friday, by calling (415) 476-1814, or by writing to The Committee on Human Research, Box 0616, University of California, San Francisco, California 94143.

Consent:
I will be given a copy of this consent form to keep.

Participation in research is voluntary. I am free to decline to be in this study, and I may refuse to answer any questions at any time. I may stop the interview at any time as well, without affecting my employment in any way.

Date____________________ Signature of Subject______________________________

Date____________________ Signature of Researcher
Obtaining Consent ______________________________

My address (only if I wish to receive a copy of the final report of the research):

____

Nurses! Do You Feel "In the Middle"?

Registered Nurses Needed for Ethics Research Project

- Doctoral student is studying nurses' experiences of being "in the middle" of ethical situations in their clinical practice.
- Research is aimed at understanding the role bedside nurses play and the experiences they have had in dealing with ethical situations.
- Interested in the views and comments of registered nurses working at the bedside in acute care.
- Legally sensitive issues will be kept confidential unless disclosure is mandated by law.
- Research involves approximately one hour, taped interview, and a short questionnaire conducted on off-duty time.

If you are interested in participating, please call Nicki Edwards, RN, PhD(c), at (209) 239-8365 during the day, or (209) 521-8316 in the evening, or by e-mail, nicki.edwards@tenethealth.com

Interview Questions

The following are examples of leading questions that may be used in this research:

1. Tell me about some of your clinical experiences in which you have felt really conflicted;

2. Tell me about some of your clinical experiences in which you have felt torn, confused, pressured or pulled in several directions;

3. Tell me about some of your clinical moral experiences in which you felt particularly effective in your role as a nurse;

4. Tell me about some of your clinical experiences in which you felt your perspective on the situation was helpful in its resolution;

5. Tell me about a situation in which you felt your duty to your patient influenced your actions in an ethical situation.

Demographic Questions

1. What is your gender _______________

2. What is your age__________________

3. What is your race/ethnicity___________

4. What is your marital status ___________

5. How many years have you been a registered nurse________________

6. What is your highest degree in nursing__________________________

7. How many shifts do you work in a pay period____________________

8. What shift do you work? (8 hour shifts, 12 hours shifts?)_____________

9 What was your childhood religious/spiritual affiliation________________

10. What is your current religious/spritual affiliation_____________________

11. Have you ever taken an ethics or philosophy class in school or as continuing education? If yes, please describe____

    ____

12. Have you ever participated on any type of ethics board or ethics committee? If yes, please describe____

13. When you experience an ethical dilemma at work, who do you go to for support and/or guidance?____