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EXPERTISE, FORMALISM, AND CHANGE IN AMERICAN NURSING PRACTICE: A CASE STUDY

by

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by

Deborah R. Gordon

To Dr. Elizabeth Colson

PREFACE

Anthropological studies often create the illusion that groups are unchanging (Colson 1983). For better or worse, such an illusion could not be sustained in this research. In a matter of months, the concerns of people on the hospital units I studied shifted from the problems of nursing turnover, one focus of this study, to the problems of keeping the staff employed. A dearth of patients, created in part by policy changes in medical insurance coverage, threatened closure of one of the units.

Further, the new program of nursing I will describe, both as it was intended by its creators and as I observed it in practice, is quickly becoming history. Beginning with the arrival of a new Director of Nursing in 1980, incremental changes in the program have gradually chipped away at its initial design such that in many ways it is becoming a thing of the past.

Despite these changes, the processes I describe here-- nurses' discourse and practices around knowledge and the implications of formalism and science for nursing practice in an institutional setting-- are more pervasive and permanent than the shifting rates of nursing turnover or the lifespans of new models of nursing.

This study began through my work as an anthropologist on the AMICAE Project (A Mechanism for Intraprofessional Consensus, Assessment and Evaluation), a nursing research project directed by Patricia Benner, a nurse/academician (see Benner 1984 for a comprehensive presentation of

this study). In this study of the skills expected of new graduate nurses, Benner posed two major questions: 1) what do nurses do that make a difference for patients?; and 2) what does experience teach?; what is the transition from the novice to the experienced nurse? These research questions and the theoretical framework from which they derived (Dreyfus 1979; Dreyfus and Dreyfus, in press; S. Dreyfus 1982; Heidegger 1962; Polanyi 1958; Kuhn 1970; Taylor 1971) became the organizing framework for my own study and analysis as I came to address them on the social and cultural level.

We pursued this research in several hospitals between 1979 and 1981 through interviews with groups of four to six nurses who had been identified as "experts" by our research contacts. Nurses were asked to present in narrative form "critical incidents" from their practice in which they felt their intervention made a significant difference (see Appendix A for protocol). These incidents were recorded, transcribed and interpreted in terms of the competencies or skills involved in them, using an hermeneutic framework of interpretation drawn from Taylor (1971), Heidegger (1962), Rabinow and Sullivan (1979), in addition to that of Glaser and Strauss (1967).

The second research focus was on the differences between novice and expert performances. In this we worked with Hubert and Stuart Dreyfus whose Dreyfus Model of Skill Acquisition (see S. Dreyfus 1982, and Dreyfus and Dreyfus, in press, for summary statement) posits a progression of five stages from "novice" to "expert" practice. We used this model as an interpretive framework to describe levels of skill among nurses as found in data collected from interviews and observations of nurses with varying degrees of experience and skill. In particular we compared pairs of nurse preceptors (clinical teachers) and new graduate

nurses and sought to describe the transitions in performance that nurses progress through in the development of their clinical practice.

It was in the context of this nursing research project that this study began. Armed with these two research questions and the theory from which they grew and over which I had but a tenuous and sceptical hold, I began my research.

ACKNOWLEDGEMENTS

To the nurses who so openly and warmly withstood my persistent presence and questioning, who taught me what nursing can be, and who made this research a pleasure to do.

To Patricia Benner, whose insight, commitment, intellect, and humor made it a blessing to work with her, who opened me to the richness of nursing, and who taught me that there need not be a conflict between theoretical and applied research.

To Dr. Elizabeth Colson, who helped open and sustain my commitment to anthropology through her challenging teaching, who inspired a love of learning and an excellence of understanding, and who shaped this book and graciously and generously helped me finish it.

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ABSTRACT

EXPERTISE, FORMALISM, AND CHANGE:
IN AMERICAN NURSING PRACTICE :A CASE STUDY

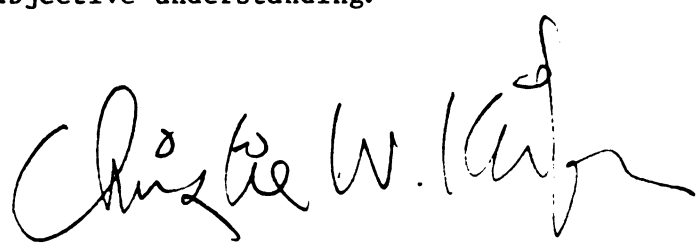
By

Deborah R. Gordon

This study explores nursing's changing definitions of ideal nursing expertise and practice. It is based on a two-year case study of registered nurses on two adjacent general surgical units in a teaching hospital of a metropolitan city in the United States. Several things stood out on these units. First was the high rate of turnover among nurses. This resulted in a relatively inexperienced nursing staff, with which the units seemed to be actively and effectively coping. Second, one found a strong and explicit commitment to practicing "professional nursing," epitomized by nurses taking nursing histories, writing care plans, teaching patients, doing discharge planning, problem-solving for both "psycho-social" and physical problems, thinking and acting independently, and evaluating each other in peer review. Emphasis was on implementing a "scientific" approach to nursing practice, i.e., one that was systematic and rational, and on theoretical in addition to practical knowledge. Historical exploration revealed that these practices and vision of "professional nursing" had been recently implemented in this hospital, beginning in the 1970s in what I am calling here "The Clinical Program."

The third notable thing on these units was the prominence of formalism and formal models (formal models as explicit, written statements composed of elements that have been selected out of a larger context and reordered into a new whole), used both in patient care and in teaching and evaluating nurses.

This study explores the relationship between these three findings. It analyzes the strong emphasis on science and formalism: a) in terms of nursing's bid for legitimacy, improved patient care, and liberation from medicine and its own traditional roles; and b) in terms of change and inexperience, drawing on the Dreyfus Model of Skill Acquisition and Benner's application of it to nursing. For one found a mutual reinforcement between the inexperience of the profession in institutionalizing professional behaviors and the inexperience of the individual nurses who arrived on the units with minimal practical experience. This two-fold inexperience, resulting in an absence of a background of shared, implicit culture, partially explains the strong reliance on formalism. Formal models and practices provide an explicit foreground which compensates for the lack of practical knowledge, cultural consensus, and dense intersubjective understanding.



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CHAPTER ONE: INTRODUCTION

This book will explore the following questions:

Has nursing, in its bid for improved patient care, professional recognition, and greater autonomy, pursued legitimacy and authority by emulating qualities of male physicians and by eclipsing some traditional "feminine" nursing attributes from official sight, attributes that patients may in fact need most?

Has nursing, in its effort to cope with nursing turnover and to become more scientific, professional, accountable and recognized, relied on formalism to such an extent that "quality care" sometimes becomes equated with the documentation and representation of that care more than the actual care itself?

Has nursing, in the face of nursing turnover, "a nurse is a nurse" approach in hospitals, and the belief in formalism and the pursuit of theoretical knowledge, arrived at a shrunken notion of expertise, such that competent practice is sometimes defined as expertise?

Finally, has nursing, in its search for recognition, authority, and autonomy, turned inward to create its own reference group and community where these qualities can be taught and practiced?; and if so, with what implications?

These are some of the questions this book will raise and explore in the context of a case study of nursing practice on two general surgical units. I will focus on nurses' discourse and practices about and around knowledge, their definitions of expertise, and how formalism both fosters and limits development in nursing practice in a context of

social and cultural change. The study is based on observations and interviews conducted primarily in a large hospital in the Western United States that was characterized by rapid nursing turnover. The turnover resulted in a steady influx of new and inexperienced nurses who needed to learn quickly but safely the complicated role of nurse. Formal models became an important vehicle not only for teaching and evaluating new nurses but for defining optimal nursing care. This formalism, as I will argue, was indeed best suited to the needs of nurses at the beginning stages of expertise. It was less suited for developing, recognizing and rewarding higher levels of expertise. The latter are characterized by traits and processes in opposition to formalism and to a traditional view of knowledge embodied by science.

Evolution of the Study

This study progressed through several questions, methods and theoretical frameworks. It began, as described in the Preface, in the context of the AMICAE Project (Benner 1984). The theoretical framework of that project-- the Dreyfus Model of Skill Acquisition-- is the most prominent of this study. The Dreyfuses (S. Dreyfus 1982; Dreyfus and Dreyfus, in press) describe five stages in the development of practical skill, which they call Novice, Advanced Beginner, Competence, Proficiency, and Expertise (this will be presented and applied in Chapter Seven). Contrary to current academic understanding, the Dreyfuses argue that formal models and analytic reasoning is most representative of the early stages of skill acquisition where a backlog of experience is absent. Expertise, on the other hand, is characterized more by an intuitive rather than an analytic response to a situation and a reliance on past concrete experiences rather than formal rules. Theirs

work points to the functions and limits of formalism in a practice setting.

This study began with the goal of exploring the limits of formal descriptions of nursing practice. By carefully observing and describing full episodes of nurses in practice, I hoped to describe important dimensions of nursing that were excluded from formal nursing language and evaluation (see Benner 1984 for an example of this approach). This remains one theme in this work, although the in-depth descriptions of observed nursing practice are not here included (Gordon 1980).

I began research by following two "expert" nurses from one of our study groups back to their respective units for in-depth observations that formed the basis of case studies (Gordon 1980). Selection was made in part on the basis of the nurses' willingness to be studied closely and their interest in the project. Diane and Elizabeth, as I am calling them, endured my observations and questions for approximately one month each. They worked on the same floor on adjacent units. Both specialized in general surgery. As I was essentially an anthropologist in search of a community to study and as the nurse leaders and staff on the two units were very open to being studied, I selected them as the context of my study. My focus at the time, however, was predominantly on the nurse/patient relationship and less on the cultural and social context of the units.

My first clue that anything was unusual about these units came when Diane, a young and energetic woman, grumbled one day about being the "old lady" on the unit-- the oldest R.N. working at the time. When I learned that her ripe old age was 33 years I was surprised. When I learned that she was also one of the most veteran nurses on the unit,

having been there a total of one and a half years, my bewilderment grew. My interest in nursing turnover, however, was only beginning. Two weeks after I began observations, Diane announced she was leaving the unit and moving to another city. Weekends, days, and often nights thus became dedicated to catching a last glimpse of this excellent nurse at work in this particular setting. With Diane at last down on paper and tape, I turned my attention to nurse # 2, Elizabeth, a nurse with the unusual distinction of having been at the same job for six years. But now she too decided to leave hospital nursing. Once again, I rushed to capture her behaviors with patients and staff in writing before her hospital nursing turned into history. It was thus harshly that my interest in nursing turnover began. Rather than be its victim, I decided to study it.

Turnover, I had known, was not a new problem. Volumes of articles, queries and studies attested to that (see for example, Price and Mueller 1981; White 1980; Wolf 1981; Span 1981; Wandelt et al, 1981). In fact, as I was to discover, turnover was a fact of life in nursing; and institutions, nurses and people working with nurses seemed to have adjusted to it. As many of the reasons, but not the cures, for nursing turnover were known, I decided against further exploration into the causes of nursing turnover. Rather, what struck me was how well and naturally these units functioned despite the turnover, how they took it for granted. Walking down the hall one day, for example, I passed a nurse I did not recognize. "Is she new," I asked the nurse I was shadowing at the time. "No," she replied, "she's been here a couple of months."

I thus decided to focus on how the units coped with turnover and how, despite so much turnover, they functioned relatively smoothly. Had

turnover become a part of the culture and social structure of the units? Was adaptation to turnover in fact perpetuating turnover? At one point in this questioning I surmised that nursing turnover had become institutionalized in the hospital, that it had become the norm and that hospitals and the nursing social structure and culture were well prepared for it (Gordon 1981). This hypothesis was to be strongly refuted in the near future.

Given the centrifugal force of nursing turnover, I wondered what kept these units together. Part of the answer, I observed, lay in the nurses' commitment to an ideology and model of quality nursing that the units sought to operationalize, what I am calling here the Clinical Program of Nursing. The units prided themselves on putting the ideals of professional nursing into practice. They stressed nursing care plans, peer review, a clinical ladder and a constellation of qualities that coalesced around the term "professional nurse." In tracing this model back historically, I discovered it had been pioneered at the hospital in the early 1970s, in a project generally referred to as the Clinical Program, and was implemented in the late 1970s. In fact, the units I studied had been relatively stable prior to this time and it was primarily with the implementation of the Clinical Program that nursing turnover began. The units were still recovering when I entered.

The Clinical Program and the ideology behind it embodied a particular vision of nursing practice. In exploring this vision my framework is of the nursing role as composed of traditions particular to nursing, to health care, and to the society and subgroups in that society (such as women) in general. This approach has a long and solid history in the study of nursing (see for example Parsons and Fox 1952;

Devereaux and Weiter 1950; Hughes, et al 1958; Mauksch 1966; Stein 1967; Nahm 1965; Shulman 1958; Bullough and Bullough 1969).

In other words, health care roles are made of societal stuff. More specifically, nursing has long been and continues to be dominated by the fact that it is a female occupation and intimately tied to the role of women in this society. Not surprisingly, then, changes in the role of women and expectations for women in the society at large are echoed by demands for changes in nursing.

The Clinical Program and the ideology behind it relied on formalism of many different types to achieve that vision. Formal models and formalism were a prevalent dimension of the life of the units I came to study. Using a simple functional framework I analyzed their functions and limitations from a number of perspectives, such as those of the unit, of nursing in general, and of nurses at different levels of skill.

While the hospital was prepared for nursing turnover, neither the hospital nor the units nor I were prepared for the sudden changes that took place between August 1982 and February 1983. The summer of 1982 was the one in several years in which no nurse left Unit A. State financing of hospitals was changing, the economy slowed even more, and even acute hospital nursing, which had been relatively immune to the slow economy and unemployment, began to show the effects. From needing to recruit nurses as it did six months prior, the hospital suddenly faced the possibility of closing units and laying off nurses. One of the units in this study almost closed at the beginning of 1983 and eventually changed specialities. The drastic change is reflected in the fact that nursing turnover is not the central theme of what I shall describe here.

This research progressed, then, through several major questions: how did a formal description of nursing practice differ from a

phenomenological/anthropological one?; how had the units adapted to nursing turnover?; what kept the units together given the extent of nursing turnover?; what were, in fact, the ideal qualities nurses in this setting wished to establish as normative in nursing practice?; and what role did formal models play in that vision, in operationalizing it, and in nursing turnover? These questions are integrated through my focus on nurses' standards and practices about knowledge-- their definitions of nursing expertise-- from where these derived, and the role of formalism as both an ideal and a means for achieving those aims. These foci, however, are in the context of nursing turnover.

In sum, three theoretical frameworks guided this study. Two of these are common in anthropology. The first considers the role of nurse part of a larger social and cultural fabric, that is, as constructed of traditions deriving not only from nursing's past but also from specific subcultures and from the society at large. The second framework used is functionalism, in that I will analyze the practices that nursing adopted in terms of the possibilities they allowed and the limitations they held for various social groups. The third theoretical framework derives from Hubert and Stuart Dreyfus, whose model of skill acquisition I will consider on a social and cultural level (Chapter Seven).

Methods

My data derive from several sources. Most importantly, they are based on my participation and observation on two general surgical units in one hospital over a two year period, intensely from January to December 1981, sporadically from June to December 1980 and from January to November 1982. The baseline is 1981 unless otherwise indicated.

Initially my research consisted primarily of shadowing nurses (n=35) in their work with patients. As my focus expanded to include nursing turnover, the units' lives became more of a focus. I attended meetings of all types on and off the units on a regular basis. These included classes for new graduate nurses, nurse evaluations, Peer Reviews, leadership meetings, staff meetings, hiring interviews and nursing reports. In only a few instances was I prohibited from observing, although the most questionable situations for a few nurses was my attendence at particularly carefree social occasions. As there were many departure parties for nurses leaving and as the unit personnel socialized often off the units, I went to many of these occasions. Further, I interviewed, either formally or informally, over half of the nurses who worked on the units during the two year period of study (n=40). Nearly all of the formal interviews were tape recorded and transcribed. The interviews explored some of the following: critical incidents in nursing practice in which the speakers felt their intervention made a difference; how their practice or that of a preceptee changed over time, and what they had learned with experience; the social background of the nurses; their past, present and future career plans; the meaning of "professional nursing" to them; how they felt about nursing turnover, and about many of the practices of the unit, such as care plans, and how they used them.

Since the AMICAE Project focused on experienced nurses and since several recent studies addressed the adjustment problems of new graduate nurses (Kramer 1974; Kramer and Schmalenberg 1977; Benner and Benner 1979), I biased my study time more towards experienced nurses. In addition the study was biased slightly towards the nurse

leaders, both administrative and clinical, on the units, as they were the major representatives of the formal ideology and tended to be more experienced and to have more influence.

While the staff on both units was composed predominantly of Registered Nurses (R.N.s), both units included a few Licensed Vocational Nurses (L.V.N.s) and Hospital Aides (H.A.s). I restricted my study to R.N.s and their perspective. The impact on the L.V.N.s and Aides of a decision by the hospital to move towards an all-R.N. staff is an important topic that will not be addressed. In keeping with this singular R.N. focus, I use the term "nurse" to refer to Registered Nurses (R.N.s) unless otherwise stated.

For one month I followed members of two teams of surgical residents on the two units; and thereafter and when possible I interviewed residents (n=10) in order to learn their perspective on the units, on the nurses, and their understanding of nursing practice.

My study did not include a patient sample. When patients volunteered their thoughts, perceptions, and feelings I listened and later recorded their comments. I conducted, however, no formal interviews with them. Where necessary I will rely on the years of research by others on the needs and expectations patients have of nurses (see for example Lederer 1952; Brown 1965; Duff and Hollingshead 1968).

To supplement my work on the two units I observed briefly on another unit in the same hospital known for very low turnover and on two units in another hospital, shadowing one nurse at a time. These experiences, together with my participation in group interviews, workshops, and other activities of the AMICAE Project, from 1979-1981, and my field research of nurses and physicians in 1970 (Gordon 1971),

together with my general review of nursing manpower problems in California and the United States (Gordon 1970) provided a supplementary background.

Historical information on the development and implementation of the Clinical Program is based on interviews-- with three of the four major pioneer leaders of the project, two hospital administrators and eight nurses who were active in the hospital at the time. I also used primary archival material and published articles (which in the interests of anonymity will not be cited by author in this text).

Analysis revealed the importance of the Clinical Program for an understanding of practice on the units only after most of my intensive fieldwork. I therefore did not systematically survey all the nurses I interviewed on how they evaluated and used some of the practices I here discuss.

A Summary of What I Observed and How I Interpret It

I've described how, in fact, the study evolved and what methods I used. As the theoretical framework and analysis of much of the data are reserved for the last chapter (done in order to provide the reader fairly detailed data from which the inductive analysis flowed), here I will present a summary of the argument I will be developing. First I will review what I observed and then how I interpret it.

On Units A and B in Ramsey Hospital in Carver city, as I am fictitously calling the setting, one is told by nurses at all levels that on these units, "the ideal is really put into practice." This is an ideal most representative of collegiate nursing schools and captured by the term "professional nurse." It is epitomized by nurses taking nursing histories, writing care plans, teaching patients, doing

discharge planning, and problem-solving for both "psycho-social" and physiologic problems. This is sometimes referred to as practicing "total patient care."

Many of these ideals and practices are new developments in nursing practice in the United States. Structurally, the nursing staff is organized along two "career ladders": a clinical ladder that allows nurses to be promoted while remaining in patient care, and an administrative ladder devoted to the administrative needs of the unit and the nursing staff. Patient care is organized around a version of "primary nursing"--that system by which one nurse takes full responsibility for the care of her patients during a 12 hour shift (as distinct from "team nursing," in which patient care functions are distributed among members of a team). Nurses are evaluated in peer review, after two months, six months, and one year from when they begin, against a standardized job description which specifies behavioral objectives that can be quantitatively evaluated.

Ideals of autonomy and egalitarianism reign on the units. Nurses are encouraged to think for themselves, to believe and stand up for their assessments, and to obediently bow neither to medical nor to nursing authority but to reason, preferably their own. Nurses are to question physicians' orders and they do; they are to understand what they do and why, not just how. Further, the nurses are taught that they have power, that the unit is theirs to govern to a significant extent. Responsibility and leadership are to be shared, everybody is to provide "feedback" to everyone else, and each person must take responsibility for herself[1], her needs and those of the unit. All nurses, in fact, rotate daily through the important role of charge nurse, the nurse who

oversees the whole unit on a shift. Decision-making is shared among the nurses. Authority is minimized. Status differences are levelled and individuality is encouraged.

Both the physical and the moral independence of the patient is also cultivated. The patient is encouraged to do for himself what he is physically able to do, and to take responsibility for understanding and determining his care, both nursing and medical.

Before long an observer also notices that nurses are hired and resign at a very fast clip and that this turnover is accepted, accounted for, and even valued. Nevertheless, turnover results in an inexperienced nursing staff, many of whom are recent graduates from nursing school. Even the leaders are inexperienced. At one time, for example, the clinical leaders on one of the units, who were described as the "experts," had little more than one and a half years' experience each.

Much energy is expended orienting and socializing the new graduate nurses through the use of preceptors who teach them to practice "professional nursing." Few dimensions of the neophytes' practice are left unscrutinized: their "presentation of self" to others, particularly to physicians, their handling of their emotions, their career plans are all matters of professional concern. In fact, these units function much like finishing schools for professional nurses, and in some ways resemble an internship in nursing. Loyalty to the units is not expected on a long-term basis; the good of the group derives from the good of the individual here, and if and when the good for an individual lay outside the unit, thus contributing to a nurse leaving, it is accepted as best for the nurse to leave.

Professional and personal development, in fact, is a high priority. Like the hospital nursing service, the units are committed to fostering

professional "growth" as much as possible. Learning opportunity after learning opportunity is provided the nurses. In many ways, the administrative nurses of the units function as teachers and career counselors who work to cultivate in others a sense of purpose and pride in nursing. In fact, nearly every nurse leaves with a positive sense of nursing and of what nurses can do. While independent judgement and individual initiative are prominent values on the units, they are present in conjunction with an emphasis on formalism, rationalism and standardization.

Formalism of many types pervades the unit's life and nursing work. Patients are described and discussed in terms of a number of constructs, such as "patient problems." Nurses do not just nurse, they "process" or "problem-solve." The nursing leaders provide new nurses with checklists of the types of procedures, medications and surgeries their patients will have and that they must learn. If such lists sound usual, consider that no such lists are provided physician residents when they arrive for their five to six year residencies. After two months, six months, and one year in the hospital, nurses evaluate each other in peer review against a four-page job description organized around what is called the "nursing process" model. This model consists of four categories: assessment, planning, intervention, and evaluation. More experienced nurses are evaluated annually by other nurses against the same job descriptions, regardless of their years of experience. Whenever they are promoted they are again evaluated in the same fashion.

Nurses on the unit were taught to take seriously the printed nursing care plans provided for the major types of surgeries treated on the units. These care plans are formal models consisting of several

components. For example, the care plan for "major abdominal surgery" lists the typical "problems," "expected outcomes" and what nurses "should do for each problem." The plan calls for progress notes to be organized following the Problem Oriented Record System model designed by Weed (1970). This has the acronym SOAP, from subjective, objective, assessment, and plan. Formal procedure manuals, which spell out the rules to follow for particular situations, such as a Code Blue, and protocols, which spell out how to do particular procedures, such as insert an intravenous line, again describe and regulate what a nurse may legitimately do. Nursing activities are recorded on activity sheets; the acuity of patients (level of illness and care needed) is assessed daily using an acuity scale. The nurses readily drew upon other models from the literature, such as Kübler-Ross's model of the stages of dying, to explain patient behavior and to guide their practice (Kübler-Ross 1969).

Interpretation: The interpretation I will pursue in this work will identify a recurring set of themes and values on these units that reflected those central to the Clinical Program of Nursing referred to above. These are:

1) Patient-centeredness
2) Autonomy
3) Growth
4) Rational, Scientific, and Pragmatic Approach
5) Differentiation
6) Formalism and Standardization

I interpret many of the practices on Units A and B in the following way. The background of the Clinical Program lay in a generation of nurses trying to move away from having their careers defined as a dependent, subservient, female occupation. In their bid for liberation, from medicine and their own past, legitimacy, and improved patient care, they used the ideology of professionalism. They embraced the scientific

ideology and many of the qualities of male physicians as the conscious ideal. At the same time, they rejected many of the qualities associated with "traditional nurses": nurses as intuitive, subjective, subordinate handmaidens of physicians--handmaidens who know only how, not why, and who provide "tender loving care" ("TLC") in a natural and maternal way. They downgraded the traditional caring and what is often referred to as the "expressive" dimension exclusively associated with nursing. They professionalized it and gave it status through concepts like "therapeutic communication" and "psycho-social skills." They saw the nurse as teacher, problem-solver and patient advocate. Their move towards redefinition of nursing reflected changes in the society at large, in particular, the women's movement of the 1960s and 1970s.

The quest for redefinition and independence was pursued in several ways, including the embracing of scientific epistemology and an emphasis on theoretical over practical knowledge. Until nurses knew why, it was assumed, they would continue to be restricted to following orders and unable to make sound independent judgements. This placed a premium on abstract, written, conscious, and rational thinking--theoretical knowledge-- over other kinds of knowledge. This was also one strand that explains the emphasis on formalism.

The practices of objectification and formalism have another explanation. One finds a mutual reinforcement between the inexperience of the profession in enacting professional behaviors and the inexperience of the individual nurses who arrive on these units needing to learn to practice independently in a short period of time. This two-fold inexperience, resulting in the absence of a background of shared, implicit culture-- of knowing how to practice "professional nursing"-- partially explains the strong reliance on formalism. For formal models

and practices provide an explicit foreground which compensates for the lack of practical knowledge, cultural consensus, and dense intersubjective understanding. Formal models are also the accompaniment to greater autonomy in decision-making, a safeguard against greater latitude in judgement.

But reliance upon formal models and formalism may have untoward consequences. It may contribute to a restricted notion of expertise and even a confusion between competence and expertise, as I will later discuss. Reducing nursing practice to a checklist, no matter how carefully conceived, reduces nursing to a finite set of behaviors; nursing becomes something anyone can do. In fact, of course, only certain qualities can be formalized and quantified. Many important ones, such as a nurse's warmth or sensitivity to a patient cannot. It is these qualities that are deleted from the official descriptions of good nursing practice. The constant objectification of nursing practice through writing and formal language and constructs generates a wedge of abstraction between nurse and patient and a nurse and her practice, such that the latter is mystified, obscured and distanced. In fact, quality care sometimes is equated with the representation of that care and with following rules rather than the actual care itself. Similarly, the legislation of autonomous practice through creating rules and formal models to follow can become a contradiction in terms and in practice (Colson 1982). What was once meant to liberate becomes a new set of chains once it is outgrown.

In many ways what I observed was that nurses created their own society in their quest for legitimacy, autonomy, social recognition and reward. Within it esteem, autonomy, cooperation, and professional

growth were cultivated and supported. They created standards of quality care which to them symbolized professionalism. These standards represented not only what patients needed but what nurses supposedly needed as well. I found the culture of nursing on the units geared towards teaching professionalism to new graduate nurses. It was less geared towards cultivating and recognizing nursing expertise in more experienced nurses.

Very importantly, however, I must emphasize that while the nurses on Units A and B did not formally evaluate caring, commitment, and sensitivity, much took place. It seemed embodied in much of what nurses did. While science had to be put into the foreground, in the search for change and greater power, perhaps caring was and could be taken for granted and so did not become highlighted.

My Stance

Several factors are of particular significance in the stance I take in this work. One is that I began work in the context of a study organized by nurses and thus of nurses researching nurses. Further, this nursing study took the position of critical insiders and conducted the research as a dialogue. While I never have been nor will be an insider among those I studied, I am an insider in the other sense that I am a resident of the same state and a concerned student of health care in the United States. I too came to adopt a critical voice and pursued the research at times through dialogue rather than as a persistent ostensibly neutral observer. In this way this is a study in the tradition of practical reason (Bellah 1982).

Another important factor in my stance is that my theoretical framework derives in large part from the work of Hubert and Stuart Dreyfus and other philosophers of science. As I am an anthropologist some justification for this framework is in order. This study looks at a slice of American culture through examining underlying Western assumptions, particularly about science and knowledge. While anthropologists are relatively new to the study of science, clearly, philosophers of science are not. And much as cross-cultural study can expose taken-for-granted assumptions, so too can a philosophical questioning of the assumptions of some of our sacred traditions--in this case traditions of science. This is particularly important given that much of my training has been in the same scientific paradigm as that of the nurses involved. Here, then, philosophy provided the proverbial mirror, perhaps with the difference that I used the questions raised by philosophers to help me break the mold of my Western scientific socialization, whereas most anthropologists have been forced to query their assumptions when encountering foreign cultures.

Finally, I must stress that while this study is predominantly on nursing culture as it impedes and facilitates nursing, its emphasis does not reflect any belief that the cultural dimension is the most important variable in nursing's fate or development. Very serious structural, politico-economic and cultural factors, in particular the continued dominance of physicians, impede nursing's development. The fact that such considerations are not center stage in this work does not imply that they are not very important determinants. My focus is a function of the genesis of the study, my personal interests, and my perception that nursing culture is important, even though it in turn is affected by external forces. Further, let me stress that my target is nursing

culture and not particular nurses. My analysis should not be heard as criticism of the nurses or of the nursing practice I observed. In fact, from all accounts--my observations, patients' reactions, other nurses, and physicians--the nursing practiced on the units was at a very high level. This does not preclude consideration of avenues for further development.

Definitions

Throughout this work I use several concepts with specific meanings. I have already introduced some of them. Here I will elaborate on them as well as others.

Formalism: I use the terms formalism and formal models to include two processes: 1) rationalization: to rationalize, according to Weber, is to approach under the guide of reason (1947); and 2) objectification: to make something objective and explicit entails taking distance from it, separating the known from the knower. Objectification also includes reduction, representation, and taking out of context.

Formal models: Formal models are explicit statements composed of elements that have been selected out of a larger context and reordered so as to make a new whole. They are representations, and in this sense are abstract, appearing often in written rather than verbal form. They put into fixed statements meanings that are often implicit, unstated, and loosely interpreted. Formalism, as we will see, is both a value--seen as a good in and of itself--and a means to achieve other ends.

Experience: Following the works of Gadamer (1970) and Benner and Wrubel (1982), the term experience is used to mean being changed by an encounter, having one's preconceptions and expectations challenged and questioned by a situation. In this way, the term is not synonymous

with the passage of time (referred to in nursing as seniority or tenure). Rather it describes the interaction between time and a person.

Implicit/Explicit Culture: The units I studied were short on what I refer to as implicit culture, that is an unstated, shared background understanding. My use of the terms implicit and explicit culture differs slightly from that found in the literature. While I do not know exactly who coined the term and when, one finds early mention of explicit and implicit culture in an article by Kluckhohn et al, first published in 1945, entitled "The Concept of Culture" (Kluckhohn et al 1962). The distinction between explicit and implicit was often the distinction between empirical and inferred, taken primarily from the perspective of the researcher. Explicit culture were culture patterns that could be observed, even counted; implicit culture, on the other hand, had to be inferred. They were the cultural postulates and assumptions that vary greatly in different societies, the unstated premises of a group (1962:58). For example, in situations of culture change, while the "extremities changed"-- the observable patterns of behavior, the "container" remained the same (Ibid). Implicit culture, that container, involves such basic attitudes that they are sometimes not even accessible to questioning. Because they are so taken-for-granted they do not even enter consciousness and must be inferred.

Hall (1976), in writing on implicit culture, introduces the notion of "high context" and "low context." In contrast to explicit rules, high context culture functions more in terms of the "situation" or "context," which determines meaning and what one takes in or ignores. His usage closely approaches that which I use here.

Situation: This central concept refers to the composite circumstances at hand. It is a gestalt concept, referring to an

intersubjective phenomenon. It refers to an actor's grasp of a real situation that can be interpreted in varying ways, some more correctly than others (Taylor 1983).

Context: Related to the concept of situation, in fact almost synonymous with it, is the term "context" or "background." Situations are in part functions of background contexts. Facts gain their significance from the context in which they are perceived. Neither the situation nor the context are composed of fixed elements. Human order is situational order (Dreyfus 1979).

Organization of the Study

Chapter Two will look at the present context of the study, providing the ethnographic context and description (while much of the information in it and subsequent chapters is basic and often well known to nurses or administrators, the explication is for the benefit of those less familiar). Chapter Three will address nursing turnover and outline the passage of new nurses from entry to exit. Chapter Four will look at the source of the Clinical Program, briefly describing its historical context and its development. Chapter Five will look at this Program more closely, its models, practices, and themes during the period of genesis. Chapter Six will look at how the Program was implemented and perpetuated on the units I studied. Finally, Chapter Seven will present the Dreyfus Model of Skill Acquisition and its theoretical framework. Following Benner (1982, 1984), I will apply this model to nursing practice, throwing light on the limits and possibilities of formalism for practitioners at different levels of skill. The vehicle of this analysis is a case study of one prominent formal model-- the job descriptions for a clinical ladder. The book will conclude with considerations of some of the

NOTES

1. In the interest of easier reading but with the regret of perpetuating stereotypes, I shall resort to the use of single gender references. As the vast majority of nurses in this study were female and the vast majority of physicians male I shall occasionally refer to them accordingly.

CHAPTER TWO: THE PRESENT CONTEXT

The Setting [1]

Several things about the city in which this study took place are noteworthy: 1) Carver city is known for its liberal and progressive climate and for being a center of change. In this vein, for example, the human potential movement of the 1970s found many followers in Carver. 2) Carver is beautiful and a pleasant place to live. It thus attracts a steady supply of recruits for nursing positions. 3) Carver and the surrounding area have a number of universities and nursing schools. This may contribute to more prominence of nursing perspectives characteristic of the educational sphere of nursing than would otherwise be the case. 4) The standard of living in Carver is one of the highest in the country, and while nursing salaries are often higher than in other places, so too is the cost of living.

Ramsey Hospital is a prestigious teaching hospital founded in the 19th century and considered a major research and training center in the country. With it are affiliated several health professional schools, including a medical, nursing, dental, pharmacy and graduate school. The hospital counts over 500 beds; in 1980/81 it served approximately 20,000 patients.

The units in the hospital are organized around specialties, the major division being between surgery and medicine. Patients are normally placed on units according to a specialty, though not infrequently patients of one specialty are placed on units of another; these patients are called "boarders."

Over 60 of the surgical beds are specifically devoted to general surgical patients. The rest are divided among surgical specialties, called Vascular, Cardiac, E.N.T. (Ear, Nose and Throat), Orthopedics, Neurology, and Plastics (reconstructive surgery).

Ramsey Hospital Nursing Service[2]

The head of the nursing service is also the Associate Director of the hospitals and clinics in the medical center (see Table in Appendix B outlining the formal structure of the hospital administration). The hospital nursing service is organized in two "ladders," an administrative and a clinical ladder. Each ladder has five levels. The Director of Nursing heads the administrative ladder, assisted by an Associate Director, labeled, Administrative Nurse V. Eight Assistant Directors, who must have a master's degree, constitute the next rung, referred to as Administrative Nurse IVs, or more commonly Ad IVs. Each Assistant Director is responsible for a number of nursing units and their nursing staff in a specialty area, such as surgical, medical, maternity and child care. The administrative leaders of the individual units, one for each unit, are the Administrative III nurses, called Ad IIIs. Joining them on the units are the Administrative I Nurse or Ad Is, a position first implemented in June, 1981. There is no Administrative II position.

Paralleling the administrative ladder but oriented to the clinical domain (direct patient care) is a clinical ladder, at the top of which are 15 Clinical Nurse Specialists (called "clinical specialists"). They are titled either CN V or CN IV, depending upon individual ranking and seniority. Clinical specialists all have a master's degree in their specialty area, such as in general surgery, oncology, or cardiology, and

function as independent specialists directly accountable to the Director of Nursing. They rove throughout the hospital, and while committed primarily to the units of their specialty, they care for a selected number of individual patients only. They are not in an authoritarian position vis a vis the clinical nurses on the unit. Rather they are regarded as a "resource" for the units.

The next rung on the clinical ladder is the Clinical Nurse III position, or CN III. Each hospital unit is allocated a limited number of the CN III positions who constitute the clinical leadership on the unit level. Promotion to the CN III position must receive approval from a hospital-wide promotion Peer Review committee (for a description of the role of this committee, see Chapter Five). Next is the Clinical Nurse II position, CN II, the position of the regular staff nurse and of the majority of nurses working in patient care on the units. A new nurse with an R.N. degree enters at the Clinical Nurse I classification, or CN I, until she passes Peer Review after a minimum of six months and is advanced into the CN II position. Only nurses with an R.N. degree (approximately 90% of the hospital nursing staff) are on either ladder. Nurses with a Licensed Vocational Nurse (L.V.N.), a Hospital Aide (H.A.) or a Nurse's Assistant (N.A.) degree are not. They form 10% of the nursing staff.

As implied, these two ladders are not exactly parallel. The Director of Nursing heads both ladders and the Clinical Specialists are answerable to her. Advancement through and into the administrative ladder usually requires prior advancement to the position of a CN III in the clinical ladder.

A recruitment pamphlet of the nursing service describes the ladders in the following way: "Nurses are encouraged to develop a professional career at Ramsey Hospital and have the opportunity to advance along either administrative or clinical career paths." These ladders were in fact pioneered in this and affiliated hospitals.

Working Conditions

Most of the hospital units and nursing service (3/4ths of the units voted in this policy) are organized in a 12 hour shift in which nurses work approximately 14 shifts a month, with every other weekend off. Rotation between day and evening shifts is mandatory. Some 8 hour shifts are available and the hospital employs a Per Diem staff of nurses who work on a daily basis either as "floats" to a unit which needs more staff or as regular special duty nurses for patients who require intensive care.

Salaries at the hospital are some of the highest in the country for nurses and are competitive with other hospitals in the city (this parity was achieved in approximately 1980). Starting salary for a CN I nurse in Februrary, 1981 (see nursing salary scale, Appendix B), was $1693/ per month, progressing to $1770, $1860, $2139, and $2351 for first year salaries in each rung of the clinical ladder. Salaries increase yearly for five years only.

During 1980, the initial period of this study, the hospital also filled vacancies by hiring nurses from the "registry," private agencies that hire out nursing services on a daily or sometimes weekly basis to hospitals and other institutions. Beginning in November, 1981, the use of the registry was drastically curtailed and eventually stopped.

The nursing service describes itself as following the model of "total patient care" and using a care planning system that is "problem-oriented." The recruitment pamphlet notes that some nursing procedures, such as dressing changes or the placing of tubes or "lines," were created by this nursing service itself and have been published in a book.

The nursing service draws on a training school which shares its definitions of good nursing. It is affiliated with the School of Nursing at University Center, a school ranked among the best in the country. It has been a pioneer in higher education for nurses, first at a bacclaureate level, then at a master's, and then at a doctoral level. It offers the D.N.S. (Doctor of Nursing Science) degree. Significant effort has been exerted to strengthen the alliance between the School of Nursing and the Nursing Service of the hospital; for example, nurses employed full time are entitled to a two-thirds reimbursement of their University tuition.

Beginning in 1979 and continuing for three years the nursing service hired and oriented between 60 and 100 new nurses each summer who had just completed nursing school. This was an attempt to fill the vacancies left by a turnover rate of 30-40%, (that is more than 30 % of the staff left annually). The nursing service provided an individualized 8-10 week orientation program with preceptors for new graduates as well as large numbers of classes and special "skill days," at which nurses had an opportunity to practice and learn the nursing skills needed on the units. Classes were offered in all areas of practice, including leadership, research, and group process, as well as in specialty areas. Ongoing learning was also strongly encouraged by the Ramsey nursing

service. It provided many learning activities, mostly under a Department of Education and Research.

July 1980 saw a new Director of Nursing arrive at the hospital. Karen, as she was known to everyone in the hospital, brought many changes and a positive, forceful voice and visibility for nursing to the hospital. While she supported nursing politically and advocated and fostered the pursuit of higher education by nurses, her immediate commitment was to developing the administrative component of nursing service. Her concern reflected the times. By 1981, the hospital began to press for cost containment very seriously, reflecting the greater national concern to contain hospital costs, and more concretely, a more restricted hospital budget.

The Third Floor: Units A and B

The Third Floor of Ramsey Hospital is devoted primarily to General Surgery, often entailing general abdominal surgery. The floor is divided into two units, Units A and B, with a total of 60 beds. Unit A, the 36 bed unit, is divided by a hallway into two wings, referred to as A-East and A-West. A-East houses the only private beds (8) on the floor. These are used for patients requiring isolation or for extremely "sick" patients who need "one-on-one" nursing care, or in some cases, for patients who are there by the request of their physician (often of the V.I.P. category). The other rooms on the floor contain four beds.

Amenities on the unit are minimal. Each unit has but two showers and few toilets. The four-bed rooms house a bed in each corner. Curtains can be swung around to close off sight but not sound. Tubes, bandages, appliances often line the window ledges and surround the bed, along with the usual IV pole. Television sets are mounted on wall brackets above

each bed. The rooms are often noisy with visitors, personnel, and the regular sound of strained coughs by post-surgical patients.

Each unit has its own nursing staff and functions independently. There is, however, much interchange, consensus in approach and policies, and sharing of resources between the units, enhanced by the fact that the two administrative leaders of the units, the Ad IIIs, share the same tiny office cubicle.

Patients and Personnel

The major actors on the units are the patients, the nurses, and the physicians. However, like the hospital in general, the units are a whirl of personnel of every variety and specialty, including the following categories:

patients
patients' relatives and friends
nurses: Ad III, Ad I, CN III, CN II, CN I, L.V.N., N.A., H.A.
surgeons: attendings, chief resident, R III, R II, R I, medical students, visiting fellows
unit secretaries
housekeeping staff
pharmacy (attendings, residents, and students)
anesthesiologists
surgical or medical or psychiatric consultants
dietary personnel
ostomy specialist
hyperal specialist
social worker
infection control specialists
respiratory specialists
pulmonary specialists
volunteers
chaplain
anthropologist

It is the nurses who provide the most consistent presence for patients on the units, as they are scheduled to work over an entire 24 hour period. They spend more hours with patients than any other personnel.

The Patients: The patients are primarily those labelled "general surgical" (Unit A and B), with a few patients from Ear, Nose and Throat ("ENT") on Unit A only. A small number are "boarders," that is, transferred from other units due to lack of space. Patients are also classified into two types: private and clinic. Private patients, the majority, are the patients of one of the attending physicians who come as the result of a referral from a primary care physician or other specialist. "Clinic" patients enter the hospital through living in the catchment area of the hospital and using the clinic or emergency room services. Their "primary" surgeon is the chief resident of one of the two teams of general surgical residents on duty. Their attending physician is whoever is currently in charge of the services as this rotates on a monthly basis. Except for V.I.P. patients, whom nurses are occasionally pressured to treat particularly well, I never observed or heard of private vs. clinic patients receiving different care from nurses. In fact, the classification had little relevance on the units for nurses, except when they helped clinic patients secure financing for their care.

The patient population is diverse in age, sex, ethnic background, class and occupation and diagnosis. Children up to 18 years old, however, are rare. They are hospitalized for a range of surgeries, from relatively simple, such as the removal of an appendix, to the extremely complex, such as esophagojejunostomies, from the typical, such as mastectomies, to the extremely rare. Compared to non-teaching hospitals, however, more surgeries involve the complex procedures. Some of the surgeons, in fact, are ground-breakers in their specialty area and perform surgeries or procedures that they alone create and perform. As

indicated, patients come to some of these surgeons from out of the area, the state, and sometimes the country.

In 1979 a system of assessing the "acuity" or level of sickness of patients was implemented by the hospital nursing service (Appendix B). Each patient is assessed twice daily for his/her nursing needs and given an acuity rating from 1 to 6. Staffing and assignment are based on these "acuities," as they are called. Generally speaking the patients on these units are acutely ill. Whether a patient has a "line" inserted in the body for any number of reasons is one indicator of acuity. Many of the patients would have been treated in an ICU (Intensive Care Unit) with a smaller patient/nurse ratio in another type of hospital. A significant number of the patients are labelled "very sick" by medical and nursing staff alike, having multiple and complex problems that require a delicate balancing of treatments and a great deal of nursing care. When the demand for nursing care becames too great for the regular staff, a "special" private duty nurse is hired.

Due to their surgery and sickness, patients on the units are often in signficant physical and emotional pain: not infrequently one receives a diagnosis of terminal illness.

Among the patients one finds several kinds of paths to and reasons for hospitalization. There are patients with acute episodes such as appendicitis, that require quick yet relatively straight-forward surgery; most often these patients live in the city. Others come in for elective surgery on a non-emergency basis; this means that while their surgery is recommended, in some cases mandatory for their health, timing is open. Some patients are referred from another state or part of the state. They come because their treatment has been mishandled elsewhere

or because no one else can perform some of the complex, state-of-the-art surgeries performed at Ramsey. These cases tend to be more complicated and serious. A third type of patient is what is called sometimes "a repeater," i.e., patients who return time and time again over the years for the same or related reasons, sometimes self-induced, sometimes not. Some return to complete or correct a procedure started on a prior visit. The units also handle oncology patients who come in for exploratory tests and/or surgery in which the feasibility and usefulness of surgery is assessed; some of these result in an "open and close," that is the planned surgery is not performed after the initial assessment. These patients rarely die on the units. They are usually discharged or transferred to another unit. In general, the patients who arrive on the units usually all have some possibility of recovery, even those with severe cancer. Finally, some patients who are not seriously ill are placed on the unit to receive hyperalimentation feedings (the intravenious administration of complete nutrition to patients) or pass through for monitoring and observation on their way to a Board and Care Home. The average stay is approximately two to three weeks. The longest stay during my study was one and one half years.

The Surgical Staff and Organization

The General Surgery department is divided into two services called the Red and Green Teams (or services). Each service is organized in a hierarchy led by a surgeon attending, the term for physician faculty. The Red Team consists of 11 attendings, most of whom have a particular area of specialization. A significant number work only part time and thus perform few surgeries. As a group, they are older and more established than the seven attendings on the smaller Green Team who

tended to perform more surgeries. In fact, the Green Team was by far the busiest of the two services, so much so that at one point in the study one of the busiest attendings who also took some of the most difficult cases was shifted from the Green to the Red Team to even out the load. Attendings have the final responsibility for the care of patients on the service.

The balance of the two teams is made up of surgeons-in-training, called house staff or house officers (referred to as "HOs" by the nurses), who are ranked from I to V according to their year of residency training: Resident I, II, III, IV or V, referred to as R I, R II, R III, R IV, and R V. The housestaff is headed by a chief resident called, the "chief", who is responsible for the day to day treatment of patients on the service as carried out by the team of housestaff. The chiefs rotate through different services every four months. The team usually includes one or two medical students (in their third or fourth year) who rotate onto the service on a monthly basis. Above them, the work horses of the team, are the R Is or Interns, as they are often referred to. These R Is rotate through 12 different services in three hospitals during the year, one rotation a month (this was changed in 1982 to bi-monthly rotations). The surgical residency program in Ramsey requires two years of general surgical training of most residents, regardless of their future specialization.

Above the medical students and the R Is are the R IIs and R IIIs who rotate through services on a bi-monthly basis. While they supervise the interns and students, they are less central to the work of the nurses, who tended to turn to them only when dissatisfied with a response received from an intern. As the fourth year of a surgical residency is devoted to research, no R IVs worked on the service.

Each team is associated primarily with one of the units on the Third floor, the Red Team with Unit A, the Green Team with Unit B. This means that when possible, the attendings' patients are admitted to these units and most of the time they spend with patients (out of surgery) is on these units or in the clinic. The affiliation, however, is only partial. Some patients require a private room and as these are only available on Unit A, many "green patients," as they are called, are housed on Unit A. Occasionally, the units were full and patients had to "board" on another unit, often only until a bed was vacated. Some Green or Red patients are assigned to another unit, such as ICU, for more intensive care. In other words, the patients of the general surgical teams were primarily but not entirely co-terminous with the units on the Third floor.

A second surgical service, Ear, Nose and Throat surgery, used Unit B until it moved to another unit after 1981. This was a small service of only a few attendings (quite renowned), one chief, and two other residents, the lowest at the R II stage. I shall not deal with this team further as its role on the units was relatively minimal.

How does the team of house staff operate? The two interns are clearly on the front line, responsible together for "covering" the patients around the clock. While on the bottom of the surgical hierarchy, they are the designated communication link with the nurses, the first contact. They follow closely the patients of the service and communicate information to their superiors during rounds. The chief resident speaks to the attendings daily and disseminates the medical plan down to the team. Often, however, the interns and residents have not heard the medical plan from the attending and chief, a fact that often affects nursing care.

Each chief has his own particular style of running the team and interaction with the nursing staff. More than anyone, the chief sets the tone of the unit for the duration of his tenure, a tone that ranges from excellent, cooperative, and productive to miserable and distrustful, from the perspectives of the nurses and housestaff alike.

Let us consider the surgical team's routine. Each surgical team has specified days in the "clinic" and days in the Operating Room or the "OR." This is only the formal scheduling and does not account for the inevitable emergencies. On OR days, morning rounds are held at approximately 6:30 AM (sometimes 7:00 with a few chiefs) in order to complete rounds, eat breakfast, dress and scrub and be ready for an 8:00 AM surgery in the OR. The interns on the team do "pre-rounds" on the patients, as early as 5:30 in the morning depending on the number of patients and their level of expertise and experience and the time of year. Some pairs of interns apportion the patients between them (and a medical student if available) or alternate on different days, one on and one off. Pre-rounding entails collecting specified "data" they will need to "present" on the patient to the group. These include vital signs, Intake and Output (Is and Os) data, lung and bowel and wound assessment, lab values and any other significant data. Morning rounds take from one half hour to one and a half hours. Occasionally rounds are led by the R III (this takes place more commonly at the end of the year if at all). Those present at the morning rounds are the residents, medical students, any visiting fellows who are participating on the team, and usually a pharmacy resident. No nurses attend. The team gathers by the patient's room while the intern presents what he/she thinks are the significant data on that patient (For fuller descriptions of medical round routines

see Bosk 1979; Becker et al 1962; Carlton 1978). The chief or more senior resident asks relevant questions which stem from practical concern for patient treatment or are aimed at assessing the intern's knowledge of both patient and medical theory. Some teaching often takes place at this time.

After rounds on the unit, the team visits any patients they may have on other units in the hospital. They then take breakfast before going either to the OR or the clinic across the street.

On a scheduled OR day, the team is usually in the OR most of the day. It is here that residents observe and participate in what is regarded as the most important part of being a surgeon, the act of surgery itself. It is here the medical hierarchy is most visible (see Bosk 1979) with the attending clearly leading the surgery. Residents seek opportunities to perform or to observe particular types of surgeries, and effort is sometimes made to spread the goods-- the experience--around. One person is left on call to the units. If lucky, the residents will manage to break for lunch or a brief bite between surgeries, but not infrequently they are in the OR all day long, sometimes without lunch. After they finish, a time is set for afternoon rounds. The interns return earlier to the units to "work up" the patients.

The organization of team routines has several significant consequences for relationships between the nursing and the medical staff. First, while someone is supposed to be available and "on call," it is sometimes very difficult for a nurse to reach a physician. This can cause frustration and anger. It may also contribute to a catch-as-catch-can strategy by nurses who question any physician whom they see with little regard for the preferred protocol (to be described). It also

gives nurses much autonomy in handling situations as they arise during the day (see Coser 1958 on the differences between medical and surgical teams for nursing). Another consequence of the division of labor between nursing and medicine is that the surgical residents, having observed the surgery and heard about it in full detail, know much more about the patient's surgery than do the nurses. Not all gets recorded nor recorded exactly as it took place, particularly if there were untoward occurances. This contributes to a larger knowledge differential between physicians and nurses than one would find, I expect, on a medical unit. On the other hand, the nurses who are present on the units all day while the physicians are gone, gain a different body of knowledge, such as mood changes of a patient or how difficult it was for the patient to walk or cough. Nevertheless, surgery is clearly the most dramatic event for the resident team, a place of high drama, although sometimes tiring and boring as well.

The nursing care problems of the unit sometimes appear mundane and unimportant to the residents, compared with the drama and life-and-death action of surgery. The residents also know that their evaluation will rest on their surgical technique. This further downgrades their interest in nursing routines which are largely directed to the interns.

The interns are the low people on the totem pole among the surgical staff, a fact that is visibly demonstrated during the allocation of surgery tasks. On the units, however, they are the only surgical personnel regularly found. They are the first responsible. They are often sleepless and exhausted. Some may seek to rebound from their low position with the medical team through assertion of their status with the nursing team. All this affects their interaction with nurses.

The attendings appear often on the units, usually in the morning and the afternoon (after surgery), but at no designated time. They are most in contact with the chief resident of the team who reviews the patients with them daily. Attending rounds (as opposed to work rounds led by the chief resident) rarely take place on the units but are held regularly in a plush, comfortable and spacious room off the floor. The surgical residents on call use a small cubicle room down the hall from the units and retreat to it at night for as many winks of sleep as they can steal. It is near the unit so they are readily available if needed. The Chief residents have an office on the same floor.

The Nursing Staff and Organization

The nursing staff on these units consists predominanty of Registersed Nurses (RNs) with a few Licensed Vocational Nurses (LVNs), Hospital Assistants (HAs), and Nurse Assistants (NAs).

The nursing schedules are organized around 12 hour shifts (88% of the staff voted for this in January 1981; it was supported by a second vote six months later). This means that the staff is divided around only two shifts, day and night. The majority of the staff work full time of 14 to 15 shifts a month. The "day" shift begins at 7:30 AM and lasts until 8:00 PM: the night shift begins at 7:30 PM and lasts until 8:00 AM. One half hour overlap is allowed when nurses of both shifts are on duty and present for the "change of shift" report or "report." Some of the LVNs and aides work 8 to 10 hour shifts 5 days a week and a few of the RNs also work 8 hour shifts though this is discouraged.

Given the 12 hour shift, schedules are sought that put a nurse on duty for at least 2 days in a row but never more than 3 at one time due to the strenuousness of the work. This sometimes means that a nurse may

be off duty from 2 to 6 days until she returns, creating episodic discontinuity of personnel.

Administrative Nurse IIIs are the only nurses on duty on a regular daily basis from 8:00 AM to 5:00 PM. The newly implemented Ad I nurse has the next closest regular schedule with two 8 hour shifts and two 12 hour shifts a week.

Five to eight nurses on each unit are on the day shift and approximately three on Unit B and five on Unit A on night. Whereas the nurse in charge on the day shift does not carry a "patient load" herself, the charge nurse on nights must care for patients as well as handle the responsibilities of being in charge.

On the day shift, each nurse is assigned approximately 4 to 6 patients, an assignment determined both by available staffing and by an acuity rating of each patient. Each nurse is responsible for all the care given her patients for that shift: medications, changing the bed, giving baths, emptying bedpans, changing dressings, ambulating and exercising, assessing the patient, teaching, writing care plans, charting, talking to the family-- everything. The RNs "cover" the LVNs and Aides, meaning they give medications, document and write care plans and make most of the decisions regarding the care.

Not infrequently, the regular staff on a given shift is insufficient or a nurse calls in sick. In these situations nurses are drawn from the hospital Per Diem pool, called "floats," or the Registry; some have previously worked on the units and return as part-timers in the pool.

Nurses rotate from day to night shifts throughout the year and are scheduled for a minimum of 4 months of nights. However, several on each unit choose to work permanently on nights, thus decreasing the other nurses' obligation. This creates some constancy of staffing.

The Nurses: Who They Are: For the most part, the nurses who worked on Units A and B were young (under 30), female, white and from middle or working class backgrounds. More specifically, on Unit A in February 1981, 27/28 of the RNs were under 30 years old; on Unit B, 14/19 of the staff were under 30. On Unit A, all but 5 of the nurses (23/28) were Caucasian with European/American roots; on Unit B, 18 of 19 fell into the same category. Approximately one half of the staff of each unit had migrated from outside Carver city area (Unit A, 12/28; Unit B, 11/19).

The majority of the nurses on each unit held the B.S. degree in nursing (Unit A, 15/24 known cases; Unit B, 10/19 cases), leaving a significant number holding either the A.A. or Diploma degrees. Few of the nurses were married (only 4 on Unit A, 3 on Unit B), with one person on each unit divorced. The vast majority of nurses were of a Christian religious background, most often Catholic, and frequently Irish Catholic. Two nurses were Jewish.

Unit A had three male nurses, all of whom were openly gay. They, along with other staff on the unit who were lesbians, constituted a known homosexual contingent among the staff. Homosexuality was present among the staff on Unit B, though less public.

All LVNs and Aides on both units were black, over 30 years old, married or divorced with children and had worked on the units over 5 years.

Dress and Terms of Address: Tradition and hospital policy require that nurses wear white pants, skirt, or dress. For many nurses, this is the maximum of white. Usually they wear a colored, non-uniform top. No

nursing caps are worn. In general, their dress allows them to express their individuality, in many cases their femininity and their youth, with only minimum presence of a uniform. The image of the clean, starched, white, selfless, and pure nurse is far from apparent. Around their shoulders drapes a stethoscope, long an exclusive symbol of physicians (see Krantzler, in press). When not involved in patient care they most often wear knee-length white coats. This is a uniform worn by nurses, particularly administrative and clinical specialists, throughout the hospital.

Mutual first-name address was used between nurses, including with the Director of Nursing. It is also used between nurses and house officers, often including the Chief Resident, but not between attendings and nurses or attendings and house staff in public contexts. If names are used in these contexts, the attending used the first name of the nurse while the latter addressed the physician as "Dr."

In all cases I observed, a nurse introduced herself to a patient with her first name, such as "My name is Suzanne. I'm going to be your nurse this evening." Patients are called by "Mr,""Mrs.," or "Ms." when first admitted though this usually drops to first name address after increased familiarity.

Staff Organization: As described, the nursing staff is organized along an administrative and a clinical ladder. The distribution of staff in these positions in February 1981 was as follows:

Table 1. Distribution of Staff on Units A and B

Unit A (36 beds)	Unit B (24 beds)
1 Ad Nurse III	1 Ad Nurse III
1 Ad Nurse I	1 Ad Nurse I
5 CN IIIs	5 CN IIIs (only two positions filled)
26 CN IIs or CN Is (two positions unfilled)	17 CN IIs or CN Is (two positions unfilled)
2 LVNs	1 LVN
2 HAs	2 HAs
3.5 secretaries	3.5 secretaries
38.5 F.T.E.s (Full Time Equivalents)	29.5 F.T.E.s

The Ad III nurses are responsible for maintaining the unit's functioning: budget, scheduling, hiring, firing and promoting, evaluating care and personnel, ordering supplies, assessing and meeting the learning needs of the staff. Additionally, these nurses are expected to participate in "patient care" which they do only occasionally. The Ad I nurses, added later, took over some of the above responsibilities from the Ad III nurse, particularly the budget and scheduling. They more regularly perform patient care.

The Clinical Nurse IIIs are responsible for setting and monitoring the standards for clinical practice, for being "identified leaders" for the staff and for precepting new nurses. Other than these activities, they perform the same roles as the other clinical nurses, who together

with the few LVNs and Aides, provide patient care. Two main roles are distinct: "patient care" and "charge nurse," often referred to as "charge." Little role differentiation is made according to the level of the nurse (CN I, II, or III) except in terms of the acuity and number of patients assigned and whether or not a nurse is precepting another nurse.

The charge nurse is the designated head of a total unit for a shift (on Unit B, one nurse is in charge; on Unit A, two, one for each wing). In general, the charge nurse oversees of the whole unit and staff. She keeps track of and disseminates medical orders, attends to new admissions and discharges, and is the conduit for communication between nurses and physicians. She remains alert to how each nurse is coping with her assignment and to who needs help, lending a hand herself if she can. The charge nurse collects and passes on in report the statuses of the patients to the next shift. On these units, significantly, all nurses must learn and rotate through the charge role. So she knows all the patients, a nurse is ideally assigned charge only after having been on duty at least one day prior.

Nurse-Physician Communication: Communication between nurses and physicians takes place through several formal and informal channels. A major avenue for nurses' communication to physicians is the "scut" sheet-- a list, ideally posted after change-of-shift that includes things that need to be taken care of but not urgently, such as renewals for medications. Communication from physicians to nurses is through a medical order, given either verbally or in writing.

A third forum for communication is the medical rounds in the afternoon, attended when possible by the charge nurse. Here the communication is primarily among physicians and for the nurse to listen in, although the nurse is expected to communicate important information to ask questions, or make suggestions (this expectation is more from nursing than consistently from the physicians).

Patient management rounds are held weekly. Here the nursing staff and other health professionals (a discharge planner, a diet specialist, a social worker) meet with the chief resident. Typically the charge nurse calls out the name of a patient and the chief relates the latest developments and plan, which then may or may not be discussed. A nurse may provide information and opinions regarding the treatment of a patient. This is sometimes requested by the chief, sometimes not.

The official route for direct verbal communication between nurses and physicians is for the charge nurse to speak directly to the intern or appropriate physician. Nurses involved in patient care are supposed to channel their questions and information through the charge nurse. If the charge is not satisfied with the response of the intern, she moves up the medical ladder.

"Bollexing up" the system (and both physicians and nurses agree on this) occurs when each nurse approaches each intern independently; when a nurse speaks to the intern and then goes above him without informing him; or when the nurse circumvents the intern entirely.

Nurse-Nurse Communication: The major forum for communication among nurses is the nursing report, held at the change of shift. Report is usually presented by the charge nurse to the group of nurses coming on duty (an alternative method sometimes used is for each nurse to report on her own patients).

Speed of report is stressed, as up to 24 patients must be reviewed in 30 minutes. In fact, people gain reputations for being slow or fast and for giving "a good report." Regardless of the quality of the report, the nurse is usually thanked afterwards and sometimes praised. Negative criticism is not usually expressed.

Nursing report progresses according to the room and bed number of patients. A patient's name and bed number is announced and sometimes the medical team to which the patient belongs, the type of surgery, diagnosis and date of surgery. Other data included are vital signs (blood pressure, temperature, pulse), what I.V. solution they are recieving at what dosage and frequency; lung and bowel sounds; when the patient is going home; how the patient is feeling; anything unusual or notable about the patient's day or condition; what the medical plan is on the patient; what was done and what remains to be done; the state of the patient's wound and the type of dressing; the treatments and tests planned or had by the patient; the extent of ambulation (walking), diet, fluid and food intake and output, and often comments about the patient as a person, such as "she's such a great lady." Standardization of report is rare yet continually striven towards.

While nursing report parallels medical rounds in many ways, there are some interesting differences. Nurses, who are visibly present on the unit throughout the day and night, remove themselves at this time to disappear into a special room with the door closed, not to be bothered. Contrastingly, the physicians, coming from different places and absent from the units much of the day, are visibly on the units during rounds as they join together, often in the middle of the hall to be navigated around.

In medical rounds a clear authority structure is demonstrated, and the intern or medical student informs that authority of the latest developments. It is also a time for teaching, quizzing, hazing, decision-making, and a once-over by the chief resident to check on what is happening with each patient and how well the residents are following a case. Not infrequently the intern is grilled to test his knowledge, understanding, and responsibility.

Nursing report, on the other hand, only exchanges information among nurses and is an opportunity for nurses to "touch base." But it too can be a showplace for the reporting nurse, and new nurses experience much anxiety over their "performance" and are concerned over "being judged." They are not alone. Some veteran nurses also find report stressful as it is an accounting of their whole shift-- one can see what was done and inevitably, what was not.

Significantly different from the medical context is that questioning of the nurse reporter is for information not for training. Questioning is sometimes informally and successfully discouraged by the new nurses. Uncomfortable over "being tested," they discourage other nurses from asking questions.

Staff meetings, which provide another occasion for communication, are generally held monthly between 6:30--7:30 PM in the nursing report room (Unit B) or a classroom or the solarium (Unit A). As the report room of Unit B is very small, sometimes up to 20 people are cramped into a tiny space with little room to breath and certainly few chairs to sit on. Staff meetings are predominantly business meetings directed by the administrative nurse. She announces new policies, reminds the staff to follow old ones and why, praises and sometimes criticizes, introduces new people and opens the forum for questions or comments.

Nursing care plans, while almost never read by physicians, are a much emphasized channel for communication among nurses. Written communication of this sort is seen by many of the nurse leaders as preferable to oral communication. Often nurses write notes to each other, usually an evaluation of care, which they leave in the each others' boxes.

The Surgical Trajectory

A definite trajectory centering around the surgical episode structures the expectations and actions of the nurses towards the patients. The model is that of a patient who enters the hospital, referred to as "new admit," one or two days prior to surgery. The patient is prepared for surgery, labelled at this time a "pre-op" (pre-operative) and eventually taken down for surgery during which he is said to be "in the OR." The surgery complete, the patient is transferred to the "PAR" (Recovery Room) for close and temporary observation. When well enough to return to the unit, the patient returns as a "fresh post-op," usually still under the effect of the anaesthesia. At this time, the patient receives intense attention from the nurse as she monitors his/her progress carefully. This tapers off gradually over the next 24 hours; thereafter the patient is referred to as "one day post-op," "two day post-op," and so on. The progression from post-op to "discharge" can be from one day to weeks, though in some cases it can be months. Patients often undergo dramatic changes from admit to immediate post-op to discharge.

In many ways the system and the nurses are geared towards a model of short-term high dependence and then gradual preparation for return home and independence. The orientation is towards getting people better

and is based on motivation of the patient, as it was described to me. It does not deal well with dying. Many nurses feel they are "doing nothing" for those who cannot be helped medically. Death is not expected, and in fact it is relatively rare on the units. It is almost a failure to have a patient die on the unit, some say, particularly those patients who had been there a long time whom they wanted to see go home. In fact, seeing patients go home is the major goal of the nurses.

As the stages of the trajectory-- admit, pre-op, post-op, and discharge-- are the major categories guiding the nurses, it may be easiest to describe nursing work by describing what nurses do throughout these different phases.

A New Admit: A newly admitted patient is usually met and taken to his/her room by the unit secretary. As soon after as possible, the assigned nurse greets the patient, records articles brought in, shows where things are and helps the patient get settled and changed. As soon as possible, the nurse takes a "nursing history" in which, among other things, she solicits information on diet, sleep patterns, life style, past hospital experience(s), and current expectations. Already at this time the nurse begins to collect a picture of the home life to which the patient will be returning, in order to prepare the patient over the course of the hospitalization.

At this time the nurse also takes a set of vital signs and checks the problem areas of the patient's body, such as the patient's abdomen. She describes the hospital routine, details of meals and other regular occurances, and answers patients' questions. She and the patient begin to get acquainted.

Pre-op: Preparation for surgery requires several things: bodily preparations, such as enemas or "clean outs" administered by nurses; assuring that the patient neither eats nor drinks after midnight before surgery; assessing the condition of the patient, both emotional and physical, in the event that the possibility and potential value of surgery is being evaluated; and pre-op teaching. Pre-op teaching of a patient is a routine review of the surgery in which the nurse explains and reviews the process and evaluates the patient's understanding of what is to be done. While the physician's primary focus is on the surgery itself, the nurse describes the entire surgery process with an emphasis on the experiential dimension (see Krantzler 1982 on how nurses address "illness" while the physicians address "disease"): what will be done, how it will feel, for how long, why, and what can be done about it. Discussion of the patient's feelings about the surgery is encouraged.

The nurses are also responsible for making sure that patients receive the tests and treatments that are ordered and for assessing their reactions to them. The nurse sends the patient off to surgery, usually helping to move the patient onto the gurney (the patient's bed when in transit), which can be physically difficult.

Fresh Post-op: After the patient has been moved from the Operating Room to the PAR (Recovery Room) and is ready to be transferred back to the unit, the nurse receives a report from a PAR nurse on what was done and what to expect. She and sometimes other nurses move the patient back into bed. Since patients are often still anaesthetized, this is often physically strenuous and awkward work. Patients must be closely attended to and observed at this time, with an eye to how much anaesthesia still remains, how much pain the patient has, and how much pain medication

he/she can tolerate. Vital signs must be checked frequently, often every 15 minutes. The nurses also check the patients' circulation and help them with the nausea and vomiting that frequently occurs. Families and friends are often present and very concerned, and to varying extents, the nurses answer their questions and offer them support.

Soon after surgery, patients are encouraged to cough and to take deep breaths in order to prevent lung infection. This usually requires much effort and causes much pain. Similarly, they are encouraged to walk as soon as possible, and one sees nurses in the halls walking patients who are barely awake and sometimes hooked up to an array of different tubes. In general, the nurses' major concerns at this time are maintaining proper respiratory and circulatory function, the alleviation of pain and discomfort, and the prevention of post-surgical complications, particularly infection, and being alert to any significant changes in the patient's condition.

Later Post-op: During the later post-operative phase, usually ranging from 2-3 days to several weeks, the nurses continue to administer medications and other treatments, such as dressing changes and irrigations of the many tubes attached to the patient (dressing changes can sometimes take up to two hours). In fact, patients often have lines and tubes of a variety of sorts, such as I.V.s and N.G.s (naso-gastric), which nurses monitor and work to keep flowing correctly. If the patient has a new appliance on his body, the nurse explains its nature and works to help the patient adjust to it emotionally and practially. This is called "patient teaching."

Pain management, scheduling of tests and specialists' visits, alerting physicians to changes in lab values or signs of complications,

assessment of the medical plan, reinforcement of it or suggested changes in it, assessment of psycho-social concerns of the patient, ambulation, prevention of infection, wound assesssment and care, and discharge teaching and planning are among the dominant concerns of the nurses during this period. As during other phases, many nurses see their role as patient advocate. Keeping patients comfortable is also a high priority; this means responding to requests (for juice, bedpans, pain medication), turning patients, cleaning them, giving backrubs, and repositioning them. The nurses encourage patients to express their feelings and concerns and spend time talking to them about these and other matters.

Discharge: While preparation for discharge takes place ideally from the moment the patient is admitted, a more explicit set of practices is followed immediately before the patient leaves the hospital. The nurses teach patient and family about how to adapt to any appliance, the signs and symptoms of infection, future medical plans and any other forseen needs. They help the patient adjust and manage the life changes an appliance may create. They work with the physician and social services to assure that the patient will receive any available help. They write out instructions, called "teaching plans" for the patient which spell out how to change dressings and other self-care activities that are needed. When possible and necessary, the nurses try to control the date of discharge until they are satisfied that the patient no longer needs skilled nursing and is practically and emotionally ready to go home.

The Reputation of the Third Floor

According to float nurses, nurses who left the units and worked elsewhere, current residents and the current nurses themselves, the

Third Floor is very difficult to work on (it was sometimes referred to as a "dirty" place to work, referring to the work with patients' feces and other discharges). Many residents regard the Third Floor rotation, in particular the Red Team, as the most difficult and busiest of their whole year. Furthermore, the relations between physicians and nurses on Unit B were considered by some to be unusually tense, during part of the period of study, and unusually egalitarian. The floor is known for its teamwork, and commitment to and provision of high quality nursing care. Among new nurses the Third Floor is considered an excellent though difficult place to learn nursing, as we shall see in the next chapter.

NOTES

1. In the interest of anonymity, some identifying characteristics of the area of study have been deleted or altered, when irrelevant. This was particularly necessary as the study addresses a pioneer movement which by its very nature is unique and thus more identifiable.

2. For a statistical profile of registered nurses at the time of study see Levine and Moses (1982). For a picture of trends in nursing at that time see McClure and Nelson (1982) and Aiken's book in general (1982).

CHAPTER THREE: NURSING TURNOVER

One prominent and important nursing reality during the period of my study was nursing turnover, to which I will now turn.

A Description of Nursing Turnover

"Just passing through"— for many people, both patients and staff-- describes their orientation to and tenure on units A and B. Much of this is intended. A teaching hospital is deliberately designed and organized around the regular rotation through various services of students and residents in medicine, pharamacy and nursing. But on these units, rotation is also due to the specialty-- general surgery-- where the average patient stay is two weeks (although a good many stay longer). Patients, according to plan, are supposed to come and go.

Weathering the organized and intended traffic of trainees and patients there are also figures of expected stability-- the attendings, housekeeping staff, unit secretaries, and the nurses. While relatively stable compared to medical trainees and patients, nurses working in teaching hospitals typically come and go at a fast rate. In this sense, Ramsey hospital is no different, averaging around 35% annual turnover rate in 1981, a rate on a par with others in the area (McCloskey 1974) and the country (Donovan, 1980). Like many other institutions, however, Ramsey hospital has not been fully staffed in the last five years. Beginning in 1979, an extensive effort was made to reach full staff by hiring massive numbers of new graduate nurses.

Here I consider the nursing turnover I encountered over a two and one half year period from June 1980 to December 1982 from the units' perspective.

The first notable thing about nursing turnover is that it touches every level in the hierarchy of nursing service. In July 1980, a new Director of Nursing stepped in after the position had been filled by an Acting Director for several years. In July 1981, the Assistant Director of Nursing who supervised Units A and B left to join her husband in another state; she openly acknowledged that if she did not find work she liked, her next job might not be in nursing. In March 1982, the Ad Nurse on Unit A (Ad Nurse III), left after 6 years of nursing and administration on the unit for a 6 month leave of absence, maybe to return, maybe not. The equivalent administrative nurse on Unit B became pregnant and took a leave beginning November 1982, no one knowing whether she would return or not. In fact she did not.

The second notable thing is that the non-RN nursing staff on these units is tremendously stable. They were, in fact, invited to work elsewhere when the hospital attempted to change to an all-RN staff. The staff who remain chose to exercise their legal right to keep their positions. All six are black women.

In marked contrast to this stable para-professional nursing staff is the turnover among the RN staff. The turnover rate among RNs on these units ranges from 30% per year to over 40% at one time, slightly higher than the hospital-wide rate, yet significantly lower than that found in other hospitals in metropolitan areas (Price and Mueller 1981). Thus, these units do not represent necessarily extreme cases in the nursing world. And as part of an elite teaching hosptial in an attractive city and as general surgical units often sought by new nurses, these units have a relatively easy time recruiting new people.

But what, exactly, does a 35 % turnover rate mean? One can describe the situation several ways. Consider, for instance, that in June 1982 only 6 nurses remained of the 28 who had staffed Unit A in June 1980 while only 4 of the 19 remained on Unit B (three of these were clinical or administrative leaders). Another way of describing the situation is by the years of experience of the nurses on the units. On Unit A, in February 1981, 8 out of the 28 RNs had 6 months' experience or less; 15 had 1 year's experience or less and 23/28 had 1 year and 9 months' experience or less. Only 3 out of 28 nurses had more than 3 years' experience. On Unit B the situation is slightly different though no less extreme at times. As mentioned, only 4 nurses remain on the unit since June 1980. Especially remarkable and pivotal in the dynamics of the unit, however, is that in February 1981, when the last of the "experienced" nurses left, the most experienced clinical RNs on the units had been there only one year and 8 months each. Two of these were the clinical leaders on the units, the CN IIIs, regarded as the "experts." Of the rest of the staff, 5/19 RNs had 6 months' experience or less; 17/19 had 1 year and 9 months' experience, or less, while only two nurses had more than 2 years' experience. A total of 18 nurses came and left in the past 2 years. Nearly all of those hired on both units were new graduates nurses. This being their first job, they required extensive on-the-job-training.

Turnover rates tell only a fraction of the story. They do not tell who left or who came and what the difference was. Further, they do not capture the whole process of leaving-- the deciding process, the waiting-for-future-plans-to-jell process, the deliberation process of the potential departee, or the uncertainty and alertness of the unit administrative leaders trying to keep people and yet keep track of their

plans and make sure that all positions are filled. Further, they do not capture the extent that change is an element in the everyday life and the calendar year of the unit, and that the only really stable months are from January to April. They do not tell about periods where people begin to wonder, "who's next?" nor of periods where the staff seem like they have been together for years when it has only been months.

The fact is that at any given time on these units nurses are coming, going, deciding whether to stay or go, announcing they will be going, or working some of their last weeks or months before their planned departure. A few others return, either on a permanent or a part-time basis, and some decide to stay after having decided to leave. Following is a three-month summary from my field notes of such activities among the RNs on three active months.

> JANUARY: January 21st is Elizabeth's last day after 6 years on the unit. She is the last of the "old" group of nurses to leave, the ones who were here with the implementation of the Clinical Program. A big party is planned for her. She hopes to work in community nursing. People are relieved for her that she is finally leaving, as they feel that for her sake she has been on the unit too long and it is time for her to move on. For her part, she has "had it with the system": the way it blocks communication, the way it encourages detachment. She is tired of orienting new graduates every summer. She never intended to work long in a hospital anyway-- community work had always been her goal. Somehow she got "sucked into the comfort of the enveloping institutions," as she described it, meaning she got accustomed to having large numbers of supporting staff and technology to work with, despite all its frustrations. Elizabeth's leaving means that the most experienced nurses left on the unit have been there only one year and 8 months. No one seems particularly worried about this, however, as most feel that it is best that Elizabeth leave.
>
> January also brings an announcement from Barbara G. that she plans to leave sometime in the near future. She is a quiet, does-her-own-work and doesn't-bother-anybody kind of nurse. She hopes to find employment with the VNA or public nursing. She had worked on the unit for one year and a few months.

The shocker this month, however, was when Donald announced that he was going to leave. This really made waves as Donald is a very influential and competent nurse on the unit. He was a member of the first cohort, and although he holds no formal leadership position, he has much influence on other nurses, particularly as he works regularly on nights. The administrative nurse III was trying to talk him out of leaving; he wants to get into television if he can and is not satisfied with nursing. While Donald and Barbara announced their intent to leave this month, they as yet have no definite plans. No new arrivals this month, except for Mary, an LVN who worked on the unit before and will work on nights, beginning February 1st. She is orienting a few nights this month.

FEBRUARY: Another shocker came this month when Saul disclosed that he too is considering leaving. He's just not satisfied with his job; he's not sure if he wants to get into administration or what. He's not sure in fact if he should get out of nursing altogether. He's not even sure if the problem is in him or in the profession. He just feels the need for some change. Saul worked as a maternity nurse for several years before coming to the unit 9 months prior. Most see him as a very good and capable nurse. Hannah left this month, a quiet departure after having worked almost one year. She was not a pivotal person on the unit and did not cause many waves with her leaving. I did not know her.

MARCH: Problems with two new graduates continue and have moved to center stage. They don't seem to be 'making it,' that is meeting the standards expected and demanded by the unit leaders. Much discussion is taking place among the administrative and clinical leaders and some with the new graduates as to whether they should be given a final probationary period in which to come up to par or should be asked to leave now. This is clearly not easy for the nurses involved.

While nothing has actually changed in the work lives of Barbara and Donald, they continue to talk about leaving. Coming on board this month was Linda, a nurse with over a year's experience in another hospital. She fitted in easily, both professionally and socially.

The other significant change this month is that two new people became candidates for the CN III position that were open (there are 5 positions in all, only two are filled). One of them is Saul. After some discussion with the Ad nurse and others, this was chosen as a way to give him some new life on the unit and an avenue for more influence in his work, something he wants. The other candidate is Julene, a nurse who has not yet a

> year's experience under her belt. They say that she is a "little Nancy," one of the two present CN IIIs who were promoted to that position themselves after only one year on the job.

As we can see from this brief account, coming and going and talking about coming and going are part and parcel of the lives of nursing staff.

A Structured Passage From Entry to Departure

The incorporation and socialization of new nurses into the hospital and onto these units has been formalized and intensified. From a simple "buddy system" in which one nurse teamed up with a more veteran nurse for awhile, we here see a proliferation of mechanisms, timetables, grids, status changes and learning opportunities that structure the passage from a new, very inexperienced nurse often in a state of "overwhelm" to a fully functioning nurse who is precepting another nurse 9 or 12 months later. In following this passage we will consider how the model of nursing subscribed to on these units is perpetuated and how nursing turnover was an important factor on these units.

Entry: At least half of the new nurses who enter the unit do so during the summer, forming part of a cohort of 4-8 new nurses per unit, entering each summer from 1979-1982. Like all new nurses in the hospital, they went through one week of hospital orientation where they learned their rights and obligations as employees, the services, the setting, and how the hospital runs.

On the unit, newcomers are met by the administrative nurses who provide them with a preceptor as well as a folder containing a number of lists and printouts (see Appendix B). For their first week the new nurses generally buddy with another nurse, not necessarily their preceptor, whom they simply watch and help out where possible. They then

begin to take patients on their own, beginning with one, under the close guidance of their preceptor. They start with patients who are not considered to be "very sick," though the acuity is gradually increased over time. During the next 4-5 weeks they work intensely on patient care under the supervision of their preceptor as they try to meet the many required experiences on their checklists. Either their preceptor or another qualified nurse must observe and approve their demonstration of adequate skill on a number of procedures in order for them to be "checked off," i.e., considered safe without further supervision.

Patient care is not their only activity however. The new nurses selectively attend the many classes and laboratories offered by the unit and the hospital nursing service that provide further opportunites for practice on some of the skills they will need as well as the theory. Some of these classes are taught by staff of the Third Floor.

The model used for orienting and incorporating new nurses onto the units is called "precepting," a system implemented in 1978 in response to the many problems new graduate nurses were encountering in trying to make the transition from nursing school to the work setting (Kramer 1974; Benner and Benner 1979). The preceptor program formally links one particular nurse to a new nurse, setting up a contractual relationship between them and obligating the preceptor to oversee the development and learning of the newcomer (Freisen and Conahan 1980). For at least the first month, the two nurses are on duty at the same time whenever possible and it is primarily the preceptor to whom the newcomer turns.

Not everyone can precept; preceptors both volunteer and are chosen by the administrative and clinical leaders based on an evaluation of their grasp of nursing, their experience-- nurses start as early as 6

months into their first job to discuss it, and as early as 9 months to do it-- and the degree to which they conform to some of the basic values of the unit. Nurses who regularly meet the standards of the unit, are well organized, write histories, give good reports, write good care plans, are considered to make good assessments and be good with patients and helpful with staff, they are preferred as preceptors. Some nurses whose approach was tolerated but not emulated were not asked to precept even though they were interested. On both units one or two of the clinical leaders precepted several nurses continually over the years and had a greater hand in the socialization of the new nurses than any others.

While preceptors and orientees are armed with a number of lists and grids, one must note that beyond these there is little training for preceptors. Instead preceptors generally precept the way they had been precepted. This does not always work successfully and occasionally a new nurse does not make it on the unit or preceptors are changed.

The preceptor-orientee relationship is sometimes framed in kin terms, something of the parent/child, but the more apt idiom is big sister, little sister. In fact, its implementation was in direct response to a generational rift between new and veteran nurses characteristic of the old system, wherein new nurses felt ostrasized and hazed (see Kramer and Schmalenberg 1977; Benner and Benner 1979). When a "buddy board" list was made that listed who precepted whom, one asked, somewhat in jest, "are there any orphans?" On another occasion reference was made to a preceptor's orientee's orientee: "You're a grandmother!" they laughed. The preceptor does share some of the success and failure of the orientee, and those whose orientee did not succeed felt they themselves had failed in some way.

The preceptor is in many ways a teacher. She reviews the patients with the newcomer after report and helps to interpret the data they have heard and to organize their activities for the day. The teaching proceeds through questioning, such as "Now that you know this woman's diagnosis, what will you do and what will you watch for?" They solicit the game plan of a nurse and then made suggestions as to how to proceed. They arranged for learning experiences for the new nurse and checked off the nurse's performance on skills. Throughout the day they answered questions, asked questions, passed on tips, their pet peeves, their mode of organizing a day, and recording data, their strategies of approaching care, their way of being a nurse.

Thus it was in this process that much of the informal culture was passed on and many nurses attribute their "priorities" to their precepting nurses. Diversity ranged along such dimensions as : emphasis on legal aspects of nursing practice; organization of day; priorities, such as emphasis on care plans or on talking to patients; and ways of being with patients, such as maintaining "professional distance" or "being oneself."

Socialization of the new nurse is by no means limited to the preceptor. In fact, given the strong emphasis on independence, the orientees are not closely scrutinized during the day for the 8 weeks. Further, they are encouraged and do turn to the many other nurses for answers to their many questions. Additionally the Ad nurses keep track of the newcomer's development through direct and indirect questions. With time comes an increasing sphere of influence and the more exclusive relationship between preceptor and orientee decreases.

The major support to the new nurses is her cohort, where one exists. New nurses turn to each other for help through the painful

periods where they feel they do not know anything and need help in EVERYTHING, as it was described.

Of note, is the tremendous reliance on written lists and guidelines during the orientation process (for samples, see Appendix C). The new nurse is given a folder containing a number of lists, including a statement of the objectives--27 of them-- of the Third Floor Orientation. The new nurse is required to maintain a log that includes:

1) types of patients for whom you care
2) difficulties encountered
3) three accomplishments of the week
4) one thing you find satisfying about your job
5) learning need/goal for the next week.

The folder for the new employee also contains some of the following:

A Job Description for Clinical Nurse II, listing 57 behaviors which she will be evaluated on according to a 4-point scale

a "skills list," listing 71 skills, the majority of which must be approved by 8 weeks

A list of Models of Nursing Care (MOCs) and Procedure checklists, including 38 "common surgeries" (only on the Third Floor!) and 18 different types of tubes, drains, and medications used frequently

A list of articles they must read either before a class or before the end of orientation.

Furthermore, for each type of surgery and procedure, there is a written protocol and/or Model of Care to be read before embarking on action. The preceptor is also provided a checklist (see Appendix C) of the requirements for the orientee.

When all goes according to schedule, the new nurses learn how to "team lead" during their 7th and 8th weeks under the supervision of their preceptors. At the two month mark the first formal evaluation, called the "preliminary evaluation," takes place. Here the new nurse,

her preceptor, and the Ad III nurse together evaluate the progress according to the job description. If the evaluation is satisfactory, the new nurse begins a month on the night shift without her preceptor.

At six months, the new nurse has her first Peer Review and if satisfactorily evaluated, she is formally designated a CN II for which she receives a raise in salary and a new badge. Otherwise this status change is not highly socially significant although it does mark the formal end of being "new" to the unit. After this time "new people" will sometimes be scheduled together like regular staff, rather than be interspersed strategically with more veteran staff as was the case prior. Thus one hears comments during the 6th to 10th months such as, "It was a hard night last night, it was all new people."

After the sixth month the stage is set for some outstanding nurses to make the new move-- to become a preceptor themselves. Usually this does not happen until after 9 months though discussion begins earlier. Similarly, discussion about the new nurse's potential for becoming a CN III can begin that early through the use of a 6 month "candidacy period."

The one year tenure of the nurse is marked only by a second Peer Review; no status change accompanies this. The next major step for a handful of nurses is becoming a CN III. This can begin as early as 6 months for a bacclaureate trained nurse and after one and one half years for other training. For about one quarter of the new nurses the one year point marks the end of their tenure on the unit. Having fulfilled their one year pledge they decide for a multitude of reasons to leave. But many nurses who expected to stay only one year stay much longer.

Analysis: We must note several things about the socialization process as described thus far. One is that while the expectations for

the new nurse are very explicit and standardized, the precepting process is not and much range exists. Furthermore we must note that nurses lack a forum in which several nurses can together assess and discuss and evaluate the same observed situation and create greater group concensus. Comparison to the medical mode of socialization, through rounds or a group observing an attending perform surgery, is useful. I heard repeated stress on striving for some consensus and consistency among nurses and perhaps one of the reasons for this, according to some nurses, is that such consensus is lacking. Quite possibly this socialization process of pairs and the lack of group forum contributes to this.

In addition to the formal timetables, a set of informal assessments and categories are used to assess "where a new nurse is at." The nursing turnover that leads to a parade of new nurses onto the unit and in turn to nurses becoming preceptors very quickly may contribute to standardization and reiteration of the professional model. Precepting commits greater numbers of nurses to presenting and teaching nursing "the way it is supposed to be done." A minimum of conformity to unit standards is implicitly required before a nurse can precept, and while a nurse will pass on her own style, she does represent the establishment to some extent.

Finally, homogenity is enhanced by the large number of nurses precepted by a handful of the Clinical III nurses. One nurse particular influenced nursing practice on Unit A more through precepting other nurses than in practicing nursing herself.

"Passing Through" as Normative

Nursing turnover is a fact that people on the units have come to

accept, expect, anticipate, and sometimes value. The longevity of stay of the nurses is not used as a significant criterion for judging the success of the unit. The unit is considered successful if a nurse completes a one year committment. Keeping nurses on the units for a long period of time may be outside the hands of the administrators and leaders on the units. It is not their raison d'etre. Rather, one finds it placed in other areas, specifically in teaching and practicing a quality of nursing care they regard as extremely high and that approximates their ideals of what good nursing is. This quality is measured in terms of meeting the formalized standards of care given in the the job descriptions, in having care plans and histories done on as many patients as possible, in a nurse knowing what she is doing and not just obeying orders, in a nurse making assessments. One of the administrative nurses put it this way:

> I know that a nurse who makes it on this unit can make it anywhere. Of course, I would like to see her spend more of her future on this unit, but that would be a bonus, not to be counted on.

This administrator's cosmopolitan approach echoed that of the Director of Nursing who saw nursing turnover as a healthy phenomenon and who saw the nurses who oriented and learned nursing in her hospital as potential leaders in other places, able to spread their good practice to settings that may need it more. There is a sense that all the effort put out to develop the new graduate nurse will count somewhere else-- in the next job, perhaps. Keeping the nurse is not posed as a reasonable criterion for success. Thus, a nurse's departure is not considered a failure by the unit unless the nurse left in direct response to issues on the floor that the administrator felt should have been prevented. One must note here a similarity to the socialization process of physicians in

residency training. In many ways, the first year resembled an internship for nurses.

One sees an acceptance of turnover by the nursing staff as well. While many nurses feel committed to the units, there is no sense of disloyalty about leaving. Most nurses do not keep it a secret nor feel guilty about it. For those left behind, the departure of a nurse is seldom experienced as abandonment and betrayal. In most cases they wish the person well and see the move as a good one for the person. This individualistic orientation is widespread. For part of this lack of accusation by the stayers may be because each nurse is essentially in the same position-- few plan to stay on the unit for a long period of time and most know that soon their turn will come as well.

New nurses quickly learn that people come and go. They also learn that their childhood, so to speak, does not last long. Seeing an experienced nurse leave seems to scare them a bit as it forces them to hurry up and grow up and take more responsibility sooner. For before long, someone even more inexperienced than they will come along and need their help.

I also found that some people feel one outgrows the unit. A few spoke to me as if there was something wrong with them that they were "still there." Working on the unit is not seen as a career goal. The target is usually nursing in a setting that allows more independence for the nurse, or further education, further specialization, more variety or some other notion of growth. The units were not seen as capable of providing sustained meaning and growth for the nurse over a long period of time. This was particularly evident regarding Elizabeth when she left after 6 years. People were very glad for her that she was leaving, as I indicated earlier. It was as if it was a waste of an excellent thing,

staying so long on these units. Less was said about what meaning she may have found, trying as she did to fill the many gaping holes in patient care, covering for novice nurses and physicians, albeit, often in an invisible way to others, although quite visible to patients.

One wonders why there was so little emphasis on obligation to the unit or to the work group, a sense of loyalty and committment. This obligation it seems, smacks of the image of old nursing ghosts, most particularly the dedicated, selfless, insufficiently paid, sacrificial nurse that many of these nurses wished to bury. The good of the group here is based on the good of the individual If it is not good for the individual to be on the unit, it is best that that individual leaves. Only very positive people are really wanted in the long run.

In fact, the unit is structured around a positive, energetic and probably temporary tenure of the nurse in terms of work load. If longevity of stay is not a feasible expectation, pacing is not a significant issue. One administrative nurse put it this way:

> I expect when people are here that they give 100%. If they stay one year, that's fine. I know they've gotten a good training and education. But I do expect them to give their all while they are here.

It is significant that while this nurse could make this statement, she became more noticeably lax and increasingly flexible toward staff output over time. increased flexibility over time.

The Impact of Turnover

The ongoing turnover obviously affected nurses on the unit. One nurse with two years' experience talked about how demoralizing it was to come to work and find she did not know anybody. She was lightly apologetic about this feeling: "If you are a real professional your work

group should not matter so much. You should be committed in any case." Nonetheless, she was discovering that it did matter.

The onslaught of newcomers was particularly hard on nurses who had been through it once before. Perhaps it was because the first time around there was still a greater empathy with the newcomers, greater willingness to help out, greater involvement in precepting and seeing it as a challenge.

The second time around seems much more difficult. While the nurses have already learned that there will be an ultimate integration of the "new people" with the old, the large number of strangers makes the place feel far from home. Furthermore, work consists of ongoing answering of questions, being on guard for mistakes, and sometimes being the sole "experienced nurse" around. The lack of trust for the new nurses, the feeling that they carry all the responsibility for assuring that safe care will be given, was a tremendous burden on the more experienced nurses.

The extensive time and effort expended on new nurses on these units paid off for the new nurses: many found the place an excellent training ground, many found hospital nursing a pleasant experience that they had dreaded, many explicitly said that they really learned what being a professional nurse means. The units, for this reason, continued to attract newcomers who were looking for such an environment. Many actually stayed much longer than they had originally planned.

While the routinization of temporary passage prolonged the stay of the beginning and intermediate nurse, it seemed to shorten the stay of the more experienced nurses and stunted their development, as many of their own interests and needs were unanswered. Elizabeth described it this way:

> The experienced nurse is frustrated in her work because you want to be able to take care of your patients and not worry about the fact that you know that with patients A, B, C down the hall, certain problems are going to occur soon cause you've been around long enough to anticipate them now. And you don't know if anybody else is going to be there thinking the same thing. And so I became worried about that, such that I wasn't even taking care of the people I was supposed to be taking care of. The thing is terribly frightening. You get overwhelmed with what you know and what they (the new nurses) don't know.

While this clinician was more concerned about immediate patient care issues, some of the clinical leaders' frustrations were on a different topic. For one influential CN III, Judy, try as she might, she could not get the unit to maintain the standards of care she wanted, what she thought was good nursing care. Whereas Elizabeth was a quiet hawk in the background, watching out for something slipping through the cracks with patients, this CN III leader was the visible policewoman, the "bad guy", always harping on people to meet their legal and unit obligations. This drained and demoralized Judy.

A further frustration for the experienced veteran nurse was the absense of a shared culture, shared assumptions, standards, language that could be counted on and understood implicitly. Instead, as we have begun to see, and as we will see more in Chapter Six, much of the culture was very explicit and formal. Much time was spent spelling things out and deciding how and what to do. Much effort was expended in trying to gain control of the events on the units, a result of what Henry calls "system anxiety" (1954:146).

Not only did the experienced staff suffer from having to patiently teach and answer endless questions from new nurses, they had few opportunities themselves for interaction with their peers or higher, as they were often stratigically dispersed among the less experienced

nurses. Thus there were few opportunities for experienced nurses to reflect on their own practice, learn from others, and thus increase significantly their own knowledge and expertise. This could, in fact, freeze the development of the nurse, contributing to a minimalist set of expectations. This in turn can further nursing turnover.

The new nurses also positively influenced the more veteran nurses. Many noted that they had begun to get bored in their work and found the enthusiasm of the new nurses and their questioning to be a challenge and a source of renewed interest in their nursing. Many found new friends among the new staff who often provided each other with a primary social group.

While nurses were sometimes demoralized and not stretched professionally as much as they could have been, the units did, however, manage to function relatively well given the circumstances: patient care was reportedly good and these was usually a great deal of cooperation and unity among the staff. This was often a source of great pride.

In asking what, given the extensive turnover, kept these units together, I found the answer in a commitment to providing a type of professional nursing or "quality care" that was captured by a set of practices which in turn were part of a program designed and implemented in the 1970s. This program-- the Clinical Program-- was a response by nurses in an affiliated chain of hospitals to current problems in nursing and to newly defined goals. In order to understand this project, we must see it in historical perspective. For this, I will briefly review some of nursing's history as it is relevant.

CHAPTER FOUR: THE HISTORICAL BACKGROUND FOR THE GENESIS OF A NEW CLINICAL PROGRAM FOR NURSING

Historical Context of the Project

The Clinical Program was referred to so often I came to regard it as a significant turning point in the development of nursing in this institution and in the practices of the nurses I observed. In tracing this program back in time one sees that it was a set of solutions to many of the problems that were being identified in nursing at the time (see for example National Commission on Nursing and Nursing Education, 1970, hereafter referred to as Lysaught 1970, and Brown 1970 for an overview of these problems). It was also a response to new goals and intents among nurses that were generated by changes in health care and in nursing and in the society at large, particularly the many social movements of the 1960s and early 1970s.

The Program was first and foremost a response to a trend that had grown in nursing, in particular since World War II. This trend was a promotion system that rewarded the skilled nurse with a position in nursing administration. This took the skilled bedside care nurse away from patients and into an arena of administration and bureaucratic concerns. It led to a situation described as, "the better the nurse, the farther away from the bedside."

Despite this prestige system, the cultural ideal remained bedside care (Strauss 1966; Saunders 1958; Reiter 1966; Lysaught 1970) and many nurses as well as patients were dissatisfied with the system. This was one of the triggering factors in a movement, one could even describe as a "revitalization movement," calling for a "return to the bedside" for

nurses. This movement, led by Francis Reiter (1966), pronounced the raison d'etre of nursing as patient care, not education, not administration. The movement was called "clinical nursing."

The call for a return to the bedside was accompanied by a call for positions for clinical nurse specialists (see Lewis 1971; Brown 1970). This was an attempt to create entirely new roles--roles for nurses who had particular knowledge in various clinical specialties. It reflected the growing complexity of nursing care and a recognition of the high levels of nursing skill that were required in many hospitals.

A third problem in nursing that was identified was a lack of differentiation among nursing staff. Nurses were used relatively the same way, regardless of their training and competence (Lysaught 1970; Sheahan 1972).

Fourth, nursing had long been plagued by a large percentage of inactive nurses (Lysaught 1970). The increasing demand for nurses, however, begged for a solution and a means of keeping nurses in active nursing practice, in particular, in bedside nursing. Efforts to make nursing a viable career were called for (Lysaught 1970).

Finally, a new rift was developing in some settings of nursing practice between graduates of collegiate nursing schools and the nurses who practiced in hospital settings. New nurses were leaving nursing at a serious rate, nurses who were trained to be "professional nurse leaders" (Kramer 1974). One of the reasons offered for their departure was a conflict between the values of professionalism that they were taught in nursing school and the values of bureaucracy that they encountered in their work setting. This conflict was labelled "reality shock" (Kramer 1974). Efforts to bring these two sectors of nursing into closer harmony

were pursued (see Gordon 1980b for the history of such attempts in the area of this study).

Changes in the health care sector also contributed to the Clinical Program design. The demand for nursing care, the increase in the complexity of treatment and nursing technology, and the rising acuity of patients that were treated all created new demands for nursing skills of a level higher than before.

Very significantly, one also saw the beginning of the end of unquestioned medical authority and dominance (Starr 1982). No longer would physicians remain above and beyond questioning; no longer did patients and other health care professionals want to be so firmly excluded from participating in their treatment decisions; no longer were physicians immune to questioning.

The change in attitude towards physicians reflected changes in other areas more pervasive in American society, changes triggered by the social movements in the 1960s. A questioning attitude toward people in power, a criticism of bureaucratic demands and values, an assertion of individual rights and the rights of minorities, increasing awareness of the rights of both consumers and of women all were reflected in the Clinical Program. More specifically, the demand of consumers for more personalized health care, in particular from nurses, became a serious concern among nurse leaders (Lysaught 1970; Brown 1970).

The women's movement articulated expanded expectations for women and the assertion that women could perform activities formerly reserved for men as well if not better. At this earlier phase of the movement, the thrust was more towards releasing women from a fixed set of roles and traits and asserting equality with men. It was not the strong thrust

to assert the value of women's activities, such as motherhood that was to come later.

The human potential movement (Tipton 1982), exemplified by organizations such as e.s.t. (Erhard Seminars Training), also contributed to the Clinical Program. Here the focus was on developing the potential of each individual, with growth, personal development, and satisfaction as paramount ideals (Tipton 1982; Yankelovich 1981).

These movements contributed to a sense among many nurses that like other groups, they too were entitled to self-determination. Their years of silent subordination to male physicians must come to an end. No longer should they accept the role of physician "handmaidens."

The Clinical Program, then, grew out of the times and the changed expectations they brought. It both reflected these changed expectations and was an attempt to solve practical problems that were hampering nursing's effectiveness and development.

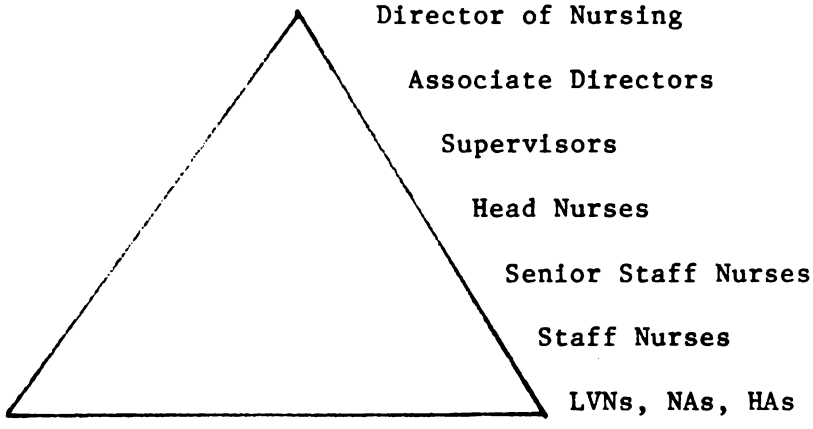
The Project Unfolds: The Genesis and Implementation of The Clinical Program at Ramsey Hospital

The Context: Ramsey Hospital, circa 1970

Ramsey Hopsital was on the cutting edge of change and experimentation in nursing during the 1960s. An entire floor was turned into a "pilot floor" on which new roles were explored and old ones altered; a satellite pharmacy and a ward manager were tried in order to relieve nurses of non-nursing duties. New roles were experimented, specifically the Clinical Specialist role in 1967 and an altered role of the head nurse that focused on patient care issues rather than paper work. While the Clinical Specialist had her difficulties on the unit, the general conclusion was that the role could improve nursing care

(Archives, 1967). The Director of Nursing responsible for these and other experiments retired in 1972 but the Clinical Model that was developed appeared to be a direct outgrowth and continuation of her efforts to keep and reward, both socially and financially, the nurse at the bedside.

Apart from the experimental floor, nursing staff were organized in the rest of the hospital in a pyramid, much like other university hospitals, with the Director of Nursing at the top, thus.



Already Ramsey hospital was unusual in the high percentage of RN staff. Salaries were competitive for the area and very high for the country. Nursing turnover was not regarded as a problem; a one-year's-experience-required policy held. The hospital was also on the cutting edge of developments in medicine. The acuity of patients in the hospital rose during the sixties and early seventies, in part due to new developments in surgery and medical care as well as increasing numbers of elderly patients on medicare. While the cost of medical care was an increasing concern during the seventies, I was told by the nurse leaders that money was not a major consideration at that time, as it was soon to become.

In the 1960s and 1970s, the surrounding city and area was very much at the heart of some of the social movements mentioned earlier. It would have been a great feat for the hospital and its personnel to have sustained itself as an isolated ostrich while surrounded by intense questioning. All indications are that that questioning made its way through the doors.

According to those interviewed, the tone of the relationships between administration and physicians on the one hand, and the nursing service on the other hand, were adversarial during this period. Many on both sides indicated that this tone was set in large part by nurses. That nurses should be more assertive and be on a more equal footing with medicine was a prominent nursing message. Medicine and administration as the oppressors and nursing as the oppressed was another idiom.

A final contextual condition for experimentation was that the hospital nursing department and the school of nursing were trying to remove barriers that had apparently grown between them. Collaboration Project, a committee of both nurse educators and nursing service personnel, was formed with the mandate of enhancing rapproachement.

The Trigger

The apparent trigger of the project came in a request from the Hospital Personnel Department to the Staff Development Department of Nursing Services in 1971 for their approval of a job description for the new nursing role, Clinical Nurse Specialist. The description, bureaucratically essential to institutionalizing the new role, was reportedly written by a non-nurse in a Personnel Deparment outside the Medical Center.

This request for approval raised several questions among the nurses in Staff Development. They wanted to know: why was the Personnel Department responsible for writing and defining such an important new nursing role? Why were administration and supervision so strongly emphasized in the definition of this new clinical role? And perhaps more importantly, was it feasible or productive to add a new role to an old organizational structure, particularly when that old structure, upon review, appeared archaic and stultifying?

These questions led to a demand for a redefined job classification structure. Yet this would be no simple matter. As Ramsey Hospital was only one among several affiliated medical centers using the same classification system, reclassification required participation and approval by nurses in all affiliated institutions. Their participation was successfully solicited. Nurse representatives from three metropolitan areas met with Personnel and negotiated a mutually-agreed upon request for a new classification system for all nurse positions throughout the system.

The overriding goal of reclassification was to establish a new Clinical Ladder that would allow nurses to advance in a hierarchy while remaining in clinical rather than administrative nursing. No such option then existed at Ramsey, or at other hospitals, for that matter. The established promotional system rewarded clinical competence with an administrative position.

Work on designing the new ladder began in 1971 as nurse representatives worked together for over two years. They included directors of nursing and staff nurses, from a range of settings, from schools of nursing to clinics to staff development personnel to student services. Feedback and approval reportedly were solicited from staff in

the respective home environments, but I remain uncertain as to the degree of contribution and/or representation on the committee of staff nurses. The nurses worked alone with little awareness of hospital administration or physicians: "It was none of their business," was one reason offered for this exclusion. Nurses needed to work together and achieve consensus before turning to outsiders, I was told. Achieving consensus proved to be no small achievement. Meetings were laborious, painstaking, politically and ideologically charged, and full of conflict. Reclassifying nursing roles forced many issues: what were the desired behaviors and attitudes for nurses, and what were the desired relationships between nurses and patients, nurses and physicians, nurses and other nurses, nurses and the hosptial, and the nurse and herself? The discussion around words, phrases, and objectives was often heated and controversial. Some of the pioneers I spoke with thought that some of the participants were firmly invested in "traditional attitudes and relationships." To paraphrase one, "We encountered nurses who held a mothering attitude toward other nurses, referring to them as 'poor little things.' They saw nurses as dependent upon the physicians, and patients dependent upon the nurses-- the very mentality we were trying to change!"

But change had begun: it was demonstrated by the very fact that the nurses rewrote their own job descriptions and structured nursing services alone; by the discussion and eventual concensus among such broad-based participants around the ideas and the practices they designed; by the very process and the excitement around it.

The clinical ladder and the job descriptions complete, several pioneers quickly published an article presenting the model of

the clinical ladder[1]; in the event that their efforts to implement the project failed, they wanted their ideas to live on.

Approval

Only after completion of the design of the clinical ladder and the job descriptions did the nurses present their proposal to the hospital administrators. The latter, clearly bothered by the belated disclosure, refused to comply with the multiple requests, many monetary and some implicit, in the proposal. The monetary implications of unlimited numbers of nurses moving up an open ladder--as was the intention -- would not be granted. Tense negotiation followed. While the clinical ladder proposal for the reorganization of nursing service was approved, problems arose with the implementation, as sufficient funds were not made available to fund the positions as designed. The result, according to one pioneer, was that the implementation and evaluation were done on a "shoe-string" and in a "basterdized" form.

Implementation proceeded nonetheless, but it proceeded, significantly, with only a clinical ladder. While clearly the most novel element of the program was the clinical ladder, the initial plan called for two parallel ladders, clinical and administrative. While other medical centers implemented both ladders simultaneously, only the clinical ladder was implemented at Ramsey; there the nurses gave priority to the clinical ladder and thought perhaps the administrative one was not really necessary or that it would "just fall into place" at some later date.

Implementation

Between September 1974 and August 1975, preparation and implementation of the clinical ladder began on a pilot floor (consisting

of 4 units). It began by the hiring of a nurse to pilot to new CN IV position. This nurse, Linda, was also charged with designing a new model of nurse evaluation-- Peer Review (to be discussed more fully in Chapter Five). In fact, at this time a number of other changes were designed and implemented: Standard Care Plans were developed; Problem-Oriented Charting was pilotted; A Conceptual Framework was outlined; an Orientation Program for new nurses was designed, and nurse classification according to the Peer Review process took place (Annual Report of the Pilot Floor's activities, 1975).

Implementation was not easy. Numerous conditions affected the process, such as a physician strike, increased acuity of patients, inconsistent leadership and secretarial help, and in several cases, nursing turnover; this latter was to become a frequent companion of the implementation process.

Implementation progressed from unit to unit throughout the hospital. Word spread ahead, in part rumors, fears, guesses as to what was going on, and on some units the model took on a dreaded quality. Some staff nurses reportedly hopped from unit to unit to avoid participating in the new program. Many nursing staff departed in the wake of the new program, some in clear reaction to it, some because they were blatantly encouraged to leave, and some because the change served as a trigger for latent plans to leave anyway.

Implementation on each unit proceeded by first finding a nurse for the CN IV position. Change was usually initiated with her Peer Review in which a number of the unit staff participated. These reviews, in fact, appear to have been like a formal opening ceremony, a marker of the initiation of the new way of practicing nursing--professional nursing.

Some of the first peer reviews were described as "public spectacles": not only did numerous participants attend, but others were invited to observe this new drama. And from all accounts it was just that. Eight people participated formally in it. After that each staff member had to be evaluated and reclassified according to the new job description. Head nurses were allowed to move to a CN III position, but only after they had gone through the peer review process, after they had prepared a folder. Yet even if reclassified, they were no longer the "ruling" force some had been in the former system; senior staff nurses had to undergo the same process. When one considers the new criteria of judgement in the Peer Review Process-- a folder consisting of written samples of these newer and "more professional" ways of nursing-- it was not surprising that many former leaders, in particular, found the transition extremely difficult. Many found the new method of care planning, for example, to be extremely cumbersome, instrusive and foreign. One of the pioneers, in hindsight, described the extent of the change implied:

> It was as if we suddenly introduced an ENTIRELY different set of standards against which we would evaluate everybody-- standards we had taken from some New Guinea tribe. And then demanded they change overnight!

Other changes that took place included the decentralization of the hospital nursing service. Hiring functions, for example, were transferred from the nursing service office (the Assistant or Associate Directors) to the units where the head nurses and staff interviewed and selected new employees for the first time.

In 1979, the clinical ladder was joined at Ramsey by the administrative ladder, beginining with the Ad Nurse III position on the unit level. Two years later the Ad I position was added, all aligned under the Director of Nursing.

Of significance is that by 1980 all of the pioneers of the new model had left their positions at Ramsey and only one remained working at the medical center, albeit in another setting. A new Director of Nursing stepped in in 1980. No sooner therefore had the new program been instituted than some changes in it were proposed and later implemented.

The Response and Evaluation

It appears than an outstanding cause of the questionable success of the Clinical Program initially was its being implemented without an administrative component. This neglect was not lost on anyone; it was perceived in some ways as a slap in the face to the administration and to physicians. Many nurses, administrators, and physicians think in retrospect that this was a mistake and that the Clinical Program took a beating because of it. A smooth and facilitating environment in which the clinical component could flourish did not exist. The clinical nurse was forced into the role of administrator, simply because numerous essential administrative tasks needed to be done. In the words of one of the pilotting nurses:

> It was a terrible mistake (to have left out the administrative ladder at the beginning). I'll use myself as an example. I was a CN IV. It removed the administrative support and I ended up taking that on myself. So it bastardized the role of the clinical ladder because the CN III had to take the role of the Charge nurse, as there wasn't one. Someone had to pick up that administrative piece. So by not implementing the administrative ladder, which was not done, was to not give us some administrative support.

Some think that there actually was a belief that administration in nursing was not really needed. It was, after all, an era in the institution in which administration was being de-emphasized and in which the relations between nursing service and hospital administration were poor.

Physician involvement was apparently little, particularly at the beginning. Most "educating" of physicians was done on an individual basis. "Nurses had to get their act together" before incorporating physicians into their plan was the feeling. In fact, this epitomized the new approach of not "asking permission." The result was that physicians were often turned into the enemy and an anti-physician attitude developed. Some physicians were supportive of the project, particularly when informed and included; others were not. Physicians' biggest concern was that while the clinical ladder was touted as a means for keeping highly qualified nurses "at the bedside," this did not occur, in large part because they were busy with administrative matters.

The Meaning of the Clinical Program for the Participants

The Clinical Model triggered diverse responses, from strongly positive to negative and to occasional indifference. As mentioned, it was referred to so often it led me to regard it a a significant movement. While the term most often used was "clinical ladder," it was used both in a narrow sense as well as a more general sense to describe the bundle of changes and approaches here described.

In interview, then, some spoke of the Clinical Program in a very specific way-- the implementation of a new ladder. When I suggested more was involved, most informants heartily concurred. An example of a broader interpretation came from a nurse peripherally active in the implementation phase:

> It was part of a larger movement designed to identify independent functions of nursing apart from the traditional dependence on medicine. The whole flavor was to establish nursing as an independent profession with an incumbent focus on the role of the nurse.

Some of the pioneers of the movement were caught by the potential they perceived in the ladder and saw it in larger terms-- an effort to establish a new model of nursing. Much excitement accompanied the project when it began. This diminished as numerous snags were encountered during implementation. In retrospect, some see that they expected more change than actually occurred;

> I think that I thought there was going to be more impact than there was. I saw the opportunity for bigger and better things and really changing nursing practice. And that's probably also because I was probably in the more idealized era of my own career. Now when I look at it, I see that there was some impact on practice and on attitudes. I think what it may have done to nursing is to offer an avenue for other institutions to look at. And the intent of the clinical program is good. We made a lot of mistakes, but that's true of pioneers. We made alot of mistakes, but we did the best we could.

That is in retrospect. What did the Clinical Program mean to its proponents at the time? This is well captured in a progress report written by this same nurse who was active in implementing the model. She admitted encountering numerous problems but went on to say:

> In spite of experiencing periods of feeling lost in terms of my role and the Clinical Program on the ___ floor, the motivating force that has driven me to try was my conviction that if the Clinical Program failed, nursing in general would also fail. If we cannot achieve control of nursing by nurses, then we will cease to exist as professionals and must again accept our position as, not a colleague, but a handmaiden of the physician (Archives Report 1975:17).

NOTES

1. In an effort to preserve the anonymity of the program, this article, although published in a nursing journal, will not be directly cited.

CHAPTER FIVE: THE CLINICAL PROGRAM: MODELS, PRACTICES, AND THEMES

We have reviewed the events leading to the design and implementation of the new clinical program of nursing practice at Ramsey Hospital. This program embodied new definitions and new ways of being a nurse which led, in turn, to new relationships. It entailed a changed configuration of traits lumped under the term "nurse" or more accurately "professional nurse," and an effort to secure more power and autonomy. While few of the goals were new, they had existed more in dream, ideology, or idiosyncratically than in institutionalized and consistent practice; the program sought to operationalize and institutionalize these goals by translating them into models for practice.

In this chapter I will examine this Program more closely-- the themes and meanings, the models, and the practices into which it was translated--looking at what the nurses sought to achieve and why. We will begin by looking individually at some of the models and practices that were designed and incorporated. Those I have selected for study are not the only ones, but they were central to the program and continued to be so through the period of my study. These are:

1) The Clinical Ladder
2) The Nursing Process Model
3) Job Descriptions
4) Peer Review
5) Nursing Care Plans

While the practice of primary nursing --a system of nursing where a nurse has primary responsibility for all the needs of a patient--is central to this program, it was not implemented as part of it; for this and other reasons I did not systematically study it.

In looking at these models and practices I will identify and interpret a recurring set of themes which in turn are composed of a number of recurring meanings. For my purposes here, theme refers to a recurring, inductively-derived category or value found in the discussion and the models and practices of the Clinical Program. This order of analysis, chosen for clarity here, poorly reflects the actual process by which the Clinical Program evolved. It is more likely that in that evolutionary process a set of goals and meanings, explicit and inchoate, were translated into practical solutions. The themes I will identify are: Patient-centeredness; Autonomy; Growth; Rational, Scientific and Pragmatic Approaches; Differentiation; and Formalism and Standardization. Finally I will explore what the project meant as a whole, summarizing and interpreting the movement.

1. The Clinical Ladder

The skeleton of the new model and the first practice designed was a "clinical ladder" for nurses, completed in 1973. I draw much of the following description and discussion from the article written by some of the pioneers of the ladder.[1]

According to the authors, the clinical ladder was developed in order that clinical competence, knowledge, and performance could be rewarded extrinsically, i.e., monetarily, as well as intrinsically. Competence in patient care would be rewarded through promotion within the clinical domain. Further, the clinical ladder had the following stated objectives:

1) Establish career patterns that provide for quality care
2) Utilize (appropriately) nurses educationally prepared for a variety of levels of practice
3) Provide for recognition and placement of the highly qualified nurse practitioner in direct patient care activities

4) Provide for differentiation of levels of nursing competence
5) Provide explicit expectations for practice that serve as guides for evaluation.

The emphasis throughout, the authors note, "had to be on direct and active involvement of the nurse in determining the nursing needs of the patient and his family." The ladder, then, places responsibility and autonomy of patient care in the hands of the individual practitioner nurse.

Four levels of nursing were defined for the clinical domain: Clinical Nurse I, II, III, and IV. Clinical behaviors expected of the nurse at each level-- the minimum behaviors expected consistently over a variety of situations-- were spelled out in behavioral terms that could be quantitatively evaluated (see section on job descriptions). The levels were designed to reflect differences in: the depth of knowledge upon which nursing decisions were based; the scope of practice; and "the degree of responsibility of the practitioner to evaluate her own performance and identify and take intitiative for her continued need for professional growth."

Let us consider these objectives more closely.

Objective 1: "Establish career patterns that provide for quality nursing care."

This emphasis on career patterns is significant. Its plea is not only to keep nurses "at the bedside" but also that they approach their work as a career, i.e., as a professional. The first target is the nurse who does a quick stint in nursing only to leave, get married, and perhaps return many years later. The hope instead is to have her stay in nursing continuously. The second target is what is sometimes referred to as "the blue collar element" in nursing, the attitude of nurses who

approach their work as "just a job" or putting in time; work is not a central passion or commitment, not something they take home with them. More generally, this reflects an effort to differentiate registered nurses from "technical nurses" or "practical nurses"-- LVNs. A job seems to imply subserviance and a lack of seriousness; a career implies autonomy of the individual, continuing growth, seriousness of effort, expectation of being taken seriously and professionalism. This objective is supposed to be met through providing a ladder of positions for upward mobility at the bedside.

Objective 2: "Utilize (appropriately) nurses educationally prepared for a variety of levels of practice."

Few practice settings differentiate between the three types of educational background of registered nurses and this is one of the objectives of the project-- to differentiate between nurses with A.A. Diploma, and Bacclaureate degrees. As Brown notes, "... while the system of nursing education is on several levels, nursing practice is largely on one level" (quoted in Sheahan 1972:440). Sheahan expresses criticisms of the undifferentiating situation:

> In the present arrangement, or lack of arrangement, no nurse is anything distinctive. The practice field, consequently, generated neither incentives nor imperatives for advanced preparation. If distinctions were made in practice... the professional character of nursing would be changed, and the esprit-de-corps as well. Only the nursing profession can make these distinctions in practice... It is imperative that the professional and technical practice be distinguished (Sheahan 1972:444).

The clinical ladder addresses differences in educational background in its requirements for advancement up the ladder. Nurses with the bacclaureate degree consistently need less experience in order to advance, as their collegiate degree qualifies them earlier

for promotion.

Objective 3: "Provide for recognition and placement of the highly qualified nurse practitioner in direct patient care activities."

As described earlier, this objective is part of the movement to recognize and utilize highly qualified nurses-- referred to here as nurse practitioners-- in patient care. This is a continuation of the effort to develop the role of a clinical nurse specialist that was being worked out at the time.

Objective 4: "Provide for differentiation of levels of nursing competence."

This objective again calls for differentiation among RN nurses, this time on the basis of competence in patient care. It contrasts with prior differentiation on the basis of seniority or on the basis of different degrees. In fact, it is another effort to move away from the common "a nurse is a nurse" approach that had long characterized hospital nursing.

Objective 5: "Provide explicit expectations for practice that serve as guides for evaluation of performance."

In this objective, we see the effort to make expectations of nursing practice explicit, standardized and universal. Emphasis in evaluation is to be on performance rather than on character or bureaucratic requirements, such as punctuality. Objective 5 is met through the job descriptions to be discussed more fully below.

The clinical ladder is more than the sum of these objectives. It is based on a new set of assumptions about nursing that had administrative and organizational implications. For example, the authors write:

> A clear implication of the clinical program presented here is that a decentralized nursing service organization will follow implementation. When responsibility and accountablity for the nursing care of patients rests with the nurse practitioner, the

> traditional role of the supervisor will become obsolete. The need for administrative services for nursing will certainly not disappear. It will be redefined. The clinician who has had responsibility without authority and who attempted to insure quality nursing care through charismatic persuasive power is no longer adequate to meet the needs of the public for effective nursing care. The authority of the supervisor and the competence of the clinician must be combined within a single role.[1]

Thus decentralization of nursing judgement from the hands of the few nurse supervisors and head nurses into the hands and minds of each and every bedside nurse, stated in terms of accountability and authority, entails the decentralization of nursing services to the unit and individual level.

Finally, in summary, the authors say:

> The clinical program defines levels of competence and recognizes the nurse who is directly involved in providing care to patients and families. The system reflects growing awareness that responsibility for practice rests with the clinician who is accountable for the quality of nursing care provided to consumers.[1]

They regard the endorsement of the new program as representing a change toward increased autonomy and self-direction for nursing as a professional discipline within the university system.

Analysis of the Clinical Ladder: In this clinical ladder we see already all the basic ingredients of the new model: the focus is on the patient, almost a "return" to the patient; the emphasis on growth and career; the autonomy, responsibility and accountability for practice of the staff nurse; the autonomy of the nursing profession vis à vis medicine and administration; the desire for differentiation of levels of competence and of educational background among registered nurses (instead of differences based on seniority), with high preference going to bacclaureate training and above; and finally, the emphasis on evaluation

As some of the pioneers indicated, in many ways, the clinical ladder epitomizes a compromise between bureaucracy and professionalism, as through the use of a bureaucratic tool-- a ladder-- professional nursing, in the sense of more autonomous and accountable, was to be defined, cultivated, and enhanced.

The development of the clinical ladder answered another long but troublesome problem in nursing, one that was never addressed directly in the discussion. Social scientists have long pointed out how nurses were answerable to two authorities: hospital administration and physicians (see Mauksch 1966, Smith 1955). While the development of a clinical ladder in conjunction with an administrative ladder does not completely ameliorate this structural situation, it clearly attempts to ease it for the nurses.

2. "Nursing Process": "A Model for Scientific Problem-Solving"

The basic organizing model of the job descriptions and to some extent the nursing care plans is a construct called "nursing process." Initial use of this term began in the nineteen fifties; it increased by the mid-sixties at which time the first book on the topic was published (Yura and Walsh 1967). By the seventies, the model had gained acceptance in nursing and had become widely disseminated (Yura and Walsh 1973, 1978; La Monica 1977; Marriner 1975).

Mayers (1972), whose work was used at Ramsey Hospital, defines nursing process this way:

> Nursing is a rational and systematic process which consists of intellectual, behavioral, and technical components based upon relevant theories, concepts, and principles from the physical and social sciences (1972:3).

Note the emphasis on being rational and systematic and that reason in nursing practice is based on theories, concepts, and principles from science. Note also the strong link between nursing activity and a scientific basis of that activity and the deletion of any reference to the emotional or relational dimensions. Mayers goes on to define nursing:

> ...nursing consciously, rationally, and scientifically intervenes in health-illness environment for the purpose of maximizing the possibility that individuals, families, and groups will have adequate personal care, maintenance, safety, and comfort (1972:3).

What is remarkable about this quote is what is not taken for granted, if we can assume that what is stated explicitly is not assumed-- that nursing is conscious, rational, and scientific.

Yura and Walsh, in a similar tone, define nursing process through reference to Webster's definition of "process":

> an action of moving forward, progressing from one point to another on the way to a goal, or to completion; it is the continuous movement through a succession of developmental stages; it is the method by which something is produced, something is accomplished, or a specific result is attained (cited in Yura and Walsh 1973:23).

The authors interestingly elaborate this definition in terms of its implications for nursing:

> To perceive a process as an action suggests a <u>power</u> behind the action or a mover of the action, hence control and/or systematic movement. Conscious and deliberate effort must be exerted to arrive at a desired goal.
>
> The absence of a planned or deliberate mover or movement results in a mechanical, automatic effort, perhaps chaotic in nature, and certainly not orderly or systematic. Absence of a task or goal towards which a process is directed renders that process useless; it has no meaning if there is no purpose or potential for application. The basic concept of the process suggests

> it is a unified whole; it can be described in terms of phases, but each phase is dependent on the others... none stands alone... a total concept of the process is necessary. (Yura and Walsh 1973:23).

Nursing process is typically divided into sub-processes, the most common being four: assessment; planning; implementation; and evaluation (Yura and Walsh 1973).

The term and concept "assessment" entered nursing vocabulary only recently, beginning in the sixties when one began to hear repeated emphasis on nurses "making assessments," decisions, and solving problems. Possibly the first article of this genre was by McCain in 1965 called, "Nursing by assessment-- not intuition." The author writes:

> Nursing, as it is taught and practiced today, is primarily intuitive. Unlike other professions of law, engineering, and medicine, nursing has not developed a precise method of determining when nursing intervention is needed (1965:65).

Intuition here is contrasted with precision; assessment, on the other hand, is assumed to be deliberate. One saw further developments in this direction in an article in 1966 by Durand and Prince entitled, "Nursing diagnosis: Process and decision"; this was followed by an article by Francis (1967) called, "This thing called problem-solving," in which the author outlines six steps in formal scientific problem-solving, stressing that is always a conscious process (1967:7). These articles all pointed the way to developing the cognitive and judgmental dimension of nursing practice, asserting that nurses could and should make judgments and assessments and that they should make them scientifically like other professions supposedly did.

professions supposedly did.

The assessment phase of the nursing process is described as identifying and defining the patient's 'problems'; it begins with collecting data and ends with the nursing diagnosis of the patient's problem (Marriner 1975:1). I was told by one of the authors of the job descriptions at Ramsey Hospital that the term "diagnosis" was expressly omitted from the job descriptions in favor of "assessment," as the former was a charged and forbidden word, a red flag to some physicians that nurses were moving into medical territory.

The "planning" phase of the nursing process means, "to determine what can be done to assist the client: it involves setting goals, judging priorities, and designing methods to resolve problems" (Yura and Walsh 1973:28). Care is "taken that goals are measurable, attainable, reasonable, and representative of the patient's aspirations" (Mauksch and David 1972:2189). Planning is recorded primarily in a nursing care plan which should contain the patient's "problems," the goals and objectives of care, and the interventions directed towards meeting them. The plan should be so individualized that it cannot be used for another patient (Marriner 1975:2).

The "implementation" phase entails carrying out the care plan. It is the actual giving of nursing care directed toward accomplishing the described goals.

Finally, the "evaluation" phase of nursing process entails the appraisal of the client's behavioral changes as a consequence of nursing actions (Yura and Walsh 1973:23-28). The outcome of the care is compared with the objectives in the care plan. Evaluation is supposed to indicate whether or not problems have been solved and what needs to be

reassessed, replanned, implemented, and reevaluated (Marriner 1975:3). Yura and Walsh explain the prior neglect of this phase of nursing as

> perhaps because there is a paucity of tools whereby the nurse could evaluate her actions with a high degree of objectivity. Some subjectivity enters into any human evaluation, but nurses are constantly striving to minimize it (1973:31).

Analysis of Nursing Process: The Nursing Process model projects several important characteristics of nursing practice. The patient has moved from being a passive character acted upon to being the primary determinant of nursing action and an active partner in the process; the term "client" seems to embody this change (see Armstrong 1983 for discussion of this change in England). Nursing care is to be more 'individualized' and deliberate; it is to focus on identifying problems and solving them. It is to be self- conscious and to evaluate its achievements and successes. And it is to be deliberate and scientific in all phases. In traditional sociological terminology, it is to become more instrumental and scientific.

3. The Job Descriptions

If the clinical ladder is the skeleton, the nursing process model the brain, the job descriptions are the flesh. If the clinical ladder is the structure, the job descriptions are the cultural code and the nursing process is the paradigm behind that code. The job descriptions became a central tool in the movement and a major device for changing nursing practice and operationalizing professionalism, as it was interpreted, in the clinical domain. The job descriptions are formal models consisting of 3-4 pages of stated expectations for each of the four positions on the clinical ladder: CN I, CN II, CN III, and CN IV. The intent was to write these expectations in the form of behaviorally-

stated objectives that could be evaluated quantitatively and objectively. Prior job descriptions "were too global and non-standardized," I was told, consisting of large categorical areas, such as "patient care" or "patient teaching" and they lacked any real definition of what good nursing practice would look like behaviorally. Such was not the case with the new job descriptions which spelled out behavior rather than attitude; it was assumed that changes in attitude would follow changes in behavior.

Furthermore, the new job descriptions were seen as necessary because the old ones were "written as a list of tasks or duties to perform." While I did not necessarily find this to be true, it is true that such descriptions and characterizations of nursing fill the literature and are common in bureaucratic settings. However, it was not the format-- a formal list-- of the traditional job descriptions that was objected to, but rather their content.

According to one of the pioneers, the items included in the job descriptions were of several types. Some were clearly new in hospital nursing practice, such as the call for nursing research. Some were behaviors that took place occasionally, but which they wanted to institutionalize, such as attention to psycho-social issues of patients. The intent was to make all nurses accountable for the behaviors and to assure consistency. Finally, some behaviors were included in order to give nurses recognition for behaviors they were already performing, such as "making assessments" of patients (diagnosing their problem). The goal here, I was told, was to legitimize nursing power, responsibility, and authority.

The language used in the job descriptions was carefully chosen, argued and haggled over, traded, bargained and negotiated for. Much as

an ideological statement, these job descriptions were charged material used as a manifesto of change. The job descriptions will be analyzed more fully in Chapter Seven. Here I shall limit discussion to general characteristics.

Overview of Form and Content: Several significant overall characteristics of the job descriptions stand out. All four positions are written in the same format: that is, a list of behaviors that can be quantitatively evaluated (see Appendix D for samples). While experience is a requirement for advancement, no provision is made for the amount of experience within a given level. This means that unless a nurse moves to a higher position, which only a minority do, she will be evaluated by the same job description, whether she has six months or six years of experience.

The job descriptions spell out at each level the "responsibility and accountability" of the nurses at that level. In general, a nurse is responsible for the nursing care behaviors of her position and is accountable to the clinical and administrative nurses above her. For example, the CN II is accountable to the CN III and the CN IV and the Administrative nurse.

The job descriptions are divided into 4 or 5 parts: 1) Nursing Process: Assessment, Planning, Implementation and Evaluation; 2) Teaching; 3) Communication; 4) Evaluation; and 5) Research (for the higher levels).

Finally, at all levels to varying extents, strong emphasis is placed on writing skills (such as nursing histories and care plans) and the nurse as a scientist collecting and evaluating data. On the other hand, no mention at all is made of the kinds of relationships nurses

establish with patients, how sensitive or caring they are, how well they work with patients. Nurses are supposed to be "client-centered" and very deliberate and informed. Significantly, one hears no mention at all of a nurse's skill with nursing technology.

A significant dimension of these job descriptions is the extent to which a nurse's practice is conceived and judged on the basis of written work or the representation of practice through nursing histories, care plans, and charting. Nursing is repeatedly and deliberately filtered through a number of nursing constructs, such as "patient problems" or "standards of care" (Table A, Appendix D). Nursing care, it seems to imply, should be an interaction between "standards of care" on the one hand, and the "individual needs of the patient on the other"; these should be construed in terms of "problems" that are assessed, solved, and evaluated. Examples of job descriptions items are;

> Identifies common recurrent patient problems, symptoms, and behavioral changes in relation to: a) standards of care and b) individual patient needs (CN II description)
>
> Revises the initial nursing care plan to the changing needs of the patient (CN II) (Note, revises the nursing care plan, not the care)
>
> Evaluates the response of the patient to his nursing care plan (CN II) (Note that the response of the patient "to his care" is not the emphasis)

Communication is mediated with the patient as well. One does not talk to a patient, rather one "applies effective interviewing skills to elicit information..." This again also emphasizes the deliberateness and skill a nurse uses.

What kinds of nurse patient relationships did these job descriptions solicit and what types of resources were nurses to be for patients? The job descriptions repeatedly call for nurses to involve patients and their families in their care (see Table B

in Appendix D). Involvement is most implied in the area of information and "learning needs" of the patients. Behind this one hears a concern for enhancing and nurturing the autonomy of the patient, doing whatever possible to let him guide and participate and take responsibility for his own care. Families of the patient are to be involved as well, a statement again that emphasizes the autonomy of the patient from the nurse and an effort to have the patient use and rely on his "significant others." Importantly, the nurse-patient relationship is most described in terms of communication, with an emphasis on the nurse being able to elicit and communicate information to the patient.

The dominant image of the nurse's relationship to the patient is the nurse as a problem-solver and a teacher (see Table C in Appendix D). Only one line addresses the nurse's impact on the emotions of the patient: "applies effective interviewing skills to elicit information from patient and/or family that is necessary to plan, implement, and evaluate nursing care...."

Finally, one must note that as one advances up the clinical ladder the implied relationships between the nurse and the patient become more formal. The Clinical Nurse IV position, significantly, announces that this nurse is to "establish mutual contracts with patients that spell out expectations."

Nurses' relationships to physicians are also alluded to in the descriptions, but noteworthy is the rarity of actual references to physicians at all. Explicit mention of them is limited to:

> implements the medical care plan as delegated (CN II)
>
> assesses the need of a specific patient population by: ...collaborating with physicians and other health care workers (CN II)

Other references to physicians are by mention of "health team members" and this reference generally refers to collaborative relationships (see Table D in Appendix D).

The job descriptions were pivotal statements in the Clinical Program. In Chapter Seven we will analyze them more extensively in terms of the kinds of knowledge they solicit and reward and their functions and limitations as formal models.

4. Nursing Care Plans

A fourth component of the Clinical Program is nursing care plans, a component that seems to symbolize the new order and to divide nurses in their allegiance to the 'old' or the 'new' way of nursing.

Nursing care plans have long been used in nursing, though attention turned to them more seriously in the late fifties. The general term "care plan" masks a wide variety of philosophies and types (McKossky 1975).

The particular model of care planning used at Ramsey Hospital was taken from Marlene Mayers, A Systematic Approach to the Nursing Care Plan, published in 1972 and pilotted in part at the hospital. A copy of this book is present on the units and its availability made known to all the nurses entering the unit. Mayers' care planning is based on the Nursing Process model discussed earlier. The image of the nurse as problem-solver, deliberate thinker, and planner is central, as the nursing care plans are considered a "systematization of the problem-solving process." The author notes her allegience to systems management and research fields in some of the strategies she incorporates.

The book is said to "present a systematic method for organizing and

managing patient care information in such a way that it results in patient-centered, goal-directed care." The design for nursing care plans is geared to setting up "rational, patient-centered plans" of action in an "organized, logical and systematic way" which also takes into consideration the realities of the nursing service setting (Mayers 1972:ix). Mayers defined a care plan in the following way:

> An abstract of data concerning a specific patient--data which is organized in a concise and systematic manner, which facilitates overall medical and nursing goals, and which clearly communicates the nature of the patient's problems and the nature of the related medical and nursing orders (Mayers 1972:13).
>
> Patient care planning is the systematic assessment and identification of patient problems, the setting of objectives, and the establishment of methods and strategies of accomplishing them (Mayers 1972:1).

Mayers noted that while care plans have been important educational tools they have been used less successfully in the actual practice setting (1972:10). With this in mind, she deliberately developed her care plans in a practice rather than an academic setting in hopes of making them more pragmatic. Nursing care plans, it should be noted, are now universal requirements for licensing and accredidation of nursing service agencies.

The care plans consisted of several parts: 1) a nursing history; 2) standards of care or models of care; 3) a list of nursing problems; and 4) nursing progress notes, called SOAT-AT or SOAP.

a. Nursing History: Nursing histories have been recently introduced at Ramsey hospital and for that matter at most hospitals; it was only in the 1970s that they were designed and implemented by one of the practice committees set up at the time of the implementation of the clinical ladder. Hours were spent deciding what exactly should go into the nursing history. The topics eventually included were : 1) activities of

daily living, such as sleep and diet patterns; 2) the physiological condition of the patient; 3) psycho-social needs of the patients; 4) perceptions of the patient and/or family regarding the patient's health problems; 5) expectations of the present hospitalization and; 6) information needed for discharge planning. The nursing history is the main component of the "assessment" phase of the nursing process.

These items were printed on a new form on which the nurse recorded while she "took a nursing history." While some of the information garnered in the history had been collected before the form was adopted, I was told that it was in a less formal and systematic way. As one nurse of the old regime noted:

> I used to collect this same information before while giving a patient a bath or something. I found it extremely uncomfortable at the beginning to go in there very formally and 'take a history.' I did it much more subtly before, but eventually I got used to the new way.

b. Standards of Care and Models of Care

Initially care plans were written out completely by each nurse. This took so much time that it was soon decided that they should be standardized. Nurses were asked to volunteer their time to write care plans for the recurring nursing problems encountered on their units. The plans were based on both a review of the literature and on experience, though in several cases, the nurses who wrote them had but one to two years' experience.

The standards of care were organized around 3 components: 1) patient problem/expected outcome; 2) nursing orders; and 3) discharge criteria.

Patient problems are presented in the form of a "due to" statement. For example, one problem cited is "nausea and vomiting due to

anaesthesia, decreased intestinal motility, malfunctioning NG (naso-gastric) tube, disease process." In other words, the "why" or cause of a problem is included in the statement. Under each problem statement is a list of "expected outcomes." These are the criteria for deducing whether the problem has been solved or not. The problems listed for Major Abdominal Surgery, for example, are:

1) Need for pre-op teaching due to impending surgery
2) Draining abd (abdominal /perineal wounds)
3) Nausea and vomiting
4) Decreased lung expansion
5) Pain
6) Radical shifts in body fluids
7) Pains and Constipation
8) Immobility
9) Need for d.c. (discharge) teaching

Each problem is accompanied by a list of nursing orders which break down the desired activities and list them in a step-by-step fashion. The orders for pre-op teaching for major abdominal surgery, to continue with the example, are:

1. Assess patient's (pt's) perceptions of disease and surgical procedure, noting degree of anxiety, denial, depression, anger
2. Encourage questions and expressions of fears and concern
3. Explain to pt. with rationale
    a. NPO p MN
    b. Bowel preps, enema, if any
    c. Pre-op meds
    d. Anesthesia visit
    e. time in PAR
    f. Other general info (visitors, chaplain, family, waiting areas, time of OR)

Nursing orders, as defined in a memo, are "those independent nursing interventions that are likely to produce the expected outcomes by the target date or time" (Archives, 1978).

Each problem has a list of "expected outcomes" that should occur if the action had the intended effect. The outcomes

expected for pre-op teaching are:

> Verbalizes an understanding of surgical procedure, altered anatomy (ileo, colostomy), and an understanding of post-operative course and expectations.
>
> Verbalizes fears and concerns related to change in body image, need for invasive procedure, pain, mutilation, death, unknown prognosis.
>
> Demonstrates ability to TC and DB (cough and deep breath), use ICS (incentive spirometor), leg exercises.

Finally, the standard care plans include "nursing criteria for discharge or maintenance" which are the overall "expected outcomes." For major abdominal surgery these are:

1. Surgical incision well healed
2. Pt(patient) able to resume pre-op ADLs (activities of Daily Living)
3. Verbalizes knowledge of and can express, using own terms, any restrictions, activities, and/or medical follow-up.
4. Verbalizes understanding of s/s (signs and symptoms) of infection and delayed abscess formation.
5. Verbalizes knowledge of and willingness to comply with clinic follow-up.

While patient care plans were standardized, they also needed to be "individualized," that is, adjusted to reflect the needs and situation of a particular patient. For example, if a patient does not speak English, the nurse will note the need for a translator and be particularly alert to finding family members with whom one can talk (this was the example given to new nurses in a orientation class on care plans). But "individualize" also means to make applicable to each patient. This is done by what is called "identifying" or "activating a problem" in which the nurse circles those problems which are pertinent to the patient at the time. Then she "assigns" times for someone to check about the problem and to see if there has been any change. This is called the "charting frequency," meaning how often nurses should check

back on the problem, how long it will likely take until some change is evident.

The nursing care plan is a legal document. Nurses are supposed to chart and initial their charting at the assigned times and are legally responsible for filling the nursing orders for an "activated problem." On the other hand, they are supposed to adjust the charting time if and when they see fit. This is called "revising the care plan."

In 1978, the term "standards of practice" was replaced by the term "models of care" or MOCs. The Director of Nursing at the time offered the following definition in a memo:

> The word 'standard' connotes expected behaviors of practitioners for which they could be legally accountable. As models only, they represent a reference source to the nurse for specific diagnosis of disease entities. They offer guidance for the management of patients within those diagnoses or categories. These models should not be read as absolute standards to be followed for an individual patient. .. Thus the professional judgement of the nurse cannot be obviated by the existence of any published diagnosis-specific model (Archives, 1978).

c. Patient Documentation Record: "Progress Notes"

The fourth component of the care plans is the nursing documentation or "progress notes." These document progress on the problems identified in the nursing care plan. A note is supposed to be charted whenever a problem is identified. The nurse is supposed to review and record the patient status in terms of the expected outcomes listed for each problem. The categories of this review are called SOAT-AT, an acronym for Subjective, Objective, Assessment, and Action-Taken.

SOAT-AT is a revised form of SOAP charting (Subjective, Objective, Assessment, Planning) which is based on a problem-oriented approach to documentation devised by Lawrence Weed (1970). Weed, in his Problem-

Oriented Medical Record (POMR), designed a method of recording information which was intended to be cross-disciplinary, process-oriented, realistic, and particular to the patient. His method contrasted with the "source-oriented" notes that were the precedent at the time, in which notes are organized according to the source of the note, i.e., the profession which authored it.

Weed's method attempts to be particular rather than universal. Rather than reviewing a standard list of "systems," as was traditional, his approach zeros in only on what is relevant and problematic for a particular patient at a particular time. The model also emphasizes patient participation; the record is to be open for the patient to study (Bishop 1980). Finally, the problem-oriented record is meant to make the health care system accountable to the patient (Berni 1974, in Marriner 1975) and the practitioner accountable for his/her practice.

Charting in the SOAP method, as it is called, proceeds in the following way. Under "S"= Subjective, the nurse quotes or paraphrases the patient, such as, " I feel terrible today," or "When is my next pain shot?" Under "O"= Objective, the nurse writes her own perception, such as "patient looks weak, depressed, and uncomfortable." Under "A"= Assessment, the nurse states her assessment of the patient's condition, what she thinks may be wrong. And under "AT"= Action Taken, she tells what she did to reverse the patient's problems, such as "gave the patient a pain shot." The care plans were envisioned to be the real guides of nursing practice and to be carefully followed and documented.

Analysis of Care Plans: The nursing care plans selected and adapted in this project, significantly taken from the collegiate educational sector, both symbolized and operationalized the type of professional

sector, both symbolized and operationalized the type of professional nursing practice the program sought to implement. As in the other models and practices discussed earlier, we hear the same themes embodied:

- a patient-centered approach with a focus on "problems" rather than on tasks
- autonomy of decision-making for the staff nurse
- accountability
- visibility of nursing practice with descriptions of outcomes
- the articulation and definition of a separate domain of nursing
- a scientific approach to problem-solving
- the cognitive and literate capabilities of nurses
- attention to "psycho-social" needs of the patient

With nursing care plans we see again the use of formalization and a formal model. This model serves several functions. It describes and operationalizes the new ideals in nursing. In so doing, it inevitably standardizes practice, albeit with a plea for individualization. The formal model here also functions as a basis of accountability as well as visibility-- it shows in writing what nurses actually do. Economically, this could come to have more significance as nurses will have greater documentation of what exactly they do with their time. This formal model, like others,also creates as a means of saving time so that each nurse would not have to write out a plan individually. It objectifies nursing knowledge, taken from books, the oral domain, and personal experience, and essentially provides a grammar of nursing. The use of this formal model also reflects the complexity of nursing practice and the proliferation of things to do and to remember, as it provides a backup memory.

Finally, nursing care plans also serve to differentiate registered nurses from technical nurses; only registered nurses write the care plans which serve as a symbol of professionalism, and according to one leader, for the following reasons:

> In nursing they (care plans) are one of the few things we have to measure our profession by. When people ask, 'what is nursing and how do you differentiate the professional from the technical or the LVN?' we have utilized the nursing process, which the care plan is the tangible evidence of that. We've utilized that as one of the things to differentiate the technical from the professional or LVN. And it has been a measurable component. Because we have said that the professional person is the one who can ASSESS and the one who gets outcomes and has alternatives in her mind if those outcomes are not achieved...

5. Peer Review

If the Clinical Ladder is the skeleton of the new program, the nursing process the mind, the job descriptions the flesh, the Peer Review is to be the enforcer and reinforcer of professionalism intended in the new program. Peer review represented another step in the decentralization of responsibility for monitoring nursing practice. Autonomy, the major pinnacle of the nursing model of professionalism at this time, is inherently linked to accountability for professional practice by the nurse: "A professional gains and maintains autonomy by demonstrating she is answerable to the client in a public forum of colleagues and health care consumers."[1]

Implementing autonomous practice for nursing in a bureaucratic institution such as the hospital was not easy, as the nurses are not directly retained by the client. Peer Review was offered as a method for monitoring nursing practice in a way that addressed the norms of bureaucracy, on the one hand, while "providing professional assessment

of practice which promotes the nurses' accountability "[1], on the other.

The committee formed to develop a new model of nurse performance evaluation found, in their discussions, that almost no one could recall an evaluation that had been a positive experience. Rather, they were remembered as threatening and generally negative. The old model, as described to me, was essentially a one-way process between the head nurse and the employee. Most of the evaluative mechanisms were seen as punative or not constructive, in which the supervisor told the employee about performance. A nurse's deficits were mostly emphasized.

Further, the criteria for evaluation of the old model were idiosyncratic of the head nurse and were often global, across the board, non-operationalizable statements, such as "She has a lousy (or good) attitude." Much discretion was left to the head nurse. Finally, few evaluations ended with any mutual goal formation but rather with some general statement such as, "You need to improve your organizational skills."

In designing a new evaluation, the designers intents were stated as follows:

> We wanted to design a process that would be objective, that would be fair, that would be as non-threatening as possible. And we spent a lot of time debating back and forth about, "Do we have a consumer on the committee or don't we," since in the clinical program the client of the nurse is the patient. We wanted a process that would reinforce the professionalism, operationalize it as intended throughout the clinical program (Interview with the chief designer, 1982).

> We wanted a forum where nurses could acknowledge and recognize the practice of other nurses, not just talk about areas that needed further development, but really recognize and acknowledge practice. One nurse doing this for another. These were the things we were really working for (Ibid, 1982).

They sought mechanisms that would provide a mutual learning process. "Since the clinical program was implementing the professionalism in nursing, we wanted a process that would project evaluation as constructive recognition and as learning process. And one that would have mutual accountability-- I as a practicing nurse would have accountability for my evaluation and my performance. And whoever my superior was would be accountable to me; it would be shared accountability." An educational model stressing growth was applied (not incidentally, the leader of the committee had taught several years in nursing school).

The phrase "peer review" had then been used primarily in the medical literature to describe physician's practice in terms of patient outcomes. By applying this same concept, the designers hoped to derive a prototype evaluation procedure for nursing, to measure nursing practice in relation to patient outcomes, a relatively new concept that had only been minimally developed until that time. Further, the new approach contrasted with the more traditional model of evaluation through audits in that

> it attempts to identify nursing behaviors in relation to a stated standard that includes accountability, collaborative goal setting, clinical judgement, and self-initiated responsibility for continued professional growth[1].

Peer Review was defined in the following way:

> Peer review is the process used to appraise the quality of a registered nurse's professional performance and is conducted by a group of registered nurses who are actively engaged in some component of nursing practice. A consumer representative also participates in the process to reflect the nurses' accountability to the client. This appraisal employs the standard of nursing practice established by the hospital nursing service as described in the clinical program job descriptions and conforms with university personnel policies.[1]

The stated purposes of the peer review were:

1. To establish an objective means for providing evaluation feedback to individual nurses

2. To recognize the individual nurse who has outstanding nursing skills and performs at a high level of clinical practice.

3. To identify individual areas of the nurse's practice needing further development

4. To analyze the consistency of the individual nurse's practice compared to accepted professional standards.

The Peer Review Process: All nurses in the institution are considered candidates for peer review for an initial classification between their 5th and 6th months on the units. Furthermore, any staff person seeking promotion as well as all staff persons annually go through peer review.

The candidate for Peer Review, with the help of a preceptor, that is a person in a leadership position on the unit, submits a written profile which documents her current work and accomplishments. The peer review committee reviews the profile and then interviews the candidate. They write an evaluation of the candidate's competency and a recommendation for classification to the Director of Nursing, who then makes the final decision. The candidate and preceptor then discuss the evaluation and formulate a contract which establishes goals and accountability for achieving them (dates are set when they are to be met). It is of interest to look into the contents of the "profile." For the CN II, the first level, the folder was to contain the following:

1. Two Behavioral Performance Evaluation Checklists completed within the past six months; one by the preceptor, using additional resources as necessary, and the other by the candidate. The evaluation done by the preceptor must be shared with the candidate and signed by both before it is placed in the folder.

2. Two reference letters: one written by a Staff Nurse I, the other by someone of the candidate's own choosing. Neither letter is to be written by the preceptor.

3. A narrative Self-Evalaution Form, which contains descriptions of short and long-term professional goals, including a specific description of assets and areas in clinical nursing practice needing development: committee work and special projects; ongoing education within the past year; and the candidate's contribution to nursing service.

4. Two nursing histories or assessments, each with a care plan containing a problem list and problem-oriented charting developed with the history and reflective of the candidate's work in actual, current practice.

5. One example of current, original work reflecting the candidate's professional practice with patient care or unit organization.[1]

Significantly, the Peer Review candidate is allowed 4 hours of off-unit time to prepare the folder (off-unit time itself being a new concept). Once submitted, the candidate makes an appointment for the review. The folder and the interview are the only data used by the peer review committee to recommend the candidate's classification. The interview is to clarify and elaborate on the submitted materials.

Peer Review Committee: With the implementation of the clinical program, which called for reclassification of all staff in Peer Review according to the new job descriptions, a Peer Review committee of permanent members was established which included: 1 CN II, 1 CN III, 1 CN IV; 1 Nursing Administrator; 1 School of Nursing faculty member; and 1 "consumer." Consumers were selected from interested non-nursing employees of Ramsey (or their families), former patients or family members, or volunteers and auxiliary staff members.

The Peer Review Interview is supposed to be "growth-producing" for the candidate and the committee. Members of the committee are encouraged

to look for discrepencies and inconsistencies in documentation in the folder; they are encouraged to note and comment on positive accomplishments. Questions are to be derived solely from the profile folder material; gossip or hearsay reports of performance are not permitted to enter the deliberations. Members of the review meet 45 minutes before the interview and 35-40 minutes during. After the candidate is dismissed, they reflect on their assessments and "work to assess each candidate according to the standard, not to other candidates." The committee recommends each candidate and includes statements on the candidate's practice, suggestions for improvement and recommendation for classification. The latter is made through consensus with dissenting opinions recorded. The committee, it must be remembered only recommends; it is not a deciding body. It is the Director of Nursing who makes the final decision. After the candidate receives the recommendations, she meets with her preceptor and together they formulate a contract. "The contract is a mutual agreement between the nurse and the unit preceptor stating goals for improving practice and accountability for achieving them. It is confidential."[1]

The novelty of this process is apparent in that orientation classes for peer review are offered to teach staff preparing to undergo review as well as the committee members. In the actual practice of peer review the designers discovered discrepancies from the ideal:

> The ideal of peer review, taken in the abstract, is generally perceived as positive; however, the reality of the process often produces anxiety and conflict. The issues of accountability, autonomy, responsibility, and authority, whether stated or implied, evoke some degree of anxiety in everyone, regardless of previous experience with peer review.[1]

People commented upon the extent to which these reviews were meant to cultivate professionalism in nursing.

> Many candidates expressed concern that part of the peer review committee assessment of their professional ability included an evaluation of how the candidate presented herself in the interview. These individuals were helped to understand that presentation of oneself is important in the current, preofessional world, and were assured that they could present themselves in a professional manner.[1]
>
> As mentioned... committee members developed personal anxieties because of their sensitivity to the candidate's need for understanding and acknowledgement. A conflict arose from their need to be humane while attempting to render an objective performance appraisal[1]

Analysis of Peer Review: Peer Review seems to serve several major functions. First, it is used to reclassify nurses according to the new job descriptions, to select out those who want to go with the new program from those who do not or cannot. It is a group mechanism for spreading the responsibility in establishing the new regime, new leaders and a selected membership. The reviews are described as sometimes brutal.

The Peer Review functions as a ritual of professionalism in this setting, ritual here referring to social behavior that is separated out from normal, everyday behavior, that asserts and reconfirms the important social ties and values of the community (Turner 1967) through formalized, prescribed pattern of behavior. Social alliances and distances were demonstrated in the ritual as well as the central values espoused.

Nursing autonomy, to begin with, is central in this process. Significantly this was a forum of nurses evaluating nurses on the basis of self-defined criteria. Self-regulation has long been cited as a symbol and component of professionalism, best epitomized by physicians from whom the term "peer review" was borrowed. Notably absent from the review team were physicians, non-RN nurses and hospital administrators.

Notably present on the other hand was a "consumer", symbolizing nursing's direct relationship and accountability to "clients." The fact that nursing is "patient-focused" is also displayed in the use of the job descriptions written around patient care issues. Also conspicuously present in this design is a representative of the School of Nursing, demonstrating the strong alliance between collegiate nursing and nursing practice that pervades the whole program. Nursing, then, as separate from medicine and from hospital administration, as different from "technical" nursing, and as alligned with the university and with direct service to the patient as a client are expressed in the choice of participants on the review panal. Further, a picture of nursing as differentiated-- with four levels of clinical nurse-- yet united and functioning as 'peers' is also displayed in this ritual.

Along with nursing autonomy comes nursing accountability which is demonstrated by the fact that nurses are accountable to each other, to the consumer and to themselves. Authority, on the other hand, rests in the hands of each individual and is vested in rational-legal criteria of evaluation, stripping the authority of the traditional head nurse who could judge nurses on individual and "subjective" criteria. The responsibility of the individual is stressed; responsibility for patient care, for self-evalutation, for meeting a contract to "grow" and for the initiative to grow.

The emphasis on growth-- for everyone-- is strongly evident as an absolute value in itself. This growth, while serving the good of nursing and patients in general, is very much directed at the individual level and reflects a belief and commitment to the self-actualization of individual nurses. In turn it is assumed that nursing will progess. As one nurse noted, the belief was that self-actualization would lead to

the professionalism of nursing.

The repeated emphasis on nurses' acknowledging each other's practice is also noteworthy. It perhaps reflects the efforts to develop a sense of support, identity, and even sisterhood among nurses (in contrast to loyalty to physicians) and is an attempt to emerge from relative individuality and obscurity; nurses will provide their own forum for mutual recognition based on their own values.

Another theme that pervades the peer review is the emphasis on reason, science, and objectivity. Universal, standardized, explicit and objective criteria for evaluation were sought and efforts were made to eliminate "subjectivism" among the nurses.

Similarly, we notice that nurses are evaluated very much on the basis of written material. While there is little way for nurses from other units to observe the practice of a nurse, the extent of judgement based on nursing care plans and nursing histories may underscore the extent to which the emphasis is on the cognitive/assessment dimensions of nursing -- what "goals" are accomplished-- than the relational dimension of practice or the emotional dimension.

A third function these peer review undoubtedly provided was a forum in which nurses could practice being professionals. Here the practice is not only for nurses and patients, but is explicitly and implicitly directed at changing relationships between nurses and physicians.

Summary Analysis of the Clinical Program Movement

We have looked at the Clinical Program in terms of its parts in a number of ways. Here, let us consider the movement and the program as a whole which chartered changed relationships between professional nursing on the one hand and medicine, hospital administration, technical nursing

and patients, on the other.

In many ways this was a movement to liberate nursing, not only from medicine but from its own past, from hospital administration and even from patients. Like many of the human potential movements in the 70s, however, the target of change was nursing itself, not the surrounding structures, culture or personnel. It was an attempt to carve out some autonomy where none had been given, by taking control of and defining the conditions in which nurses work and making nursing criteria more primary. Not worrying about the physician response or "fitting in" to physician expectations was itself a statement of autonomy.

The direction of change, however, entailed in many ways an appropriation of medical culture and structure for nursing. Advertently and inadvertantly, medicine was the dominant reference group for what nursing worked to become. Thus while medical authority was challenged through the cultivation of nursing authority and rational-legal procedures, medical culture was largely (by no means totally) accepted and in many ways imitated. For example,

a) The model of practice is the medical practitioner whose client is the patient, who has an unmediated relationship between himself and the patient; and who is accountable directly to the patient

b) Many of the traits associated with medicine are those same traits nursing tried to incorporate; nursing as intellectual, scientific, working from the head not the heart; instrumental, autonomous, and educationally restrictive.

c) The new nursing hierarchy was designed to parallel the medical pecking order, matching power with power, such that each nursing position would be matched with a position on the medical hierarchy: Attending/CN IV; Chief Resident/CN III; R II, III/ CN II: R I/CN I.

d) Science is seized upon both as a means of legitimacy and of liberation.

In this way, however, we see evidence still of medicine's power in defining truth for nursing (Foucault 1980), as legitimacy is very much in terms of medical traits.

Structurally, nursing not only took nursing under its own wing, it took it out from under the wing of medicine. Remember the scant reference to medical orders and to physicians in the job descriptions; and more significantly, the job descriptions outline a domain of nursing behavior exclusive to nurses and for which they are accountable. Beginning on paper, then, nursing moves away from being strongly defined by medicine. This entails a greater separation of nursing from medical functions. But with this separation, one sees a decrease in the traditional division of labor between nursing and medicine, frequently described in the literature as physicians providing the "instrumental" functions while nurses the "expressive" (Johnson 1958) or a separation between the heart and the head, between curing and caring. In some ways, nursing has moved towards greater similarity to medicine.

We see here as well changes in nursing's approach to authority. One type of authority which nurses sometimes used with physicians was charismatic authority, control on the basis of charisma, charm, likeableness or other talents. No longer did these leaders want nursing influence to be based on this type of authority or on diplomacy or the indirect influence of yesteryear (Stein 1969). They wanted nursing authority institutionalized, made explicit and rational and legitimate, a function of knowledge and competence, not of the person.

Starr (1982) defines medical authority as based on two components: legitimacy and dependence. Here we see nursing chip away at this authority by competing with medicine and questioning the

legitimacy of medicine as the sole cultural authority, by decreasing its dependence upon medicine by increasing the knowledge of its own practitioners, specifically by increasing theoretical knowledge.

Medicine, however, was not the only group from whom this movement sought liberation. The Clinical Program also sought to free nurses from the hospital organization. Mauksch (1966) sharply describes how nurses were often placed in a mediating position between hospital administration and physicians, the on-unit representatives of the hospital policy to the independent, anarchic physicians. The notions of autonomy and accountability to the patient seem to free the nurse from devotion to the organization in favor of the patient. This movement sought to break nursing's primary loyalty both to medicine and to the organization and to cultivate instead a direct relationship, described in terms of "accountability" with the patient, the nurses' client and to nursing. Otherwise stated, the client of the nurse is not the physician, not the hospital, but the patient. All this is captured by the term "clinical."

Further, the movement sought to liberate nursing staff from the stifling hand of traditional nursing authority as it was perceived and to create instead a community of autonomous professionals, albeit stratified. In many ways many of these practices sought to diminish the gap that had grown between management and employees. In fact, many of the mechanisms used were borrowed from management practice, such as job descriptions. We see as well a reshuffling of prestige and status among nursing's various factions; prestige and power shift to clinical nursing from administration in an attempt to make clinical nursing equal and different.

We see changed relationships defined between staff nurses and their

superiors. Instead of authority resting in the hands of the few, it is decentralized. We see a shift to bureaucratic authority or rational-legal authority instead of the personal authority of the Head Nurse of the former system. In other words we see nursing turning here to bureaucratic rationalization in the name of professionalism. We see a shift from hierarchy and authoritarian relationships to egalitarian, collegial ones, as well as shift from organic solidarity to mechanical solidarity in which each nurse works independently under personal rationalization.

The fourth area of change described in the program was between patient and nurse. In a jaded sense, one can say that this program tried to introduce patients formally into the social structure, something that Mauksch (1966) and Coser (1958), among others, have noted is not always the case. The patient is to be interdependent with the nurse, approached as an "equal partner" (Interview with pioneer). Further, the relationship is relatively unmediated, in its ideal. And thirdly, we see further elaboration of the relationship away from a kinship idiom to one emphasizing teaching and egalitarianism and problem-solving, rather than nurturing.

While structurally the nurse-patient relationship is less mediated by other people, it appears to be more mediated by concepts. There is a proliferation and expansion of concepts and representations and "objectivity" that is cultivated between nurse and patient. One must consider whether this formalism is a requisite accompaniment to greater autonomy in the face of greater closeness between nurse and patients.

One can look at the clinical program as an attempt to reconcile a number of conflicting tendencies in nursing practice and to make the

ideology -- which was not so new-- work. Attention was given to what they called "the setting", i.e., the practical and real constraints within which nurses worked. In fact, without considering these contraints, one cannot understand the program. It was not a rejection of bureaucracy and rationalization but rather their use in the name and service of professionalism. In general, the model tried to reconcile the needs of patients for more personalized care with what were sometimes referred to as the demands of bureaucracy for standardization and legal accountability. Perhaps no better compromise example exists than the clinical ladder for professional nurses. In fact, when I asked one pioneer whether in fact there was a contradiction between the notion of a ladder and of professionalism, she answered:

> Conceptually, perhaps there is a contradiction, but not in reality. Particularly when you are talking about nurses who have been in a dependent role, particularly in the hospital environment. The ladder idea begins to provide more flexibility which reinforces part of the definition of professional. But if you are looking overall and talking generically, yes, professionals don't need ladders.

In many ways one can understand this program as a blend of traits associated with bureaucracy and with professionalism (noting that were are referring here to bureaucratic regulation of employees as opposed to managers). Bureaucracy is often associated with explicit hierarchy and graded and centralized authority (Weber 1946:197). Activities are governed by an explicit set of rules. In nursing, bureaucracy has traditionally been seen in the systematic division of actions into parts relegated to different parties. Specifically this meant the division of nursing care according to activities, such as giving medications, making beds, among a number of nurses. Decisions about patient care were reserved for the superordinate level-- head nurses and supervisors.

reserved for the superordinate level-- head nurses and supervisors. Professionalism--here referring most to nursing's autonomy and authority-- has some of the following implications: decentralization of nursing decisions to the nurse/client level; activities explicable and defendable in terms of scientific rationale; and the power to control the profession resting among the profession itself, through peer review. In acknowledging hospital bureaucracy, this program built on a foundation of where nursing had been and stood, on what could not be taken for granted by nurses and would thus have to be made explicit if it was to be institutionalized.

One sees in this movement a recurrent set of themes that coalesce within the concept "professional nurse. Each theme can be considered to collect a set of meanings. These meanings were translated into language and practices. The meanings and practices find their sources in a number of social groups (for a summary of these themes, meanings, and practices see Appendix E).

Differentiation Among Nurses: As Strauss pointed out, professions are by no means homogeneous groups (1966). They rather are composed of factions with different ideologies and constituencies that are dynamically in process (Bucher and Strauss 1961). In this program we see a particular set of alignments among factions of the nursing community. For one, this movement stressed nursing as a profession, not an occupation, emphasizing the autonomous professional dimension, not the work culture or "blue collar element" (Melosh 1982). While Melosh defines a conflict between work culture or informal culture on the one hand, and the institutional/management culture or formal culture on the

other, we see here a dissemination of the formal work culture deep into the domain of the work culture which is usually more informal.

Repeatedly, the program drew upon models generated in collegiate nursing education- nursing process, performance evaluations, nursing care plans. Nursing research, long the exclusive domain of education, was also incorporated into the practice domain.

The program sought to highlight and emphasize the differences between RNs and LVNs and NAs. It implicitly called for a predominantly RN staff, and in fact, non-RNs were encouraged to leave.

In this chapter we have looked more closely at the models, practices and themes that comprised the clinical program during its genesis phase. In the next chapter we will turn to the ethnographic present and consider a sampling of how the clinical program was perpetuated as observed during the period of this study.

NOTES

1. In the interest of anonymity, the reference will not be cited directly.

CHAPTER SIX: PERPETUATION OF THE MODEL

Transition: The Implementation of the Clinical Program on the Third Floor

At this time let us return to the Third Floor of Ramsey Hospital to see how Units A and B fared in the implementation phase of the Clinical Program. Implementation began in 1978. At this time Kathleen Drake applied for employment at the hospital, a nurse trained at the master's level with a specialty in surgery, specifically general abdominal surgery. She was "snatched," "plucked" only the Third floor, the only specialist hired from outside the system who had neither been trained in the system nor worked in it before the change. Significantly she was hired by the leaders of the movement and given significant freedom to implement the program as she saw fit.

Things changed dramatically after her arrival in 1978. Intent upon introducing the new program quickly and on gaining the support and respect of the staff, she began by being the first to go through the peer review process. Her folder was well stocked and unarguably sufficient; she had worked extensively on it and was approved for the new CN IV classification with ease. Once established in the position with staff mandate, she began requiring the former head nurses and senior staff nurses to undergo the peer review process themselves in order to be reclassified according to the new system. Her demand for conversion to the new system forced staff to decide whether to convert or to leave the unit; many decided to leave. Some had never been trained in the care planning process and were not willing to "pick it up overnight," as they felt was expected of them, nor to be judged by their

peers according to competencies they had never developed but were now on the job descriptions. What is referred to often as the "mass exodus" followed, in which reportedly 95% of the staff left. In fact, more than 30 nurses left in one and a half years; on Unit B, four nurses left within 24 hours.

The reasons for this exodus appear to be many. Kathleen was often cited as the singlehanded "cause" of all the turnover, not so much by the content of the new program as by the way she implemented it. She saw people as expendable and felt it best to force people to decide whether or not to stay and to weed out those who did not want to go the new way. The number who did not was apparently large.

Many did not like the changes in clinical practice that the new program entailed: "Suddenly you had to chart everything down in a language that was foreign and organized in terms of "goals." What was once autonomatic wasn't any more. Everything took twice as long." Some found it very difficult to do. Furthermore, many did not see that the new system made any difference in practice.

For others, the new program was the trigger for a move to leave made for non work-related reasons, a last straw in a series of incentives. These were people who had long been planning to leave when a husband finished school, for example, who chose to leave and this time.

From all accounts the amount of change implemented at one time was too much for the staff to handle. As one survivor put it, "I think it was the unrelenting quality of change in such a short period of time that led to the exodus and made it so difficult." With so much change, much depended upon the leader and Kathleen was not loyal to the prior staff.

Confusion and instability followed the initial period after the exodus. With a small core of regular staff, the majority of nurses were hired from the registry; they did not belong to the unit or to the hospital but changed daily. This meant that they needed to be supervised and "covered." Yet there were but a few registered nurses to do this. "It was hell, " one nurse remembered it. At one time, Unit A, with a total of 28 positions for RNs, had 19 positions unfilled.

Rebuilding

It was in this context that Kathleen planned an extensive rebuilding program. She trained the other senior clinical nurse in interviewing and together they interviewed for new staff extensively and intensely. She appointed two new clinical III nurses to fill the new Administrative III positions on the units. For Unit A this was Teresa, who had already worked on the unit for three years. For Unit B this was Diane who had worked on another surgical unit for four years. Neither had had any administrative experience.

Kathleen described what she looked for when hiring new staff:

> We wanted nurses who were assertive and willing to question things, nurses who wanted to be clinicians, who had SOAP charted, who understood what nursing is all about, who could define it. That is, who saw the patient as person, who tried to help a patient move toward independence at all times, who cared for the patient as a total human being.

Using these criteria and spending up to two hours interviewing potential employees (such extensive interviewing was relatively new), Kathleen hired nine new nurses the summer of 1979. I will call this group Cohort # 1.

It was also in this context that Kathleen set up the first systematic and formal orientation program for nurses in the hospital. Units A and B oriented together in order to maximize the five preceptors available. The system was carefully structured. "Behavioral objectives were written for everything," one nurse described it. Nurses kept a log and had a calendar and timetables of when things were to be done. Weekly sessions were held for "feedback."

Cohort # 1 developed into a close work group. All of the nurses were fresh out of the school with little to no experience; none were married, half were new to the area, and all were under 25 years old. In other ways the group was diverse: some had A.A. degrees (two years), others Diplomas (three years) or bacclaureate degrees (four years). One nurse was a man.

During orientation, the new nurses were "indoctrinated" to the SOAP charting system. As the care plans had not yet been standardized (written up and printed), each nurse had to write out the care plan herself.

> Each person's work and problem became identified with that person; it was <u>their</u> problem, <u>their</u> expected outcomes and everything, and you seemed to have more of an investment in it. The care plans were seen as more permanent then. Each person's name was like NEON all over the chart. And people evaluated you accordingly; all were aware of that. People were definitely judged by this.

A critical time came for Cohort # 1 when two of the group on Unit B, Nancy and Tina, "declared their candidacy" for leadership, that is for the CN III position. This means they declared their intention and were supported to pursue this role. One of these nurses described how overtly and covertly they felt the question: "How have you come from this close group to identify yourself as different from others?" While

they did not feel exactly a sense of betrayal, they did feel strain and were caused to question their move, as if someone was asking, "why are you taking this more seriously than we are?" This nurse continued:

> Another feature of the strong reaction was that none of us had really declared that we were going to be a professional nurse when we came on, that we had career goals. We just thought we'd work here for a couple of years, then go to school and so on. No one had a really clear cut commitment, saying, "I'm going to succeed in this field and go up the ladder." No one. Nursing never asks that out of you and being seen as going up a step in a clinical ladder (was new).

Her last comment highlights the fact that nursing had not been seen as a career in which one could be rewarded by advancement. Those who wanted careers had to convince those who saw themselves as involved in a temporary job. Evidently, the teaching about the clinical ladder was intense, described by one as "indoctrination." The symbol was a ladder with the CN III definitely one step higher than the CN II. And that, according to this candidate was the whole issue: "I felt some guilt at the time toward some of the other nurses. I wondered, 'Should I do this?'"

Another source of differentiation entered the picture at this time. While the nurses in Cohort # 1 were a tight social work group, their educational background differences were significant. Only the nurses with the bacclaureate degrees were able to move to the CN III position after one year. Two years of experience were required for nurses with a Diploma or an A.A. degree.

The factors contributed to the gradual dissipation of the once-solid work group as "people started going their own ways." One put more energy into a man and marriage; another into film, while the two leader candidates chose to put more of their time into nursing.

After they declared their candidacy for leadership on Unit B, the two CN III candidates precepted the next group of new nurses who were hired the following summer, that is one year after they had begun to work on the units. For the summer of 1980 brought another large group of inexperienced staff to the units (6-8 new nurses per unit)-- Cohort # 2. This last arrival was a small trigger for some of the most experienced survivors on Unit B to leave; while all had planned to leave earlier, for reasons not related to the unit, their departure was in part sealed by the difficulty of starting over with another new group of "new people." We enter the story through observation and interview for a first glimpse beginning that summer of 1980.

The Perpetuation of the Clinical Program in Practice: Selection, and Socialization, and Social Control

Sometimes articulated, sometimes not, a model of ideal nursing practice dominated these units. In the Introduction I described some of the characteristics of that model and in Chapter Five we looked at some of its components more closely during the period of genesis. I must here emphasize that while much of the behavior I observed can be understood in terms of the new Clinical Program, it by no means accounted for all of the behavior. Further it must be stressed that the perpetuators of the model were not the generators and that a new Director of Nursing stepped in at the time of observation.

In this chapter we will look at how the professional model of clinical nursing was perpetuated through selection of staff, formal and informal socialization, and social control. In so doing we will observe some of the practices earlier described (Chapter Five) in operation and

consider some of their functions and limitations for the unit and for nursing. To review, some of the themes we will see in a different way are:

1) patient-centeredness, clinical nursing, "total patient care"
2) nursing autonomy and accountability
3) rational--pragmatic, and scientific--nursing
4) differentiation
5) growth, both professional and personal
6) standardization and formalization

Membership on the Units

Who got hired, fired, and promoted on the unit, and who did not reflects in part two concerns: perpetuating a type of nursing epitomized by the professional model and preparing and coping with nursing turnover. In fact, I was told that while the mass exodus and high turnover of the earlier years was extremely difficult to cope with, it did allow the administrative nurses freedom to hire nurses who would practice the type of nursing they sought to foster.

The vast majority of applicants to the unit were new graduate nurses and this was acceptable from the perspective of the hirers and the hospital. In contrast to the policy of former years of requiring one year's experience, the system was oriented towards processing large numbers of new graduate nurses.

The two Ad nurses on the Third Floor developed their own semi-structured interview. They looked for nurses who understood what "professional nursing is about," who were selfmotivated and "assertive" and who could be leaders. In fact, there was high selective value on "independent nurses," those who would be able to make it on their own, who would not need a lot of "close mothering," who could and would articulate their "learning needs."

The themes of individual responsibility, growth, leadership, documentation, and total patient care were evident in the questions they asked potential employees listed below, a list derived both from the interview guide of the administrative nurses as well as my field notes.

Table 2. Themes in Hiring new Nurses

Individual Responsibility:

- Who is primarily responsible for your growth?
- Who is responsible for giving nurses constructive criticism?
- What do you think you are responsible to communicate to a head nurse?
- Have you seen any unsafe practice? What would you do about it?

Nursing/Medicine Relations:

- What is your definition of nursing?
- What is your definition of medicine?
- What are the grey areas? Where is nursing held back?
- What is your philosophy of nursing?

Leadership:

- Have you ever functioned as a team leader?
- What makes an effective team leader?
- What were your duties, role?
- What are three qualities that make a good nursing leader?

Growth:

- Would you describe yourself as internally or externally motivated? How do you learn best?
- What are your strengths?
- What are your areas for growth?
- What do you envision as the biggest problem in transition from student to professional practitioner?
- What would you do if confronted with a procedure you had never done ?
- What are your expectations of an evaluation?

Documentation:

- What are your feelings regarding SOAP charting and Nursing Care Plans?

Job Satisfaction:

- Describe your ideal nursing job.
- Describe favorite types of patients.
- Stress reduction: how do you do it?
- What did you find most positive about your education?
- Preferences in patient care?

Experience:
Describe past experiences, areas of responsibility, types of patients worked with.
Describe your strongest areas clinically.

Stress:
What frustrates you?
How do you handle stress?

Teaching/Learning:
Were you instructed in the teaching/learning process? When do you see teaching plans as appropriate?

Goals: What are your short term (6 months) and long term goals in nursing? How do you plan to achieve these?

Patho-Physiology Background:
What is your background in patho-physiology?; in fluids and electrolytes?

What could employees expect to find on the Third Floor, according to their intake interviews? They were told that the staff was structured in a clinical ladder; that the pace of the unit was very fast and busy; that the staff was very supportive of each other, though everyone was expected to "hold their own"; that the standards of the unit were very high, and that these included nursing histories, care plans, SOAP charting, teaching and conferences; that the unit expected each nurse to carry his or her own weight within two months (i.e., practice relatively independent of supervision). Further, they are told that the unit is organized around "total patient care" which includes discharge planning and teaching: "We're trying to meet physical, psychosocial, and spiritual needs. Total patient care encompasses everything." Finally, potential employees were told that the units would support the professional development of the nurse, but that much of that had to come from the nurse herself.

The importance of communication was stressed already in this first interview. As one Ad nurse recounted:

> I tell them that I expect communication. I expect them to be able to receive feedback, constructive and positive. I expect them to give feedback, constructive and positive. I expect them to communicate their needs to me because I will not go seek them out that whole mother issue.

While the first choice for hire was a nurse who appeared to be "a potential leader," (particularly for the Ad nurse on Unit A), there were periods when 8 or 9 new staff were needed (usually before a summer exodus), and thus the "standards were lowered." Furthermore, with more experience came a realization that both "leaders" and followers" were needed on the unit.

Considerations of nursing turnover were also apparent in 1980 and 1981. The selection was not necessarily for longterm investments, i.e., slow learners who may produce in the end but who take a long time to develop. Many nurses were this type but it was not what was being sought. Rather the interviewers were assessing "how quickly and easily this nurse could take on this difficult role and produce good professional nursing now." In fact, a one year's verbal was requested from and usually given by a new employee. The rationale for the one year was primarily economic. The new nurse is considered productive only after 8 weeks and fully productive only after 6 months.

Group membership was determined not only by hiring but by who was kept and who was not. The following case of a nurse who was invited to resign illustrates how the interests of the standards of the unit were enforced. For despite the frequent vacant positions, due to turnover, nurses were not kept only for the sake of having another staff person. Standards often prevailed over body count.

Erica: A Case of Invited Resignation

Erica was one of the most veteran nurses on Unit B, having worked approximately two and a half years nearly exclusively on the night shift (the only time the administrative nurse is not on duty). From all accounts, Erica was well liked and considered a very supportive staff person to work with. She rarely slept and was happy to take over and "cover" for other nurses so they could sleep longer on their break.

As all new graduate nurses rotate without their preceptor onto the night shift after two months, this made Erica the prime orienter, placing her in a position of relative influence. It was this influence that most concerned some of the leadership. For Erica did many things that were not in the rule book, things that she knew how to do and that made life easier for all involved. For example:

- she gave patients medication changes before getting them signed by residents who she "knew" would "cover" her
- she drew blood samples from patients (while this was done in some hospitals by nurses, it was not done officially at Ramsey)
- she took "more responsibiity in a crisis that was warrented"; she seemed happiest when in an "ICU type of situation" and was praised for her ability in this con text
- rumors circulated that she had sex with a number of the interns and residents who passed through on their rotation.

On the other hand, Erica was not a firm believer and devotee of documentation and rarely documented care plans, histories, interventions, or incident reports as was required. In this way, she did not meet the requirements of the unit, as evaluated in her peer review on the basis of her job description. On paper she did not practice nursing "up to par." Further, by her own admission, she was "down and in a rut" around nursing.

Yet many, including her strongest critics, said that she was very good and supportive to work with and that she knew more nursing than most on the unit, that in many ways, she was one of the strongest in practice.

To understand why Erica was invited to resign one must see that she was perceived as a very influential "role model" for the new nurses on the night shift. A powerful person (she was somewhat charismatic) who did not embrace the standards and ideology of the unit, she was perceived as a significant threat. As such her approach was a public concern and seen as a potentially powerful negative influence that had to be minimized. There was a fear of contagion and a domino effect that she might take the standards of the unit down with her. The standards needed to be preserved, one may say, "for the sake of the children."

What is noteworthy about this case is that in many ways Erica practiced nursing as it used to be practiced on the units at one time-less formally with much less documentation and more bending of the rules. Nurses who have practiced for years have traditionally done many things that are not in the rule book but that they know how to do and that make life easier for all involved, given the cumbersome formal protocol of hospital life. We must also note that Erica was judged against an abstract view of nursing; negative outcomes were not cited as the basis for criticism, rather it was that she did or did not act according to the "standards" of the unit.

What happened to Erica? Following her unsatisfactory evaluation, which she herself agreed with, confusion and misunderstanding resulted in the evaluation becoming part of her permanent record. Thus, rather than pass through a second evaluation, she was invited to leave. This upset both Erica and many of the staff. The transition was eased by the

administrative nurse's efforts to help her secure the position that she sought and some bitterness and hurt were smoothed over.

Formal Evaluation

Preliminary Evaluation

As outlined in Chapter Three, the first formal evaluation took place after two months for a new nurse. At this time, the nurse, her preceptor, and the administrative nurse evaluated the nurse's practice against the job description.

Egalitarianism and the responsibility and accountability of the nurse for her own practice was emphasized. When evaluations diverged, points of disagreement were discussed and differences easily accomodated. The nurses were often told something like the following:

> The standards on this unit for putting theory into practice are very high. Even floats say so. So if your evaluation is not as high as you want, this may be part of the reason. In another place, you would excell!

Furthermore, they were usually forewarned:

> Peer review needs to be on a daily basis. If you are not doing well, you would have heard about it before today. Your preceptor should be keeping you informed of how you are doing.

The job description was then reviewed line by line, usually by asking the nurse where she thought she fell in her ability to perform each function. Not infrequently the nurse did not understand the language of the description and was provided with examples to illustrate a point and to teach the desired nursing practice.

Much came under the scrutiny of the evaluators, including how a nurse presented herself to physicians and to other staff. It was here that these units appeared most like finishing schools, teaching nurses how to be professional. This was well captured by the following example

taken from a preliminary evaluation where the touchy subject of a nurse's style of interacting with physicians was raised. The nurse's preceptor thought that her flirtatious and high feminine voice and manner presented a bad image to physicians. The Administrative nurse concurred and in the actual evaluation raised the issue, albeit with apologies:

> Okay, there is one area here that is something that your preceptor and I have talked about. In terms of your concept of nursing, yes, you are professional: You look at your histories, you look at your care plans, you look at "expected outcomes" for patients, etc. You do look at the global picture and that is acting as a professional. You do realize you need to be a patient advocate, communicate things that need to be communicated, give peer review on a daily basis, not once a year. I mean, those are all real parts of professional nursing. The one thing that I would just like to throw out as a thinker for you is your presentation of self to other professionals, meaning specifically physicians.

The Ad nurse stumbled around trying to say what she wanted to say, and she was encouraged by the new nurse. She apologized, "cause it sounds really awful," and then went on to describe the talking sytle of the nurse in a high, flirtatious voice. She went on:

> Yes, the goal is to get the order out of the physician. I know that. Or you're looking out for the patient, but it's how you're presenting yourself to him as a professional. It's hard for me to say because it doesn't affect the patient and it doesn't affect the outcome of the order. But it affects nursing's image... If you go to an attending, it's not just you, it's a lot of people. But is you present it like, 'Well, this is what's going on with Mr. Smith in Bed 6. We're sort of thinking, well, da, da, da, da, da, da. Maybe we should get... whatever.' I, as the physician, might say to myself, ' Is this really important?' That's different than saying, 'Mrs. so and so has this thing going on with her. I think this would be the appropriate action. What do you think?' That's coming more as a collaborative peer, rather than requesting permission to ask. It's the non verbal communication, the 'well, sort ofs, I was sort of thinking' that's the problem.... And sometimes what happens is that ultimately the order

> doesn't get written because they don't think it's that important. Or they don't value it because you've not presented it in a fashion that makes it sound important... It's getting into the female issue. If you present it as some dizzy blond, they'll think, ' She's just a nurse, don't worry about it.' That's different than coming across as intelligent and well organized. Because we really do have high level concerns. You wouldn't be on the unit now if you didn't. You do look after patients, and all that. It's how you present that to whoever is receiving it... It's an issue in nursing and an issue in this institution. And how we're going to change that perspective of being considered a viable part of the health team in other allied professional minds is how you present yourself.

This extensive quote portrays a range of meanings of "professional" that the leaders in particular, but many other nurses as well, were aiming to cultivate on the units. The fact that it entailed an attack of sorts on this woman's femininity and way of interacting with men, the fact that it could not be justified as negatively affecting patient care (though an attempt was made), and the fact that the issue was political and not just clinical all contributed to the unease of the critic here. Nonetheless she proceeded to say what she said, and this, in different ways on different occasions, demonstrates the ideological nature of the units, their teaching function, their orientation towards fostering and changing relationships between nursing and medicine. Further, while such scrutiny may contradict the autonomy and independence they also tried to foster, such a contradiction resolves itself when one considers the overriding goal to be cultivating professional nursing, as they understood it.

Job Descriptions

In Chapter Five we presented briefly the job descriptions as designed and in Chapter Seven we will analyze them more closely. Here let me briefly describe how job descriptions were used on the units. The

detailed attention given them reflects the prominent role of formal models like this had on the units, both in teaching and as a means of social control. For while job descriptions are often idle and outdated legal documents that collect dust in a backfile, ritualized bows to bureaucracy or unrealistic statements of the ideal role, this was far from the case. I rarely saw them approached as some foolish, unnecessary, alien bureaucratic device that the nurses had to deal with, as if they were someone else's charter. Rather, the standards and the expectations of the job descriptions were adopted as their own, particularly for the leaders. They were central in grooming and evaluating nursing behavior, the standards through which ideal nursing was taught, against which it was evaluated, and by which it was circumscribed. Statements such as, "I feel you perform 98% of the job description," Can she meet the job description?", "It's not in my job description," were common.

The job description was used most in the teaching and learning of a new role, specifically the CN II role for the new graduate nurse and the CN III role for the nurse seeking promotion up the clinical ladder. In this context, the descriptions spelled out what was expected of the nurses, broke the role down into a number of parts and allowed nurses to be evaluated along a number of dimensions and to focus on those they and their colleagues felt needed improvement. As nursing can be an overwhelming job and quite amorphous, the job descriptions sometimes concretized the expectations by breaking the role down into manageable bits.

The values of the unit were communicated through the job descriptions. Nurses were repeatedly taught the value of autonomy, for example, taught not only to think for themselves but to stand up for

their beliefs. For example, new nurses were regularly asked whether they had conducted a team conference yet (an informal discussion about a patient). Invariably the new nurse said, "Not yet, I've only been here a few months." The following paraphrased sequence was not an uncommon follow up:

> Ad Nurse: Well, has there ever been an occasion where you wanted to have a patient conference?
>
> New Nurse: Yes, one time I suggested that we have one but Nora, the CN III, said that since all the patients would be leaving very soon it was not worth it.
>
> Ad Nurse: But is that enough reason not to have a conference? You do know that if you want to have a conference on a patient you can have one. That just because someone else does not want to have one does not mean that you can't go ahead with it.
>
> New Nurse: I see.

Here we see egalitarianism emphasized and differences levelled among the staff, all in the interests of cultivating among the new nurses a sense of entitlement, power, possibility, and autonomy. The nursing community served as a practice forum for professional behavior, particularly for the beginners.

In a similar example we again see how the job descriptions and reviews were used to convey deeper values. Suzanne, a CN III, said the following during a preliminary review regarding the line in the job description, "Reports abnormal patient data":

> Marianne, I can't go with an "always" for you on this point. The other day you identified some real abnormal data for a patient. Yet in report you discredited that data. You reported the numbers and then mumbled something like, "I don't know what this means... maybe ask the docs about it, they'll know." When you discredit nursing like that, you discount your own assessments, I can't go with an "always" for you.

Peer Review

Peer review, both formal and informal, was taken very seriously on these units. As true during the genesis phase, the formal practice of peer review much resembled a ritual of professionalism that enacted and reiterated nursing professional ideology. While the hospital-wide reviews described earlier came to an end in 1981, the unit level reviews continued and were an important part of unit life.

Peer Reviews nearly always included the Ad Nurse III, the preceptor, and one or two people chosen by the nurse being evaluated. As in the original design, the evaluatee prepared a folder for review which included an example of a nursing history and care plan, a self evaluation according to the job description, and a statement of "goals."

The evaluators met for 10-15 minutes before the review to plan, review, and esssentially rehearse what they would say. Their outline was the four categories of the job descriptions: Nursing Process (including Assessment, Planning, Implementation, and Evaluation): Teaching, Communication, and Evaluation. All participants had reviewed and evaluated the nurse before the meetings and differences in their own and the evaluatees' assessments were discussed.

In the rehearsal, the participants decided what people wanted to say, how they would say it, and in what order. Emphasis was placed on a person's strengths, called "positive feedback", as well as "areas of growth" or "constructive feedback" (otherwise known as criticism). The Ad Nurse III or a CN III usually led the review.

In fact, Peer reviews could be a fantastic piece of wizardry. Comments were strategically allocated among participants: "Why don't you

tell her that, cause it will mean more coming from you than us," said a CN III to a CN I about a CN I. The critical was often masked or "sandwiched in," as one administrator called it, between more positive comments. Comments that illustrated the implications of a principle in nursing practice were stressed: "Tell her how it made a difference when she did such and such."

While the Ad nurse and most of the CN IIIs had repeated experience at the reviews, Peer reviews often included someone doing it for the first time; they were taught how it was done, (for example in what sections their comments should go) both directly and by example.

A minimum of ceremony accompanied the review and some effort, such as cleaning off the table, was made to honor the occasion. The reviews took place either in one of the report rooms or in the small office of the administrative nurses. On Unit A, the more ceremonious of the two units in Peer Review, the review began with a repeated phrase:

> This is your peer review for the___ position (CN II or III). We want to stress that all that transpires here is considered confidential. Anything that is passed on about it must come from you.

The nurse was usually first asked, "How are things going for you?" Her answer was followed by a general statement, usually a positive one, by the leader of the review on the person's work, such as:

> Every since you've been employed here, you've been very consistent. You individual care plans, review them. It is really nice to see. It sets a good example for others (said to a shy, quiet CN II).

> I want to start out by saying that as far as your checklist goes (the job description), you're very right on on most points. We need some personal interpretation in

> some places. Clinically you are perfect, both personally and professionally. You've pushed my standards up. You've been a very positive influence and helped mold the standards of care on the floor and keep the standards of care up there (said to one of most influential CN III leaders).

Trying to maintain a flow of comments in a choreographed way, the leader guided the review through the areas of the job descriptions. Cues were offered, such as, "You want to tell her how you see her work in teaching..." Self evaluation was stressed, honesty expected and apparently often offered.

Many of the positive comments were stereotyped and emphasized the values of the unit:

> You have a good feel for the unit, a global view
> When I follow you, your patients have good knowledge of what to expect
> You have always been real consistent with your care plans and histories.

Discussion sometimes turned to a discrepency between a nurse's self-evaluation and that of the evaluators. "I want to change your 'U' (Usually) to an 'Always.' Why did you give yourself a 'U'?" A person's self presentation and handling of emotions clearly came within the purview of the session. For example, one committee told a CN III how much impact she had on the rest of the staff when she demonstrated that she was in a bad mood and could not cope. Another committee encouraged a nurse to approach physicians in a "less palsy" and "more professional" direct way. While the nurses often struggled when saying critical things directly and did try and "sandwich things in," in the end they did confront many of the difficult issues they planned to confront. A "hard" peer review was one in which "it was a struggle to stay positive," or in which the nurse was "so nervous."

When an area of weakness was mutually agreed upon by the reviewers and the nurse, the usual route was to "goal it," i.e., to list it as a goal to be achieved in a given period of time and then later reviewed. Nurses were encouraged to realize their potential in ways that helped both the nurse and the units. Long-term commitment to the units, however, was not expected or demanded; nurses who planned on leaving the units soon were still helped in finding ways to develop that were personally and professionally meaningful and useful for the units. The suitability of a nurse for a leadership position on the unit was discussed, and a few nurses were told, "We think that you are CN III material for the future, consider making a CN III a goal."

A specific language was used to write goals, one that new nurses and preceptors had to learn. The criterion for meeting the goals were quantified. For example, a nurse who wanted to become "more assertive" was encouraged to write the following means for meeting her goals:

1) seek to be in charge three times a month
2) identify which patients need feedback on them (6 times)
3) follow-up on that and the feedback you gave. Make it to whomever you talk to, whether its the LVNs or other nurses

These goals became a signed contract that was part of the nurse's permanent file.

While Peer Reviews focused most on the practice and goals of the nurses, they also addressed how a nurse handled her emotions. The spector of "burnout" stood in the background and efforts to prevent it and to encourage job satisfaction were seriously considered.

Nurses extended much support to each other during these reviews. They genuinely tried to help each other and often emphasized that they were in the "same boat." Rank was minimized, and in general, all

appeared to be sincerely helpful, of good intent, and mostly egalitarian.

The review for a promotion, however, sometimes created confusion. A candidate for the CN III position, for example, had both CN IIs and CN IIIs at her Peer Review. With a successful review, the CN IIIs welcomed the nurse as a new member of the units CN III group. But as they were not supposed to be an exclusive club, this created a problem. As two CN IIIs voiced after such a session: "We worry about coming off as exclusive and leaving out the CN II." This presented a clear example of the tension between values of hierarchy and equality.

Typically the Peer Review ended with a general statement such as, "I'm real excited and happy to have you on the unit." The nurse was also asked, "How was this for you?" In the case of a promotion, the review often ended with, "Congradulations, you are now a CN II." The reviews generally lasted one half hour or more.

Analysis: In these Peer Reviews, one sees many of the values of the unit displayed in microcosm in a ritual of professionalism. A formal language was used to describe nursing, one in which the goals and values were explicitly discussed and emphasized. The canons of good nursing were reviewed and nurses were sculpted into professionals.

In addition to being a forum for review of good nursing, they were supposed to be "positive growth experiences." In addition to enhancing a sense of ceremony, I think the rehearsals and choreography of the reviews attempted to control criticism, to transform negative feedback into "constructive feedback."

One sees and hears ample emphasis on individual responsibility in these sessions: the reliance on the nurse's self-evaluation, the

encouragement of her to assess herself with the same values, and to take responsibility for her own evaluation and growth. Middle class socialization practices echo here, where in the context of egalitarianism, children are raised to become independent and to live by the family principles, out of their own responsibility. The voice of egalitarianism was loud, from the participation of the nurse in her own evaluation, to the inclusion of nurses of different status positions, to the term "peer" review (not judgement), and to the use of reason rather than authority or custom to emphasize a point ("tell her how it made a difference when she did...").

One hears also the emphasis on growth and development, both personal and professional, and that one grows through making and achieving goals. One hears again a standardized individuality (or individualized standardization) in offering choice among sterotypic goals. While conformity was stressed, so was the ability to allow people to develop according to their own grain and to follow and support the pursuit of their individual interests.

Informal Evaluation

"Feedback"

Few words were mentioned on these units more than "feedback." "Giving and getting feedback" was expected of all nurses on the unit at all levels and stages of tenure. The right and obligation was ascribed, not achieved. This practice served a number of functions and had a number of meanings which I will consider as well as critique.

For one, the emphasis on feedback disseminated social control throughout the entire staff. Everyone was supposed to give feedback to each other and in fact, a nurse would be negatively evaluated if she

didn't. For feedback was seen as a key to running a good unit and the means for evaluating the care or behavior of other nurses. So it was taught in a preliminary evaluation in the following way:

> Peer Review is ongoing. It's making sure that you give feedback to people. Like if you see an I and O sheet (a list of a patient's intakes and outputs) that is just 'out to lunch'. Take the whole sheet down and write, 'Cancel.' Or leave a little note for somebody, 'Hey, you know that one was a little screwy.' How are you going to change your practice otherwise? If you didn't know your SOAP notes were good, who's going to tell you? It gets back to Peer Review: "reports pertinent information to the appropriate person."

Notes and notes were written between nurses, often positive and complementary, often critical. So one funtion of feedback was the spread of benign, non-authoritarian, but omnipresent mechanisms of social control. All needed to police the units.

With so many new graduate nurses and so much pressure on the nurses in general, due to the large number of sick patients with complicated problems, such policing was necessary. New nurses had to be able to tolerate being criticized in order that they could be corrected and improve their care. Making feedback acceptable, across the board, made it more acceptable for the newcomers, in particular, helping them not to feel singled out. As mentioned, while it was customary in nursing report for nurses to ask questions of the reporter in order to gain more information about patients, some new nurses felt attacked and judged by these questions, so much so that people stopped asking them. Episodically this would be discussed and mutually agreed that questioning was acceptable and was not an attack.

It is interesting here to compare nursing report with medical rounds which are known for their hazing and sparring, particularly of the young interns. Several differences stand out. Nurses apparently

bring significantly less self-confidence to their work, and far from needing to be cut down to size, as one may argue is some of the intent in hazing of interns, the general thrust is towards shoring nurses up in order that they may better stand up to physicians. One may say that physicians are being socialized for real autonomy; nurses, like managers, are being socialized for teamwork. Further, open competition was not very acceptable on these units, Competition asserted hierarchy not equality, and it bred separation rather than unity, a clear concern on these units. Finally, the fact that a nursing shortage was publically identified at this time, coupled with the relatively less financial remuneration of nurses likely contributed to less observed hazing.

Nurse leaders also needed to be able to tolerate criticism. In fact, part of the grooming of a potential leader was in the capacity to handle criticism:

> You need to be OK with feedback... You need to see it not as criticisms but as improvements. I have a fear of hurting your feelings by what I say. Yet I'm not saying it that way. Feedback is not always critical. A lot of time it is an observation, different viewpoints. I hope you see it that way. Things can be fine-tuned for all of us. I find your criticisms... (pause, laughs at the term), I mean your observations, to be very helpful. It's professional, not personal. We can all grow (Administrative III nurse).

The emphasis on adjusting to feedback had another reason. Like life on the war front, a certain thick skin was seen as necessary for survival. Emergencies often precluded time for amenities. As one nurse cautioned another, "You need to hear <u>what</u> people are saying, not <u>how</u> they are saying it. Listen first. Cause sometimes there is no time to dress it up." Feedback, of course, epitomized the striven-for shared leadership and democratic governing. It stressed the worth of each and every nurse and their opinion and was a way of shoring up

confidence and of empowering, as depicted in the following example.

> I think people would appreciate more evaluation from you. I value your judgement. If I wrote a good care plan I want to hear from you. You have that knowledge. The staff want to hear it also (Ad Nurse III).
>
> Nurse: I don't think of that as something I can do. I need that reinforcement.
>
> Ad Nurse: It's OK to do.

Not uncommonly, this was a shy, reticent nurse who was given license and rationale to be more forthright. This points to another reason for the explicit emphasis on feedback: for many nurses it did not come naturally. In fact, far from it. Many had difficulty being critical and judgemental, much less communicating it. In leadership groups, discussion often turned to how hard it was to be the "bad guy" (note the masculine reference), and to praise of each other for learning to be comfortable with it. Many needed license and experience in being critical.

Feedback also provided nurses with a sense of power and impact. By creating their own community with their own rules, they partially mitigated against a potential sense of impotence before the medical and bureaucratic contraints they faced. This was <u>their</u> community, they were told in a number of ways, and <u>they</u> were responsible for making it the way they wanted and needed. Their needs would be met if they vocalized them, i.e., "gave feedback," to the administrators or others. It was a cardinal principle of the leaders that they take their staff's requests seriously. And almost without exception they did.

Feedback was also a gift. With growth so valued, taking the time to seriously evaluate another nurse and give insightful feedback was considered an investment. Feedback took time, energy and a certain amount of commitment, the kind of thing a family gives to each other to

make them better for themselves and the world. As one nurse told another who was uncertain about staying on or leaving the unit, "It depends on how much feedback you want, what you do with your career and your future. You can get it all here from people who know you."

Feedback then was among a community; it was expected to be given by everyone to everyone else. It symbolized and actualized the ideals of democracy, egalitarianism, and professional and personal development. It groomed nurses and policed their care with the interests of the patient in mind. And it provided "strokes" to nurses who may have lacked sufficient recognition for their work, who were praised for meeting professional nursing standards and who lacked or were assumed to lack self confidence. It was a means for nurses to strengthen themselves to meet more equally and less sensitively, their physician neighbors.

We must note a few problems however. The strong emphasis on feedback sometimes denied that there was an authority structure; it assumed that all nurses were personally able to stand up to that authority; and that if they did, things would change. Feedback was sometimes seen as a panacea, that if only one could spell things out explicity, the situation would improve. The time it took to spell things out was extensive and not always the cure. Finally, the emphasis and need for feedback also reflected the degree to which their culture and their evaluations--how nursing was to be practiced-- and their sense of self worth was <u>not</u> taken for granted.

Two Practices in Action

In this final section, we shall consider two other prominent practices--interchangeability of staff roles and nursing care plans-- in actual practice, exploring their meanings, functions, and limitations.

1. Interchangeability of Staff Roles

A significant practice on the units, while not a part of the original Clinical Program a direct implication of it, was the practice of rotating all nurses through both the roles of patient care and charge nurse. Regardless of ability, interest, or experience, all nurses had to learn and enact the charge role. This was not hospital policy but reflected the choice of the units; in fact, some other units reserved the role for the CN III nurses alone. Units A and B considered such a possibility when the problems of rotation were extreme, but decided to continue with it for some of the following reasons.

For one, rotation emphasized that everybody had to share responsiblity of the unit and carry "their own." In addition to it being an obligation, it was also a right, as it contributed to shared leadership and the independence of each nurse in her practice. It equalized the staff. Being in charge was also intended to, and did, provide nurses with a more global picture of the unit, much larger than the four or so patients a nurse cared for on a given day. The rotation system also allowed good clinical nurses the opportunity to provide patient care, as the charge nurse did not take a patient load in the day, and a restricted one at night. Finally, rotation must be understood in terms of nursing turnover--it mitigated against any one nurse or nurses becoming indispensable. Raised in the traditional system in which the head nurse "ran the show," one of the administrative nurses noted:

> I remember what happened when our head nurse was sick and missed a day. Nobody knew what was going on. Here, I want others to be able to take over if someone is gone.

The facts of life were such that at any given time, usually sooner rather than later, new nurses would find themselves among the most experienced on the unit; by force, they needed to know how to be in

charge. Staff rotation, then, protected against the consequences of nursing turnover by precluding the development of deep work niches and division of labor. It disseminated decision-making; it levelled differences among staff and asserted egalitarianism in practice.

But what are some of the other consequences of this practice? In order to understand these we must consider again what it meant to be in charge. The charge nurse had an overview of the unit; she was the conduit between the nurses and the medical team and kept a watchful eye out for any nurse in need of help. Further, the charge nurse attended daily medical rounds, led the weekly management rounds and gave nursing report to the oncoming shift.

Getting a response from the medical team was often a challenge for nursing staff at any level. Management rounds could easily deteriorate into a ritualized, uninformative and boring interchange between the charge nurse, who announced a patient's name, and the Chief Resident, who divulged what information he saw fit. A more aggressive and knowledgeable nurse pushed the Chief for more information, usually asked more questions and offered more information. Similarly, medical rounds, designed primarily for the medical team, required a self-confident, informed nurse to assure information exchange rather than simply quiet listening and recording of the medical plans on patients.

Given all this, one must consider the consequences of having novice nurses, sometimes with only 3-4 months experience, fulfil the charge nurse role. Far from quelling the anxiety of the staff on a given day, they often inflamed it; far from presenting the most informed and strongest foot forward in interactions with the medical staff, they presented the weakest. Far from having a person who knew what questions

to ask and how to ask them, they had a nurse who was still trying to grasp the clinical processes of different patient surgeries, much less anticipate what problems would arise and get appropriate guidance for them.

Because of this Unit B eventually turned to having only the more experienced nurses conduct management rounds. Yet the rotation of all nurses into the charge role continued. Not unexpectedly nor irrelevantly, many physicians preferred the old system of having one head nurse to whom they could regularly turn and who knew about all the patients. In this vein, the interchangeability of staff roles contributed to physicians' view of nurses as interchangeable; many gave up trying to establish a working relationship with any particular nurse.

The practice of rotation, then, underscores the units' commitment to nursing needs, to the needs of new nurses, to equality and democracy, and to protection against the consequences of nursing turnover. It contributed to several conflicts: a conflict between the desire to develop a nurse and to enhance a sense of equality vs. the need for hierarchy according to expertise; a conflict between the desire to develop the autonomy and independent judgement of individual nurses vs. the credibility of nursing and its impact on physicians; and a conflict between the need for long term protection against turnover and the short term need for a skilled and informed charge nurse, who could improve patient care both directly and indirectly, by helping out other nurses.

2. Nursing Care Plans

Much as they were important in the genesis phase of the Clinical Program, abundant evidence pointed to the pivotal meaning of nursing

care plans on these units.

1) In 1981 when the new Director of Nursing announced that she wanted to eliminate the care planning system as it was too costly and time-consuming, many of the staff, particularly the administrative and clinical leaders, were upset and intended to fight her decision (the change was not made, I was told, in part due to this response).

2) As indicated earlier, care planning was a factor in who got hired, fired, and promoted. Some nurses chose the units because they were two of the few that really implemented the care plan system as they learned it in nursing school; another nurse with five years experience was refused advancement to the CN III position because of her poor documentation. A compromise was made for her to "goal" her SOAP charting as something she would work on. In other words, she had to acknowledge the importance of care plans before she could be advanced.

3) On one of the units a graph was pinned to the wall of the report room that documented the percentage of patients on the unit each month who had care plans written on them.

4) The two units openly prided themselves on having the highest percentage of patients with care plans on them; they considered this an important basis of "quality nursing care."

5) Signs of bad times on the units were frequently interpreted by fewer care plans on patients; it was seen as an indication that things were "going to pot," a symptom that things were not well.

Nursing care plans symbolized quality nursing care for many and epitomized the type of professional nursing projected in collegiate nursing schools.

Care Plans in Use: While nurses were repeatedly encouraged to read care plans early in the day, many did not look at them until the afternoon or later. In fact, nurses differed widely in how they used them. Some, regardless of experience, routinely looked at them early in the shift and wrote them in the afternoon; they integrated them closely into their care and organization. Others, both new and more experienced nurses, did not look at the care plans until the afternoon and wrote

them at the end of the shift while extremely tired. The reasons for the use differed among new and more experienced nurses; new nurses were often not well enough organized to remember to incorporate the care plans and sometimes forgot about them or "didn't get to them" early. On the other hand, some new nurses followed the written models of care almost verbatim; for example one new nurse conducted "discharge teaching" (preparing a patient for discharge) by essentially reading from the care plan to the patient. Some more veteran nurses saw them as basically irrelevant to their practice-- they were too basic and static, and only as good as their authors. Their number outweighed the novices.

Care plans were also used when patients other than general surgical patients "boarded" on the units. In these situations, the printed Models of Care (which spelled out what to do for patient problems) provided much needed guidelines. Similarly float nurses or nurses who did not know what to do strongly relied on them. Some veteran nurses noted that they relied on them as a backup memory.

Care plans were central in the evaluation of nurses. Rare was an evaluation of a nurse's practice that did not mention them. Positive evaluations included such statements as, "changes frequencies (meaning changes the times for assessment)"; "makes them more valid through revising them" or "individualizes them." In many cases these evaluations were not made in comparison with the actual situation, such that the appropriateness of the care plan could be measured. For example, while changing the frequencies of a care plan indicated that a nurse read the care plan and took some action, in many cases it may have been inappropriate to change it. Other positive comments included:

Your SOAP notes are real communicative
Uses the format well
Problem-solves well
Gets a real sense of who the person is
Good, easy to follow
To the point
Revises and initiates problems

More critical comments on documentation were "too long," "too broad," "doesn't initial them."

Functions and Limitations of Care Plans

Functions:

In the last Chapter we considered some of the functions and meanings of care plans during the genesis phase. Here we shall further consider them as they were in fact used.

Particularly given the 12 hour shift schedule in which nurses were off duty three or more days at a time, nurses lost track of patients' care and progress. The care plans provided one obvious means for greater continuity of care. More experienced nurses used care plans to guide care in their absence, a means of spreading their expertise and of assuring more continuity of care. In fact, some took great pains to carefully write out a plan for patients that could be followed by others, most specifically, by new nurses. Care plans, in spelling out what to do in a step-by-step fashion guided the novice through complex care activities, serving as a substitute for a shared culture. In providing basic recipes for care, they allowed for relative interchangeability of staff, as a nurse could generally follow the prescription for care with little background knowledge.

Care plans also functioned as homogenizers, a source of conformity in the face of heterogeneity. Nursing education, as described, offers three different routes to becoming a nurse; standardization in nursing

education is still minimal. The care plans functioned perhaps not only as a unifying symbol of professionalism for all nurses, they also guided and thereby standardized care.

Care plans symbolized equality among nurses. Any nurse was supposed to change a care plan if she saw fit, regardless of who wrote it. Each nurse could dictate to the next what should be done to and for a patient. Not unexpectedly, new nurses felt uncertain about giving orders for other nurses to follow; but they were encouraged and essentially required to. No nurse's orders were supposed to be considered sacred, though nurses did respond as if some were more sacred than others.

Care plans also differentiated among nurses; they offered a means through which a nurse could make a visible mark on patient care. This decreased the anonymity of patient care and increased accountability; a specific nurse could be identified as the author of care for a day or more. In fact, care plans provided an arena for nurses to demonstrate their abilities to each other. While nurses were usually too busy to observe closely their colleagues' care, care plans presented a means by which nurses could evaluate each other. Indeed, it was significantly easier to rise on the clinical ladder with "good" care plans than without.

In general, care plans were an important area of social control. Their frequent auditing and "correction" by the administrative and clinical leaders was a means of evaluating the thinking and process of a nurse. And perhaps more than that. Often the care plan seemed to be equated with the actual care given.

For some, care plans symbolized nursing's autonomy from medicine. Where only nurses read the care plans, as was the case here, care plans created an exclusive channel of communication between nurse

and nurse; nurses gave and responded to "nursing orders" for patient care, entirely independent of medicine.

Limitations and Dilemmas

One of the problems of the care plans, like any formal model is the question of at what level are they pitched; what is or is not taken for granted (Gordon 1984). Specifically, the care plans identify patient problems that are typical of patients undergoing types of surgeries. But what constitutes a problem? When every patient is expected to have post-operative pain, anxiety, lung problems, should these be identified as problems when in fact they are routine? Thus in order for care plans to work well one needs consensus on what constitutes a problem. Yet given the diverse experiential background of the nurses, this consensus did not exist. Care plans were used differently by nurses at different levels. They could not circumvent judgement. They were geared to the typical situation, the average patient, not the particular patient; it was still left to the individual nurse to recognize and interpret a situation as relevant.

Other factors sometimes made care plans irrelevant. A patient's condition changed rapidly or the physicians' plans for the patient suddenly changed so that the plan quickly became outdated. For example, after writing up an elaborate teaching program for a diabetic patient, one nurse learned that the patient had been suddenly discharged by the surgical team before she had time to begin. Further, although nurses were repeatedly encouraged to "individualize the care plans," many reviewed them so routinely and almost ritualistically that they became relatively meaningless.

Nursing care plans, like most formal models, are relatively impersonal, both to the nurse using them and to the patients whom they are for. They do not differentiate between the beginner, the competent, and the expert nurse, as I will describe in the following chapter. Some nurses found them insulting and inappropriate. For example, the care plan may indicate that a patient with a "problem" of depression should be checked every __ hours. To paraphrase one nurse's reaction to these orders: "I resent being told to go in and visit a depressed patient. I would do that on my own, out of my own concern. I don't need to be legislated to do so." Thus nursing orders, so often geared to the novice or beginner, can insult those who know very well what to do and probably in a more appropriate way. When they are geared to the lowest common denominator of knowledge, as they sometimes deliberately are, they may be alienating and unchallenging to the those with more skill and experience.

Care plans also fail to differentiate among patients. With the depressed patient, to continue with the example, the nursing orders instruct the nurse to check with the patient so that the patient can "ventilate" his/her feelings with the nurse. This specific order ignores the patients who may not want to ventilate with a particular nurse or with anyone.

Much as care plans simplify and reduce activities, they can also overwhelm. In this way, they run the risk of endless regression as more and more things are spelled out. For example, one clinical specialist wrote a care plan for a patient's wound dressing in order to standardize the care. Nurses, new and veteran, found the pages overwhelming and had difficulty doing the dressing. When they called upon the administrative nurse to help them, the latter found that she too was intimidated and

bewildered by the pages of notes; after several readings she recognized familiar procedures and figured out what to do, which in the end she described as fairly easy.

Further problems lie in these care plans. The use of the term "problem," while pragmatically oriented, puts the onus of a situation on the patient. Describing the need for pre-operative teaching in terms of a "knowledge deficit" of the patient perpetuates a negative view of the patient as a bundle of "problems." To speak of a patient's "problem with body image" or anxiety, concretizes and objectifies the situation, sometimes to the point of rendering it meaningless. These care plans, then, generated and perpetuated a new discourse about patients, one that at times likely obscured deeper understanding and sensitivity to particularity.

Further, the breakdown of a nurse's practice into "subjective" and "objective," as in SOAP notes, perpetuated an analytic epistemology, in which the subject and object were split, and a view of patients in terms of variables, subjects and objects. While so much emphasis was placed on seeing the patient as a whole person, this approach contradicts it by breaking the patient up into parts and separating the nurse from the patient. In no area in the care plan was there room for a general narrative review of the patient as a whole person.

We must finally note the frequent equation of quality nursing with quality care plans. It is all important <u>how</u> a nurse practices nursing, not just what she does. This essential dimension, however, did not and probably could not make its way into the care plan.

Summary

In this chapter we have reviewed some of the ways in which the Clinical Program was perpetuated on the units. We saw how many of the practices and values were oriented towards teaching and practicing "professional nursing," particularly to new nurses. Given the nursing turnover on the units and given the effort to implement the new ideology into practice, the image of these units as finishing schools stands out. Professionalism was taught, cultivated, and actualized, often at the short-term expense of more experienced nurses, of physicians, and perhaps of patients. Conflicts and contradictions arose in implementing the program, such as conflicts between hierarchy (differentiation) and equality, between autonomy and standardization, and between patient-centeredness, rational and standardized.

In the next chapter I will present the Dreyfus Model of Skill Acquisition. Using this model, we can describe the culture on these units as oriented towards the needs of novice and perhaps competent practitioners, but not to those of experts.

CHAPTER SEVEN: THE DREYFUS MODEL APPLIED TO NURSING: A CRITIQUE OF FORMALISM AND SCIENCE IN NURSING PRACTICE

In this chapter I shall present the Dreyfus Model of Skill Acquisition and the theoretical framework from which it derives. When applied to nursing, this model explains much of what we observe in the uses and limitations of formalism and formal models among social groups. More specifically, it points out that while formalism is most useful for the early stages of skill, it is less appropriate for the higher levels of expertise.

Two Kinds of Knowledge: Theoretical Knowledge and Practical Knowledge

The scientific approach to reality is spreading into more and more domains of American life. One finds in its wake increasing demand for many of the qualities considered so essential to the practice of science-- the objective, the measurable, the explicit, the rational, and the neutral. Science is the product of a more general process called theorizing, and ideal theory is formalization. To formalize is to isolate context-free elements and relate them in a new, logical, explicit order (Dreyfus 1981). Science, theory, and formalization are all the natural and logical outgrowths of a particular approach to knowledge, an approach that maintains that the truest knowledge is the knowledge of a neutral intellect confronting an external reality (Polanyi 1958). In other words, true knowledge is knowing-that. Theoretical knowledge contrasts with another kind of knowledge, practical knowledge or knowing-how (Benner and Benner 1979).

Evidence of the increasing diffusion and dominance of theoretical knowledge over practical knowledge is ubiquitous. One quick glance at the abundant number of "how-to" books in a bookstore--how-to-parent, how-to-enjoy sex, how-to-make friends-- illustrates the pervasive formalizing of knowing-how into knowing-that.

The approach to knowledge as theory postulates a separation between reason and experience and maintains that the most fundamental access to truth about reality is through a theoretical, detached, universal attitude (Polanyi 1958). Dreyfus (1981, 1984) outlines four features of theory central to this approach: 1) objectification, the split between the knower and the known; 2) the attempt to make things explicit; 3) decontextualization, by taking explicit elements out of their everyday context; 4) and recontextualization of elements into a new whole.

Many philosophers of science have taken issue with this exclusive view of knowledge (Wittgenstein 1958; Heidegger 1962; Ryle 1949; Polanyi 1958; Kuhn 1970; Dreyfus 1979, 1984). Some point out that not only is theoretical knowledge not the only kind of knowledge, it is derivative of a more primordial kind of knowledge-- practical knowledge (Polanyi 1958). Kuhn discusses this knowledge in terms of paradigms:

> Paradigms may be prior to, more binding, and more complete than any set of rules for research that could be unequivocally abstracted from them (Kuhn 1970:46).

These philosophers locate this other knowledge in places other than our minds; in our everyday practices, our use of tools and our way of being-in-the world (Heidegger 1962); in our bodies (Merleau-Ponty 1962); in our dispositions (Ryle 1949); in skills (Heidegger 1960); and in paradigms (in the sense of exemplars, Kuhn 1970). Kuhn writes on the latter,

> When I speak of knowledge embedded in shared exemplars, I am not referring to a model of knowing that is less systematic or less analyzable than knowledge embedded in rules, laws, or criteria of identification. Instead I have in mind a manner of knowing which is misconstrued if reconstructed in terms of rules that are first abstracted from exemplars and thereafter function in their stead (Kuhn 1970:46).

Those adopting this position argue that knowledge is gained in an involved, committed stance which forms the background of the detached, neutral, and uninvolved one posited by the traditional approach, in which the neutral knower receives stimuli from an external reality. The knower perceives through foreknowledge, never neutrally, and has an active role in that knowledge. Polanyi discusses this in terms of personal knowledge, maintaining that the sharp lines between subjective and objective forms of knowing are inaccurate:

> I regard knowing as an active comprehension of the things known, an action that requires skill... Clues and tools are things used...and not observed in themselves. They are made to function as extensions of our bodily equipment and this involves a certain change of our own being (Polanyi 1958:vii).

> ...into every act of knowing there enters a passionate contribution of the person knowing what is being known, which is a vital component of his knowledge (Polanyi 1958:vii).

In different ways, this alternative approach to knowledge questions the assumption that intelligent practice always involves two processes: doing and theorizing (or thinking) (Ryle 1949). The critique focuses on two points. First, intelligent practice is often not preceded or accompanied by thought or theory. Many skills, such as swimming, bicycling, or practicing science are learned and practiced without knowledge of the rules or theories that explain them (Polanyi 1958; Kuhn 1970). Knowing-how differs from knowing-that and while know-how can sometimes be described in theoretical terms, knowing-that does

not need to be part of practical knowledge:

> The important thing about skills is that although science requires that the skilled performance be described according to rules, these rules need in no way be involved in producing the performance (Dreyfus 1979: 253).

Second, intelligent behavior is often not translatable into representation but is ineffable:

> Although the expert diagnosticians... can indicate their clues and formulate their maxims, they know many more things than they can tell, knowing them only in practice as instrumental particulars, and not explicitly as objects. The knowledge of such particulars is therefore ineffable, and the pondering of a judgment in terms of such particulars is an ineffable process of thought. This applies equally to connoisseurship as the art of knowing and to skills as the art of doing. Therefore, both can be taught only by aid of practical example and never solely by precept (Polanyi 1958:88).

Heidegger (1962), as interpreted by Dreyfus, argues that this ineffability is because this knowledge is based on a background of practices and understanding that can never be made fully explicit.

The contrast between theoretical knowledge and practical knowledge is more than this. While theoretical knowledge relies on elements taken out of context and approached through universal rules, practical knowledge entails situational understanding, that is, a global grasp of a situation as a whole. Things appear salient not according to some objective criteria but depending upon the particular situation and the concerns of the actor.

> Being concerned in a certain way or having a certain purpose is not something separate from our awareness of our situation: it just is being aware of this siituation in a certain light...(Taylor cited in Dreyfus 1979:261).

> What counts as an object or is significant about an object already is a function of, or embodies, that concern (Dreyfus 1979:261).

A fundamental tenet of the practical knowledge paradigm is that practical knowledge derives predominantly from concrete, real world experience. It is the know-how that comes from familiarity and encounters with concrete situations and their outcomes. This will be described more fully in the next section.

A number of terms used in everyday and academic language are typically associated with the two types of knowledge described here. For purposes of clarity and summary I list them below.

Table 3. Terms Typically Associated With Theoretical and Practical Knowledge

Theoretical Knowledge	Practical Knowledge
knowing-that	knowing-how
science	practice, technology, "art"
subject/object split	involved, perrsonal knowledge
reflection, deliberation	action, involvement
theory	practice
universal	particular
elemental	global, holistic, gestalt
mind	body, skills, practices, mind
elemental rules, models (formal)	paradigms of concrete cases
explicit	implicit, background
formal	informal
reason/experiment	experience
critical examination	tradition
propositional	experience-based intuition

The Development of Practical Knowledge: The Dreyfus Model of Skill Acquisition

How does practical knowledge develop? What is the relationship between theoretical knowledge and practical knowledge in performance? The Dreyfuses, based on study of chess players and pilots, outline five stages in the transition from novice to expert: Novice, Advanced Beginner, Competent, Proficient, and Expert (S. Dreyfus 1982; Dreyfus and Dreyfus, in press; Benner 1982, 1984). Two general changes occur

with the acquisition of skill. One is a shift from reliance on abstract principles to the use of past concrete experience as paradigms. The other is a shift from an elemental approach to a situation to a holistic grasp of a whole in which only certain aspects have salience. They trace changes in mental capacity along several dimensions: the recognition of components; the recognition of salience, the recognition of whole situations, and spontaneous decision-making (see summary table in Appendix F).

Novice: The novice, lacking any experience as a guide, is taught to identify objective attributes in the task environment, such as measurements of height, weight, temperature, and to determine action towards them through an explicit set of rules. The attributes which can be recognized without the benefit of experience the Dreyfuses call non-situational.

The novice, lacking experience, is often overwhelmed with new stimuli and the mastery of the task at hand, as a new graduate nurse describes:

> I was totally overwhelmed. I mean, I had one patient. And he had an abcess of the thumb. He had one IV line. One IV going into one big vein. He had very good veins. He needed one set of vital signs. He was ambulatory. He could bathe himself. And I was busy all day! I was busy twelve hous with this one patient! First of all, I did not know anything. I needed a vital sign sheet. I had to ask where to find one. He needed a volutrol medication. I had never given one. I went in there and counted out the drops on the IV. I kept checking the IV...Everything was a task...I had to focus my direct attention at each one of these things because every single thing was new.

Novices, so unfamiliar with the particular new world they are trying to learn, seldom can perceive important situations in that world. The following example of a student nurse illustrates how a novice in a

particular role is unable to perceive appropriately situations tied to her role:

> I was walking down the hall one day with a student nurse in the Pediatrics department while the student walked a crying baby. We passed a room; through the window we could see a mother holding a large child in her arms; the child was having a convulsion. I asked the student nurse what was happening. "The child has a history of epilepsy, " she replied; "They know how to take care of her." So we continued. After awhile she began to think about the incident and wondered whether she should have responded differently. She noted that she often forgets that she is a nurse. The next day she said that she began to feel quite badly about her non-response toward the mother and child; it was an emergency situation and she did not respond. Analytically, we can say that she was so removed, she did not respond to or really appreciate the situation.

Novices are provided rules to guide their action. They typically follow these rules exactly (when and if they remember) with little adjustment to the particular circumstances involved. For example, Cory, a new graduate nurse, remembered the first time she gave a patient a blood transfusion.

> I knew I had to do vital signs. I knew they had to be every fifteen minutes. I didn't even realize that I could wait an hour between; it's every fifteen, every half hour, and then every hour. I was taking vital signs way more than I needed to. Just because I had never done it before. I didn't really know what I was looking for. We were taught every fifteen minutes, but in fact, it depends. If the patient is spiking (having a temperature), you take them frequently; but if things are going well and they're staying totally stable (you can do it much less)... I just didn't have the clinical experience to know that things were going well.

On the other hand, novices sometimes do not have appropriate appreciation for the rules or even knowledge of them as one preceptor on a coronary care unit described:

> A lot of patients on this floor have arteriograms done. When they return, often they bleed. So we normally put an ice pack on there. ...When Carol got a patient back from an arteriogram, she took off the ice pack and

> later on told me that she took it off because the patient was uncomfortable. And that was her justification because the patient's comfort was top
>
> priority. But as it happened, the patient had a problem bleeding... and did need the ice pack.

In this example we can say that Carol did not appreciate the importance of a rule or perhaps even recognize that there was one.

Advanced Beginner: With experience and supervision, the newcomer gradually comes to perceive her task environment not only through context-free objective attributes, but also as recurrent meaningful situational components, which the Dreyfuses call aspects. Aspects are overall, global characteristics which require prior experience to perceive. Assessing how much a patient knows about surgery and how much needs to be told is an example of an aspect. One nurse, eight months into her first job, describes her progression on this dimension.

> When I first tried to do pre-op teaching (teaching that nurses provide to patients before their surgery), I didn't even know what it was. I had no idea! Then I learned how to do it. But I would just go in there and give them the old spiel! I mean they definitely got the fullest! But the poor person may have felt like the lecture didn't help. Now I can go in there and talk to the patient. First I can assess what they know. I can sit down and ask them if they ever had any surgeries before... So instead of saying 1,2,3,4,5.... now I say, 'where is the patient at, what experience has the patient had with this, what type of surgery is it, and what have I seen that happens that generally goes along with this type of surgery?' So that I know now what I need to tell them, what's most appropriate for the person.

Parallel to reliance on specific rules for determining action at the novice stage, the Advanced Beginner begins to rely on principles or guidelines that dictate action in terms of both attributes and aspects.

A nurse describes the development of guidelines in her work with IVs.

> When I was new, if I had an IV that stopped running, I would just look at it and I would say, 'OK, what can we do? It's stopped running, let's take it out. Or maybe I should ask someone else to take it out.' But now I know I'd do everything else you can do without taking it out: take off the tubing, go back and change the tubing, push it, do everything-- because I know all those things to do because I have a general idea that all that matters is to get that fluid in, if it can be re-started, and not to infiltrate it. And I know what I can't do-- push it in forcefully. And I know that. And therefore, even though things aren't all written up, I know because of a general principle, all the things that I can do without doing it wrong.

The advanced beginner, however, still lacks a sense of salience, a sense of something being more important than something else. This generally reflects the lack of an overall plan or perspective. One preceptor described this absence in her orientee:

> One of the things that struck me was a real problem with John was in priority-setting, especially with a 2-patient assignment (in the Intensive Care Unit). It would overwhelm him to the point that he would spend 2 hours taking care of one patient without even realizing the other patient was just essentially lying there. I'd keep having to go up to him and draw his attention to the second patient.

Further, the advanced beginner typically has difficulty appreciating and understanding the meaning of what she observes, as a preceptor describes in the following example.

> I would say that with Marsha as well as others, the basic problem is not having the experience to know whether something is important or not. For example, one new graduate nurse had a patient who was admitted from the emergency room complaining of shortness of breath. The work-up included differentiating betweeen a fluid overload syndrome versus a pneumonia. One of the orders was to give an IV bolus (large amount of fluid). This patient seemed to particularly respond to it and put out a very large amount of urine which I had never seen happen so fast in such a short period of time. Well, the new graduate mentioned to me just sort of in passing, "Oh, the patient put out 2 and one half liters of urine

> in one and one half hours." And I just about fainted. My concern being, 1) a volume depletion and potential cardiovascular collapse, and 2) the patient's potassium level... I took immediate action, called the internist and spent the rest of the night rehydrating this patient... (She didn't have a sense of the parameters of normalcy?) Right. Right.

Competence: The competent performer, typified by the inexperienced middle manager in business (S. Dreyfus 1982) or the nurse who has been on the job for two to three years (Benner 1982), develops when the performer begins to perceive her actions in terms of long-range goals or plans of which she is very consciously aware. These plans dictate the salience of attributes and aspects by providing a perspective. The competent performer, it must be noted, chooses this plan after conscious, analytic consideration of the problem.

The nurses typically described the achievement of this stage in terms of "being able to see the whole picture" or "being organized." By seeing the whole picture one is then able to discern the relative importance of particular parts. We see the nature of this perspective clearly in its absence.

> An Intensive Care Unit preceptor described an incident that occurred with her orientee as an example of the lack of a plan. The two together left the unit to meet a patient who was to be admitted to the unit for surgery the following day. Leaving the unit meant that their other patients were barely observed; therefore time was of the essence as they proceeded to do their pre-op teaching with the new patient. Whereas a good, fast teaching can take one half hour, the new nurse was still exploring the patient's feelings after nearly two hours. 'He took the best medical history I've seen taken in this hospital! An excellent history! Just asked every question in the book, really pursued it. Because he really took his time. But not a good history for the ICU, for what I see as the goal of pre-op teaching-- to give the patients some sense of what is going to happen to them immediately pre-operatively and post-operatively-- that they will not all of a sudden wake up and find themselves with those tubes and all this.' She noted how so much of the information he collected was of no use for the patient's short stay on the unit and that

the ICU is only one part of the picture: 'I did not see how he was going to use the information he was collecting.'

A preceptor in the pediatric intensive care unit described the larger perspective she looked for in the new nurses:

> The biggest thing that's been on my mind for the last few weeks was whether I would be able to say at the end of the three month period that a nurse gave safe care independent of me, and part of my criteria for that was not say, "Can she give a blood gas, but does she know what the blood gas means, does she know what kind of change should be made, does she know how to manage the nursing care or does she just know how to do specific tasks? To my mind, moving the child from point A to Point B is what nursing is all about. You have to perform tasks along the way to make that happen, but performing the task isn't nursing....I wanted to see a light going on-- that OK, here's this baby, this is where this baby is at, and here's where I want this baby to be in six weeks, and what can I do today to make this baby go along the road-- to end up being better. It's that kind of thing that's just happening now. They're starting to see the whole thing as a picture and not as a list of tasks to do.

Proficiency: With repeated experience with multiple situations, plans, and their outcomes, the performer becomes able to sense-- without explicit deliberation-- the best plan for a particular situation; experience has taught both what to expect from a plan and how to respond. The nurse routinely experiences her situations through a perspective that simply presents itself to her rather than needing to be calculated. Attributes and aspects now are not consiously perceived, as the grasp is holistic. However, if decision-making is required, it is arrived at through explicit use of a learned principle, called a maxim. Maxims are general and ambiguous and require extensive experience before they can be applied (Polanyi 1958).

> An ICU nurse who had worked intensely in the ICU for 4 years described her transformation to the proficient stage: I used to have to sit down and list things. I would sit and write the patient's hemoglobin, blood studies, and I'dtry to look at the picture and get

> all the pieces together and come up with what's wrong. I listed it and talked to physicians and other nurses. And then I had two experiences the same week. One was with a little kid, and it was a baby who had some kind of GI surgery, he was maybe 6 or 7 months old. He had a catheter that was up his inferior vena... And there was something screwy about this kid. And I finally decided that what he had was peritonitis. Which flashed in my mind: I practically saw the word in neon lights: PERITONITIS. So I called the physician. And the kid's catheter had slipped out of the vein and it was putting all this medication and fluids into his belly. And he did have peritonitis.

Arriving at this total, immediate grasp was the culmination of a series of stages which this same nurse described in the following way:

> What happens is that initially you look at pieces of things. You look at an arterial line in some artery, and you may even see the fingers and you may not. You may only see this thing with the stop cock. After a while when you look at that to take the blood, you notice whether the fingers are pink or not. And then when they(new nurses) do that they go to the next piece. You know, they listen to the chest, but they don't look whether the ventilators moving or what the patient's face is like. They do things in little parts. And then those parts start to expand. After awhile they listen to the chest and then they listen to the heart and then they take a look at the monitor and get all the pieces together. And then they start to look at the subjective things about the patient, not just the objective things. And for me I had a sudden dramatic change when I went from the pieces to the whole.

Expertise: Up to this stage, the performer always used some type of analytic principle (rule, guideline, maxim) to connect her grasp of the general situation with specific action. The expert, however, can now intuitively grasp the appropriate response to a specific situation as she has such a large reserve of experienced concrete situations to draw upon. "Nothing less than vast experience with concrete, real-world situations can produce expertise," the Dreyfuses maintain (S. Dreyfus 1982:146; Dreyfus and Dreyfus, in press).

Experts are frequently inarticulate about the reasons why they did something or what they saw that make them take a particular move. Things

often look "right" or "wrong" or they just "felt" that that was what should be done; or they just did it without even being aware. Benner (1982) describes the following example of expertise excerpted from an interview with a psychiatric nurse who had worked in psychiatry for 15 years and was highly respected by her colleagues:

> "When I say to a doctor, 'The patient is psychotic,' I don't always know how to legitimize that statement. But I am never wrong because I know psychosis from the inside out. And I feel that, and I know it and I trust it." The nurse went on to describe a specific situation in which she knew that a patient was being misdiagnosed as psychotic when the patient was extremely angry. The physician was convinced that the patient was psychotic and said, "We'll do an MMPI to see who's right." This nurse responded, "I am sure that I am right regardless of what the MMPI says." The results backed up the nurse's assessment and based on her assessment, this nurse began a very successful intervention for the patient.

Contrary to our current academic understanding, then, the Dreyfuses argue that formal models and analytic reasoning, in which the task environment is broken down into its constituent elements and approached through a set of rules or principles, is most representative of the early stages of skill acquisition where a backlog of experience is lacking. Expertise, on the other hand, appears to be characterized by a reliance on past concrete experiences as paradigms (in the sense of concrete exemplars), by a holistic grasp of a situation rather than an analytic breakdown of constituent parts, and ultimately on an intuitive rather than analytic response to a situation. Intuition, in their terms, is only achieved after many years of experience and is based upon solutions that present themselves to the subject. The Dreyfuses, then posit the replacement of analytic reasoning by intuitive response, as the hallmark of expert skilled performance.

If this model is accurate, as there is prima facie reason to believe, what are the implications of a practice setting which relies extensively on formal models and in which theoretical knowledge appears to be the cultural ideal? Does this not obscure recognition of different types of higher levels of expertise, and in turn, fail to enhance their development? If we return to the job descriptions referred to earlier, we have a good example of some of the assumptions about knowledge that held sway in this project and how, in fact, these assumptions differ from those posited by the Dreyfuses. To do so I shall compare the nursing clinical ladder, considered in terms of an ethno-model of competence, with the Dreyfus Model. Despite the fact that the CN IV job description was changed after 1981, my study indicated that many of the assumptions about knowledge illustrated in that job description are held to a significant extent. I will consider the job descriptions in terms of both their functions and limitations in form, content, and practice. Finally, I will explore some of the social and cultural determinants of the epistemology I here describe.

A Case Study of a Formal Model: Job Descriptions for the Clinical Ladder

The Context of the Job Descriptions:

The job descriptions formed a central part of the new clinical program movement. Let me then briefly summarize the goals of the designers and participants in that movement:

1) to develop a career ladder in which clinical competence could be differentiated, recognized, and better utilized;

2) to move away from a description of nursing as a set of tasks to a set of explicit, behavioral objectives that could be quanitifiably stated and objectively evaluated;

3) to make nursing practice more scientific, systematic, and measurable;

4) to cultivate the "nursing process" approach to problem-solving in nursing practice, based on assessments, planning, implementation and evaluation;

5) to foster the ongoing growth of nurses;

6) to develop an exclusive knowledge base for nursing;

7) to institutionalize and reward autonomy and accountability in nursing practice;

8) to make nursing input on patient welfare more visible;

In Chapter Five I briefly presented an overview of the form and content of the job descriptions. Here, then I shall consider how they compared with the Dreyfus Model's definition of expertise and consider some of the functions and limitations of the job descriptions and the definitions of expertise which they contain in the context of the hospital and the units I studied.

Criteria for Progression up the Ladder: The four levels of nursing are structured in a hierarchy. In addition to a positive evaluation according to the job position, advancement to another position requires a combination of experience and educational degrees (A.D.= Associate Degree=two years community college; A.A. degree= three years of hospital-based training; and B.S.=four years of collegiate training).

Clinical Nurse I: A.D., A.A. and B.S. degree and six months experience

Clinical Nurse II: A.D. or A.A. and two years recent clinical experience

B.S. and one year recent clinical experience

M.S. and six months recent experience

Clinical Nurse III: A.D. or A.A. and three years experience, including one in a specialty area

B.S. and two years experience, including one in a specialty area

M.S. and one year experience, six months in a specialty area

Clinical Nurse IV: B.S. and six years experience in a specialty area

M.S. and two years experience in a specialty area

In these requirements, then, one finds a currency of experience and formal education in which the degree is sometimes valued more than the years of experience. In fact, at the highest level, the M.S. degree is worth four years of experience in this model. Furthermore, it is possible to have the clinical expert of the hospital in a given specialty area, the Clinical Nurse IV, have as little as two years clinical experience (this is, however, unlikely, as very few nurses go directly to the m.s. degree in that the educational programs prefer students with experience).

How do these job descriptions compare to some of the dimensions and stages proposed by the Dreyfuses?

Clinical Nurse II. The general description for this position states:

> The level II clinical nurse identifies and implements nursing interventions that have less predictable outcomes and evaluates the results of these interventions for a given patient population, in addition to performing the duties of the lower level I nurse.

Unlike the Clinical Nurse I, the II nurse is expected to be able to recognize and access uncommon and subtle problems such as "takes nursing histories that identify less common variables." Strong emphasis

is placed on a scientific approach and on analytic abilities:

> Identifies common relationships in data collected in nursing interview
>
> Validates data collected by others
>
> Analyzes initial assessments and revises assessments based on patient's behaviors
>
> Identifies a wide range of patient problems, determines their inter-relations, and establishes priorities for nursing care plans

Further, strong emphasis is placed on a nurse knowing why she does something and on being very deliberate:

> Writes a nursing care plan, using the assessment data that.. . shows evidence of understanding nursing intervention
>
> Applies effective interviewing skills to elicit information from patients and/or family that is necessary to plan, implement, and evaluate nursing care

The role of prior concrete experience is acknowledged rather than assumed in one statement: "Uses previous clinical experience and knowledge to anticipate potential patient care problems."

In general, this description describes a very planning, deliberate and systematic nurse, one able to recognize subtle and less common problems (similar to the Dreyfuses' 'aspects'). In many ways, the job description of this level is consonent with the competent stage of the Dreyfus model.

Clinical Nurse III. It is at the III and IV positions that one sees the largest divergence from the Dreyfus model in terms of what they expect from practical expertise. The general description of the III position is:

> Under direction, the level III Staff nurse works with increasing independence to set criteria for the quality of patient care, assesses the health needs of clients using specialized knowledge and skills and anti cipates the outcome of nursing interventions.

Some of the expectations of the III level are:

> Identifies physiological, psychological and environmental variables affecting the patient and identifies the interrelationship between these variables
>
> States patient problems by drawing inferences from the interrelationships between identified variables

One hears only a slight reference to a more holistic grasp of situations, as one would expect, but rather an increasing expectation to demonstrate the nurse's analytic abilities and theoretical knowledge. The image of the nurse that is projected here is a very deliberate, rational, conceptually-oriented nurse, perhaps more representative of the competent stage of the Dreyfuses, characterized by conscious, analytic planning based on elements or principles (variables) rather than holistic and situational.

Clinical Nurse IV: At the IV position, the highest level, one hears the bells of academia most clearly with its stress on the theoretical and the analytic. The nurse at this level is expected to have:

> in-depth knowledge of her specialty area and under general direction applies theories and concepts derived from the biological, natural, and behavioral sciences and related areas to her nursing specialty...

The behavioral objectives for this level are:

> Articulates a systematic view of man as an integrated being
>
> Utilizes a client-centered approach to assess specific needs of a specific patient population
>
> Uses knowledge of a variety of conceptual models in order to consider alternatives that explain and predict present or potential patient problems
>
> Selects and adapts models (conceptual) for meeting the needs of a specific patient population
>
> Develops a theoretical framework that guides decisions about patient and staff teaching programs

It is very important to consider here that the hallmark of the clinical specialist, as this job description was meant to describe, begins by defining the competencies of this specialist through the ability to "articulate" a theoretical and practical perspective, such as an integrated view of man. It must be remembered that these descriptions were meant to reward and recognize the nurse with clinical expertise. Yet this job description solicits and rewards the greatest analytic capability of all, as revealed in the strong emphasis on theories and models above. In other words, the clinical expert here sounds very much like a theoretical expert, an expert on science and knowing-that. On the other hand, one hears little mention of some of the characteristics of expert performance earlier described in which the expert has to exercise the least analytic reasoning in favor of intuitive responses. In fact, while the achievement of intuition based on vast experience may indeed be the mark of a practical expert, one senses that nothing could be farther from the ideal presented here.

CRITIQUE

Positive Functions

These job descriptions served many positive functions. They first articulated progressive levels of clinical competence; this provided a much needed move away from the wasteful "a nurse is a nurse approach" in which nurses were given the same duties regardless of their clinical competence or educational background. For the profession trying to institutionalize new behaviors and attitudes, they provided a blueprint for change. They gave legitimacy to old and new nursing behaviors, license for more autonomous practice, and institutionalized new

behaviors. Their specificity helped operationalize their ideology.

The job descriptions were particularly instrumental in the face of nursing turnover on the units. They were used extensively to groom new nurses; by breaking down the very complicated and overwhelming role of the nurse, they allowed for systematic and careful evaluation of each nurse along a number of desired dimensions. Given the large number of nurses who passed through these units in a short period, given that the patients on the unit were very sick and the care very complex, given that the nurses needed to learn to provide safe, independent care as soon as possible, these job descriptions provided a quick and careful way of scrutinizing and grooming the new nurse or the nurse moving for promotion. One evaluation, for example, revealed a new nurse as unsafe for practice by her own and others' assessment, something that had not been identified earlier. Thus, they functioned as a strong safety net.

Review of the job descriptions in preliminary evaluations served as good teaching devices; many practical examples were offered to interpret each line of the job description to the new nurse, examples that often carried broader messages and lessons than in the actual line interpreted. These reviews and Peer Reviews were occasions where the values and expectations of the unit were reiterated.

In many ways, these job descriptions became the substitute carriers of culture on the unit in addition to the personnel. Further, they were the carriers of authority. For communities striving for egalitarianism and shared leadership as these were, the job descriptions standardized, externalized, rationalized, and depersonalized expectations; they were the locus of authority rather than the presumed idiosyncratic judgement of a "head nurse."

The job descriptions were also used to demark the boundaries of the nursing role and as a basis for refusing tasks: "It's not in my job description," nurses often replied to a further request for their services. This is no small achievement, as nurses have long been forced--by virtue of their structural position and cultural expectations--to take on others' jobs in their absence. Their role, much like that of housewife and mother, was diffuse and boundless; what needed to be done, nurses did.

Finally, the evaluations based on the job descriptions did appear to foster growth as intended. By breaking down the nursing role and discussing the strengths and weaknesses of a nurse's practice and by devising exercises for growth for those weaknesses, nurses were sculpted into full shape very quickly. Peer support was clearly and repeatedly communicated and the reviews in which the nurse was basically evaluated by the job descriptions were ceremonies of professionalism from a supportive if sometimes critical family. This care and seriousness contributed to nurses' evaluations of the units as extremely supportive.

Limitations

But what are the limitations of these job descriptions, both in themselves and the assumptions they reflect, and how they were translated?

First, the clinical ladder was designed to recognize and reward nurses who excelled at clinical practice. But if in fact practical expertise derives very predominantly from practical experience, we must note that length of experience (as inferred from longevity) is not a strong requirement for progression up the ladder. Rather, much reward is given to academic achievement and by inference to theoretical knowledge.

To some extent, expertise is separated from experience, and perhaps theoretical expertise is not differentiated from practical knowledge.

This model, then, allowed for the phenomenon of inexperienced leaders (facilitated by nursing turnover which left leadership positions vacant). This was true both at the highest level, the Clinical Nurse IV, and at the Clinical Nurse II level, the clinical leaders on the units.

The Clinical Nurse IV, hired initially to implement the clinical ladder, was broadly referred to as the "clinical expert" in the specialty. While this nurse was the most versed in the theory and research of her specialty, other nurses sometimes surpassed her in practical skill in areas outside her particular specialty area. This occasionally led to uncomfortable situations in which the CN IV nurse turned to other nurses for help. Closer examination revealed that while she held a master's degree, she had worked but one and one half years in her specialty. By her own account, she relied primarily on recipes and the literature. This nurse was however a leader in research and had published several articles in her field; she was the most versed on the "literature" and strongly believed in and used care plans. This clinical specialist was in fact a resource to the nurses in many ways; she symbolized the independent clinical practitioner, the professional nurse par excellence, she did have a more collegial relationship with some attending physicians, and she was often very effective as a representative of nursing on a hospital and even national level. She was, however, sometimes criticized by staff nurses and residents for being uninformed, unskilled, and unrealistic to the exigencies of regular floor nursing. In other words, while she may have been an expert on theory and science and professionalism she appeared to be less so consistently in the practical domain.

A second example of the minimal appreciation of experience and the separation of experience from expertise related to the Clinical II nurses (there was no CN III position on these units, so the CN IIs were the clinical leaders). The nursing turnover that followed the implementation of the clinical ladder created a vacuum of leaders and staff into which two new nurses, both remarkably able, were promoted as candidates for the CN II position after only 9 months on their first job out of nursing school.

While they had worked only a year when I arrived on the units, they were referred to as "clinical experts." This perception was increased six months later when the last of the more veteran staff left, placing them even more into the role of the "clinical experts."

Perhaps not surprising, these nurses tended to emphasize the formalized standards and requirements, such as charting, documenting properly, writing care plans, and following the nursing process rather than the informal or the contingent. They were very confrontive of physicians when they felt that the proper medication or treatments were not being ordered; in fact, tension crackled between nursing and surgical resident staff at times. Over a year later, one nurse discussed how her inexperience contributed to this tension and how she had changed. To paraphrase:

> How has my practice changed with experience? I am much more flexible now. I know now that there are several ways to skin a cat. While some may be preferable, I now know what differences make a difference and are worth arguing over and which don't. Before I would get angry at the physicians whenever they did not prescribe what I considered to be the right medication. Now I know that there are several different ones that can serve the same purpose, and while not the best, perhaps, are certainly OK.

This belief in the proper, appropriate, "right" way had also been evident in her work with the nursing staff, a frequent source of frustration for herself and the other nurses.

A second clinical II leader looked back on that period and noted: "Then I had finally learned all the recipes. Now I'm asking whether in fact we need a cake!"

Thus, in observing the development of these same nurses over time, it is unlikely that regardless of their intelligence or precociousness, that regardless of the title of "clinical expert," regardless of the M.S. degree or the clinical role of CN IV of CN III, it is unlikely that they have achieved the kind of expert practice earlier described after less than two years of clinical work in nursing. Instead one senses that what the Dreyfuses call competent practice is being defined here as expertise. (It must be noted that the use of the term "expert" is often used lightly and not in a technical sense as I am doing here).

This is also suggested in the strong emphasis on identifying variables and their interrelationship, on articulating the theories and models of action that are perhaps more characteristic of competence than expertise or more revealing of theoretical knowledge than practical knowledge. While some allusion is made to a shift from solving simple to complex problems, from the problems of the individual to those of a group, from solving problems to articipating them, one hears little allusion to the kind of shift to a more intuitive approach that can likely occur.

In fact, in comparing these two models of competence one sees a striking opposite: while practical expertise may be characterized by intuition and the quieting of the analytic mind (Dreyfus and Dreyfus

1980), this nursing model posits almost exactly the opposite-- the greatest analytic ability of all. In fact, much as it's absent in the job descriptions, there was little to no discussion on the units that would imply a recognition of the capacity for an "intuitive" grasp of a situation (before I introduced the topic); as one veteran nurse said, "That's a language that is not acceptable to use." In the following section we will explore why.

Not only is experience not seriously required as criterion for progression up the ladder, it is not taken into account within the job description. Regardless of experience, a nurse is evaluated by the same description of a given level. This led to situations in which nruses were told they "realized 100% or 98% of the job description." Where the ongoing growth is so valued, what does this say about where and how the nurse is to develop? In this way, the job description, initially a charter for growth, can become constrictive by defininining nursing as a finite set of behaviors with a concrete quantifiable edge rather than as an open terrain in which to grow. It may contribute to a minimalist notion of nursing, a sense that nursing can basically be mastered in a year or so and then its time to move on for a new challenge-- perhaps by moving laterally to a new specialty (such as public health) or vertically to a more critical care unit, considered more prestigious and challenging. Lacking an appreciation of growth through reaching higher levels of performance within an area may contribute to nursing turnover (this of course is not the only reason).

Furthermore, while the reductionism of the model is helpful for the newcomer or the person in transition, as it takes a complex field and reduces and orders it, it is also potentially destructive for developing higher levels of expertise and enhancing tenure. Reducing nursing

practice to a checklist, no matter how comprehensive, can lead to a minimalist view of nursing. This can lead to a sense of meaninglessness, something that nursing can ill afford.

On the other hand, the checklist can overwhelm rather than simplify. Confronting a four-page list of behaviors one must master not infrequently created anxiety among nurses as I observed:

> A candidate for the CN II position wondered out loud to a veteran CN II whether in fact she could do the new role. The veteran responded: "It sounds like you are trying to find out what is realistic for you in the job description. You need to do it in parts or it will ruin your sex life. It's ruined mine!"

Another point is noteworthy in this nursing model. As mentioned earlier, practical know-how at the higher levels is often ineffable. In fact, the higher the level, often the more inarticulate the performer as to what exactly was going on when she did something. Yet these nurses are repeatedly requested to make their assessments explicit, to identify the variables that went into their decisions. It is highly unlikly that the discourse on the practice that is requested can represent the experience of practice, and while these practitioners try and reconstruct what variables they assessed and why they did something, it is probably less than what was going on and not how it occurred. Furthermore, the repeated emphasis on the analytical and the nurse's perception of variables in the patient's condition may contribute to viewing the patient as an object with "problems" -- both "physiological" and "psycho-social." Nurses frequently described a transformation they underwent in which they started seeing the patient as a whole and not as a bundle of variables, where they no longer had to factor each part out. Thus the global grasp of the total situation as a whole, often achieved through experience, may in fact minimize objectification and lead to an

integrated experience and perception of the patient in a way not realized by "articulating an integrated view of man." Thus a holistic approach can be realized through action rather than just discourse. And if what these philosophers of science say is true, the holistic grasp is realized more through the involved, engaged, committed stance than the detached one. This means, as Carper writes:

> The experience of helping must be perceived and designed as an integral component of its desired result rather than conceived separately as an independent action imposed on an independent subject (1978: 17).

The equation of good nursing care with care plans is also remarkable, both in the descriptions and in practice. When the extensive care plan system was implemented, many of the veteran nurses found them extremely difficult to write: the language was foreign; some found their writing skills were not sufficient; everything needed to be spelled out. From all accounts, however, the clinical practice of many of these same nurses was very good, indicating that the skills needed to write the care plans differed from those used in providing patient care. It appears, however, that in both the model and practice, the distinction between doing and writing was not made.

We must note several other important contradictions or difficulties with this model. While clinical nursing practice invariably involves work with nursing technology, this important area was totally excluded in these job descriptions. This exclusion was repeated in formal evaluations. While informally nurses were known for their skill-- or lack of it-- with technology, this received but rare mention in evaluations. Given the hospital's extensive reliance on technology, and

the fact that many nurses have accrued a wealth of know-how and tricks of the trade, this deletion is very noteworthy. As Benner and Benner (1979) suggest, this deletion in part reflects an view of technical skills as abilities that can be quickly and easily learned by anyone and which are on a significantly lower level than leadership qualities.

A further contradiction lies in these job descriptions. One of the goals of the designers was to enhance autonomous nursing practice and in fact, these job descriptions paved the way for new behaviors that solicited more autonomy than before. However, once these behaviors are mastered, the spelling out of autonomy becomes contradictory. Rather, to spell out the behaviors expected of a clinical expert in a 4 page list seems to underscore a lack of autonomy, more than autonomy. Much flexibility and autonomy derives from the unstated and unspecified, the freedom to decide on goals and realize them through a variety of means. Further, the repeated review of the checklist encouraged standardization among nurses rather than individuality and autonomy.

A final but very important problem lies in these job descriptions as a way of describing nursing, particularly at the higher levels. Only certain abilities can be translated into behavioral objectives which can be quantitatively evaluated. Caring, kindness, sensitivity, and commitment, for examples, are not among them. What could not be make explicit and measurable was apparently deleted.

In fact, in formal and often informal evaluation, these traits were seldom raised or praised. If they were, they were often lumped into a package statement such as "good at psycho-social skills" which in saying everything actually seemed to mean very little. This was

impressed upon me as described in the following example:

> Having followed two expert nurses for over two months I wrote up my observations noting, in particular, how the two excellent nurses practiced nursing so differently (Gordon 1980). One was a very active presence, a force to be dealt with; the other worked rather like an invisible helpful force who understated her presence rather than emphasized it. In discussing what was special about these nurses with a nurse leader who knew them both well, the nurse noted how they were both excellent at "psycho-social skills." Lumping the practice of both of these nurses into such a characterization seemed to further mask important differences and dimensions of nursing practice and to devalue much of what these and other nurses did.

It was noteworthy that while nurses were evaluated for their calmness or anxiety or for "being good with patients", a nurse's warmth or sensitivity to patients was rarely raised. In fact, I found a few of the clinical leaders somewhat cold and matter-of-fact with patients and not forthcoming when a patient clearly needed some emotional warmth. Similarly I observed many nurses with patients who were extremely sensitive and supportive. However, in both the model and in practice, these qualities were rarely the target of formal evaluation nor were they significant in evaluating whether a nurse should be promoted to a higher level. While I sensed that the cognitive and instrumental problem-solving capabilities of nurses were essential for promotion, the relational dimension was not remarkably relevant unless it was plainly negative.

Finally, we must consider the source of the competencies outlined in these job descriptions. They were derived in part from performance expectations of graduates from nursing school. Other parts seem to have been taken from the new role of clinical specialist that developed in the 1960s (Lewis 1970). The image of a professional nurse/scientist/independent practitioner is very strong and it appears

that a great deal of the content was derived from theory and assumptions about what good nursing practice was. Very significantly, the competencies were not directly derived from studies of actual nursing practice, from examples of what actually worked and what was helpful for patients' experience and outcome (Benner 1984) in particular situations. In contrast, some of the elements in the job descriptions formal model appear to have been derived from theory and beliefs about good nursing practice and less from actual practice itself.

One potential source of definitions of the nursing role is patient's needs of nurses. While the consumer's demand for a greater role in health care seems to have been clearly accounted for, the competencies outlined may in fact differ remarkably from what patients actually see as important. Esther Lucile Brown who studied patients' needs for many years found the following: "When I ask nurses what they think patients most want from nurses, they tend to think a guarantee of competence." Dr. Brown goes on:

> In fact, unless a nurse appears awkward and unskilled, I believe the question of competence is certainly not what the patient wants most. In fact, they take it for granted that they are guaranteed competency by the very fact that nurses have supposedly completed the study required by an accredited school of nursing...
>
> I believe that what almost all bed patients seem to desire from nurses is immediate personal attention to relieve their pains, worries, and anxieties. They see themselves as in trouble, perhaps even in very serious trouble. They want help. They want someone who will understand their problems and sympathize with them; someone who will let them talk, listen to what they say, even hold their hand and reassure them whenever possible. Perhaps more basically, they want someone who gives prompt but unhurried attention to their physical needs thus reducing bodily discomfort and unnecessary frustration...
>
> In addition to such personal attention, many patients feel the need for nurses who will represent their interests and serve as advocates in the face of the

> increased complexity of hospital organization and of staffing patterns. They want help, for instance, when they are unable to communicate adequately with physicians, when they do not understand the meaning or reason for some rule, or when they are exhausted and want relief from the seemingly endless procession of personnel going in and out of their room to perform some small function (Brown 1983:1).

To summarize, there is strong evidence in these job descriptions that theoretical knowledge is valued more than practical knowledge and practical outcomes: 1) nurses are rewarded for academic degrees much more than for years of work experience; in fact, years of experience within a particular level are ignored; 2) the higher one moves up the ladder, the greater the emphasis on theoretical and on analytic abilities, 3) technological skills are completely ignored; 4) the writing skills are repeatedly emphasized; 5) the demand that nurses--regardless of level--make explicit the priniciples behind their assessments and 6) the image of the nurse as a detached scientist collecting and analyzing data and applying skills.

The Social and Cultural Context of Nursing Assumptions and Practices about Knowledge

How can we explain this preference for theoretical knowledge and science here described? One way of looking at this formal model, both its form and content, is to consider it a statement of nursing ideals that could not be taken for granted by and for nurses, but that had to be striven for and thus spelled out. This foreground of what could not be assumed, however, can only be understood by considering the background assumptions on which it lay and from which it grew.

This background consists of a real and perceived nursing history characterized by nursing as a female occupation subordinate to medicine as a male, dominant profession. More specifically, the background--

based on the traditional social structure and epistemological division of labor between nursing and medicine-- can be described as a constellation of some of the following traits.

Table 4. Traits Associated with Medicine and Nursing

Medicine	Nursing
male	female
father (surrogate)	mother (surrogate)
husband	wife
learned	natural
professional	kin, employee
scientific	natural, folk, traditional
instrumental	expressive
intellectual (head)	technical (hands on), emotional
objective	subjective
conscious, rational	intuitive
superordinate	subordinate

The vision of nursing described earlier as embodied in the job descriptions is an attempt to move nursing further away from traits traditionally associated with nurses and females to traits traditionally associated with physicians and males.

Professionalism was the guiding ideology of the movement represented here and science, theory and intellectual activity are together the traditional criteria of a profession (Lysaught 1970). It is on their multiple meanings (and in contrast those of practical knowledge) that I will focus. Five seem to be of particular relevance:

1) science as emancipation
2) science as power vis a vis medicine
3) science as legitimation
4) science as maturity
5) science as boundary marker with "technical nurses"

1. Science as emancipation: Since the Enlightenment, science has been perceived as a means of emancipation from traditional authority (Shils 1981), as science symbolizes the autonomy and authority of the individual's perceptions of a positive reality. As the window to truth, science was seen to provide man a release from reliance on the truth defined by tradition.

One can well understand nursing's long efforts to make nursing more scientific as in part a search for liberation. As medicine is supposedly based on the truths of science, nursing's knowledge of these same truths diminishes its dependence on medicine and in turn on medical authority (Starr 1982). On the other hand, when a nurse knows only how and not why, as was long the case in nursing, she is much more dependent on following medical orders and less able to judge independently the correctness of medical practice or her own practice. Further, by knowing the principles behind action, nurses have greater latitude for safe action.

2. Science and Theory as Power: The structure of patient care is such that nurses are both more permanent on the units than the rotating residents and more present during the day and night with patients. This position avails them of types of knowledge that the residents do not have (the reverse is of course true; the residents in surgery for example learn much about an operation that nurses are not privy to). Nurses learn, for example, the particular "treatment approaches" of particular attendings which the residents often need to learn. Nurses also can have a greater sense of the idiosyncratic norm of individual

patients as they come to know them better. Further, experienced nurses have often acquired knowledge that new interns have yet to learn.

As I observed, these differences in knowledge often led to disagreements in the diagnosis and treatment of patients. Yet the structure of decision-making is such in most hospitals that despite the fact that nursing does have its own domain of discretionary action, the majority of decision-making around patient care still resides in the hands of physicians, Thus, while nurses often make important assessments, action is dependent upon their getting a response from the physician, usually the intern. The intern is the lowest on the medical hierarchy, the least experienced, probably the most versed in book knowledge, undoubtedly the most fatigued. Getting a response from the intern is often not easy. Early into a disagreement, the physicians often recite medical facts and theory to justify their position. Whether right or wrong, this can put nurses at a disadvantage, as they often find it difficult to convince the intern on the basis of medical theory, the primary currency for influence. At such times, the differential in theoretical knowledge is very evident and weighty. As one nurse put it, "Our problem is that we know a little and have trouble backing it up."

The following example, recounted to me by an administrative nurse underscores this point. An intern repeatedly ordered a particular wound dressing for a patient which the nurses knew was not that usually ordered for that problem by the patient's attending, who was himself a specialist on the topic. Their efforts to get the intern to change the order were ineffective. It was changed, however, when the attending saw the order and explained what he wanted to the intern and why. As the administrative nurse noted later, it was only when it was explained to

him why that he accepted the other approach. Of course, the authority of the attending contributed to the changed order, but this authority was exerted with a rationale which the nurses could not provide.

3. Science and Theory as a Source of Legitimacy: As Foucault describes, one measure of power is the determination of truth (Foucault 1980). By any measure, medical truths are those nursing adopted, in the sense that they adopted the same basis of judging whether something is true or not. By so doing, they hoped to become more legitimate and eventually more equally respected and rewarded. They also hoped to further decrease nursing's dependence upon medicine (Starr 1982).

4. Science as Maturity: As Bellah describes it (1983), the Enlightenment and the dawn of science is perceived in this society as that period in which man threw off the shackles of tradition and superstition and came of age. Science is seen as a sign of maturity and the full taking of responsibility. It contrasts with dependence on traditional authority and an associated immaturity. It is very likely that this too was a meaning associated with science for this particular movement. Becoming scientific symbolized becoming mature, taking control and becoming more responsible.

5. Science as a Boundary Marker with "Technical Nurses": Nursing is amply endowned with a diverse number of degrees and licenses. Efforts to differentiate between them has been a prominent theme in recent nursing history (see Lysaught 1970;). Science, writing, and theoretical knowledge have together been one common criterion used to distinguish professional nurses, "RNs" from "technical nurses," Licensed Vocational Nurses (LVNs) and Aides. This is best reflected in the fact that it is only the RNs who write care plans.

The Meaning of Practical Knowledge

One of the triggering moves to locate nursing education in institutions of higher learning was to increase the amount of science and theory nurses were taught. While science and theoretical knowledge symbolized emancipation and legitimacy in the present and the future, it appears that practical knowledge symbolized the past, one of subordination and traditionalism. In fact, practical knowledge predominated in nursing for many years, as nurses learned nursing through an apprenticeship system of mostly practice with but scant doses of theory (Ashley 1977). Practical knowledge was associated with nurse's being the physician's handmaidens, guided by obediance and habit and tradition or even "women's intuition" (McCain 1965), in which nurses fulfilled predominantly the technical and expressive functions while medicine was intellectual and instrumental.

In adopting the values of the university, the proponents of this and other movements in nursing have undoubtedly adopted as well the acadamy's devaluation and one could say discomfort with technology (Ashby 1974; Benner and Benner 1979) as well as a view of intelligence as conscious, explicit reason.

Perhaps these meanings of theoretical and practical knowledge explain the predominance of theoretical knowledge as exemplary of clinical expertise and as epitomized in the first statement for the CN IV position: "Articulates a systematic view of man as an integrated being."

Formal Models as Models of and for Reality

We have seen throughout this work, both among the nurses designing new ways of practicing nursing and in the actual practice and teaching

of nursing, a strong reliance on what I am calling formal models. It is clear from this discussion that formal models serve two major functions, described by Geertz as models of reality and models for reality. More specifically, formal models functioned as maps of reality for the uninitiated, descriptive models, and they functioned as a basis for consensus about what reality should be, a prescriptive model (see Gordon 1984a for fuller discussion of these functions). Significantly, they functioned in these capacities both for the profession, in charting new definitions and practices of nursing, and for the inexperienced individual nurse. Let's consider these two functions more closely.

Formal models function as maps for the uninitiated. They provide a model of reality for the outsider; they divide up the terrain in parts, and provide rules for proceeding from one place to the desired destination. In this way, they provide entry and order to potentially chaotic experiences. They can serve as a substitute for personal knowledge and experience (for example, the use of care plans) and can function as the carriers of culture much as personnel traditionally do.

But like maps formal models can be largely superceeded by first hand experience, so much so that finding one's way on the map for the native proves confusing and foreign. They can be replaced by in-depth knowledge of a situation or a terrain, knowledge that allows for fine-tuned adjustments to the actual situation at hand. In this capacity, formal models are a tool that can be outgrown with greater knowledge of the actual terrain. But nursing needs formal models in this way. The abundant procedures, technology, surgeries require quick and ready access to many nurses that will assure safe performance. Formal models provide an efficient means to safe care in these instances.

Formal models also function as the basis of consensus and standardization. In this way, they not only reflect, they direct. They can be used to present an ideal or standards to be actualized in the face of diversity or lack of shared understandings.

The most common source of consensus in social groups is through shared life experiences-- time spent together. Typically social groups that share life together also share a large stock of intersubjective meanings (Taylor 1971) that all participants understand on an implicit level.

But what of groups that do not share a history, groups that not only come from diverse backgorunds but have and expect to work together only briefly, as in the setting presented here? Or what of groups who face cultural change, such that the background they shared is no longer relevant? In situations like this, as we have seen formal models can provide the basis for consensus, a blueprint or standard for behavior that all are expected to see and follow. In this way, the job descriptions provided the definition of a new ideals in nursing practice.

It could be argued that greater understanding is made possible by making meanings, expectations, and values explicit, that doing so allows for greater clarity, that even in the presence of shared understandings it is still preferable to spell things out explicitly. But, while explicit statements are important substitutes for tacit, background understanding, they are not the same thing. Formal explicit statements fix meaning and do not allow for nuances of interpretation the way tacit understanding does. Stating meanings explicitly also takes time. The kind of communication that can take place among familiars, the one look or the one word that 'speaks a thousand words,' is far from possible

when one lacks a background of familiarity. Even if one has it and one tries to spell out those 'thousand words,' one runs into problems; only certain things can be put into words. It is also worth noting that it took a good part of three years to write the job descriptions; it also took a few years to write the Standards of Care.

There is also a tendency to reify formal models. This in fact I think took place on the units I studied and in the Clinical Program in general where evaluation of care was based on the representation of that care in writing as much as or more than the actual care itself.

Social and Cultural Implications of the Dreyfus Model

What are some of the implications of the Dreyfus model and its theoretical framework when considered on the social and cultural level? This study points to several.

1. The model points to the importance of considering the experience quotient of social groups, that is the ratio of experienced to inexperienced persons in a group. This quotient has two dimensions: the experience of a particular community with its own culture and practices; and the experience of particular individuals with the culture and practices. Some societies, for example, have had long experience creating understandings and understood practices. Others, such as pioneering communities, like utopian communities or immigrant communities, are at the other extreme in that the culture of the group is new to that group.

Individuals in a particular community or group have varying ranges of experience with the culture at hand. A group of elders making decisions about issues they had addressed year after year provides an

example of a group in which most are very experienced. Contrast this, on the other hand, with a group of numerically dominant novices undergoing initiation into a new social role. Most groups have members with a range of experience.

Hall (1976) distinguishes between "high context" and "low context" cultures. High context are those in which much background knowledge is relied on in communication; in low context cultures, little background knowledge is assumed. The United States, in his terms, is a low-context culture.

If one were to consider societies as novice, competent, or expert in terms of their experience with particular skills and meanings, one might find much overlap with these distinctions of Hall. While there is clearly a cultural dimension involved (that is a value of traits characteristic of different stages), one may also suspect that high context cultures are able to be so because they have a long history and background on which to rely, a background lacking in the low context cultures. Thus one can expect some correlation between experience and high vs. low context culture, as described by Hall.

2. A second important implication of this model is the recognition that there are qualitative differences among the performances and experiences of people not only at the beginning stages of competence, but at the competent, proficient, and expert stages as well. This differentiation, however, is seldom made in social scientific works which tend to recognize but two major stages: people learning a new role or culture (acculturation) and people who already know it. Differentiation among those who have already learned a role would illuminate understanding of social groups and perhaps shine light on

another dimension of differential perception and approach among members of a community.

3. Social groups recognize and reward different levels of expertise on a normative basis. Nursing sought to overthrow a tradition that rewarded practical clinical skill with an administrative position. Not only did this curtail the further development of clinical expertise, there was no role designated to utilize this special expertise. It may be, as Benner suggests (1984) that nursing in hospitals is based on the competent stage only or primarily. Among physicians, on the other hand, a high level of clinical expertise has a long tradition and the very long socialization process in part reflects a larger normative notion of expertise. What stages of expertise are recognized formally and informally and how-- an emic version of expertise-- are questions raised by applying this model.

Groups not only differ in their notions of expertise, they of course differ in their domains of expertise. One may find, as this work suggests, that in new areas where again, a backlog of experience is lacking, one finds greater formalism in its stead. For example, while I observed no formalization of the provision of 'comfort measures' to patients, a traditional area of nursing practice, I found a great deal in areas such as teaching patients about discharge from the hospital, a relatively new and expanded area of practice. In medicine, a good comparative case for nursing, one finds formalization and use of protocols in new areas of treatment, such as cancer therapies, not only for research purposes but for greater certainty in practice in an unknown field. Or one hears reliance on formal models, such as Kubler Ross's (1969) model of the stages of dying, applied to complex patient

care situations in simplistic ways both among nurses (see example in Gordon 1984) and among physicians (Muller 1983). While dealing frontally with dying patients is a frequent phenomenon in both medicine and nursing, it is an area that has not long received serious attention and cultivation of skill and long-accrued practical knowledge and one thus might expect a greater reliance on unsophisticated and bold models rather than on the fine nuances and subtlety that reflects years of cultivated expertise.

As noted, particular traits and actions are associated with different levels of skill acquisition. For example, the competent stage is notably deliberate, rational, explicit, and analytic, significantly more so than the expert stage of the Dreyfus Model. Groups may embrace some of these traits as the ideal. Academia, for example, tends to place theoretical knowledge over practical knowledge at the apex and has a traditional disdain for technology (Ashby 1974; Benner and Benner 1979). When these values are imported into a practice setting, as I observed, one wonders if this does not obscure and eclipse the recognition of higher levels of skill that function intuitively rather than analytically. The job descriptions indicate that this very well may have happened.

4. An important distinction among groups is the extent to which behaviors are prescribed or based on the judgement and interpretation of the actor. Formalism prescribes what to do, with more or less room left for interpretation of the particular situation. It may be that when a group moves from much prescribed behavior, as one can consider the more traditional nursing role, to increased room for judgement and intepretation, as with the newer approach in the Clinical Program, one accompanying feature will be formalism, which spells out more clearly

how to behave in an autonomous way and which requires more accountability.

5. This model also suggests that people at different stages of skill use rules in different ways and that in fact at some stages, rules are not even present or in use. In other words, rule-governed behavior is not a constant in practice but rather a stage that is superseded by greater skill. As we saw at the proficient and expert stages, consciousness and deliberation around action can be surpassed by intuition based on past experience.

This model then poses a view of culture and people's relation to culture as one not restricted to concepts, beliefs, codes and rules that people are supposed to have stored in their heads, albeit perhaps not consciously. Rather, the view proposed here and subscribed to by anthropologists such as Hall (1971) is that people behave in definitely cultural ways without any intellectual or cognitive mediation. A common example is how we learn to stand at particular distances when interacting with people in particular situations. Rarely do we learn this through learning rules; and once we have learned positioning, we do not necessarily translate that knowledge into a rule (unless we are forced to do so by encountering situations of cultural conflict or a persistent anthropologist). Rules may never have been formulated. The patterning of behavior, then, is not necessarily cognitive. This approach contrasts with an information-processing model of culture and skill that has had its place in anthropology both in the past and present.

The Dreyfus perspective posits that in everyday practice we, as natives, already perceive our world as understandable and meaningful and

that we do this in an automatic, natural way. The perception of something and the interpretation of it are one process; in fact, we understand rather than interpret. The information-processing model, on the other hand, posits two separate processes; receiving meaningless stimuli and then making an interpretation of their meaning.

> The blast of the factory whistle at five o'clock serves as a signal that the workday has ended. It has various meanings to those who hear it, but before they can make use of them, they must perceive the whistle blast (Spradley 1972:9).

Rules of and for action are attached to perceptions in this view. To quote Spradley again,

> A rule is an instruction to behave in a particular way. Every symbol, because it is arbitrary, implicitly involves rules for attaching it to a particular referent. When my telephone rings, I could let it mean that someone is at my office door waiting to be admitted. Instead, I interpret it as an instruction not to attach this stimulus to the concept, "Someone wishes to speak to me on the telephone." I then may or may not follow the related rule which instructed me to pick up the receiver and say hello (Spradley 1972:15).

Many of us have been in a room or an office when the telephone rang. From these experiences it appears highly unlikely that Spradley's description, so conscious, so free from automatic, "natural," response, so full of choice and decision, adequately portrays what actually takes place in normal, everyday practice. It is unlikely that we associate a ring of the telephone with an "instruction," or worse, choose not to attach a particular instruction to a ring of the telephone. Does one pick up the phone or not because of some rule? It appears that like the example of the factory whistle whose meaning he claims we can decide on, these descriptions describe not the ordinary course of events or of how things happen, but either breakdowns, in the sense that something unexpected raises confusion, or of someone who is still learning the

correct ways to interpret things (novice, advanced beginners, competent) or of a scientific experiment.

The Dreyfus model posits that behavior can be "orderly without recourse to rules" (Dreyfus 1979). A similar idea is presented by Sudnow in his book on learning to play jazz, called The Ways of the Hand (1978). Here Sudnow describes the "organization of improvisation" which well captures the nature of expertise presented here. Instead of rules, behavior is guided by both the actors' purposes and the situations encountered. Culture and knowledge are much larger than rules or formal models.

6. The Dreyfus model and this study of nursing's view of expertise suggests further study of how knowledge is perceived and defined among social groups. Some of the following dimensions of a groups' discourse and practices regarding knowledge warrant further study. Here I will apply them to the nursing context.

1. Levels of Knowledge: What levels of knowledge are recognized and how do these compare with other analytic models of competence, such as the Dreyfus Model of Skill Acquisition?

2. Taxonomy of Knowledge; What types of knowledge do nurses designate and what do they mean? When nursing knowledge is distinguished from medical knowledge what does that mean?

3. Legitimation of Knowledge: In hierarchical order, what legitimates nursing knowledge and for whom? For example, if a nurse senses that a patient is "going sour," is she invalidated if the vital signs of the patient do not support her claim?

4. Consciousness and Knowledge: How conscious or explicit is the knowledge to be and how is knowledge deriving from different levels of consciousness hierarchically valued? For example, is intuition or the unspecifiable knowledge of a skilled technician valued when it remains on the non-verbal level?

5. Sources of Knowledge: Which of the following sources of knowledge are recognized, encouraged, rewarded, in what order and for nurses at what position: tradition, technology, experience, theory, intuition, sensory experience, authority?

6. Transmission of Knowledge: What is the structure and technology for the transmission of knowledge? How visible are different types of nursing knowledge and to whom?

7. Increasing Knowledge: How is knowledge understood to increase? What strategies are used to increase it, e.g., reading articles, doing a project, teaching a class. How does one grow and what constitutes growth?

8. Communication of Knowledge: What is the predominant mode for communication of knowledge about patients among nurses, e.g., written, oral, and what knowledge is communicated?

9. Knowledge and Prestige: What kinds of knowledge are more rewarded and most prestigious? To nurses? To physicians? To patients?

The Use and Misuse of Formal Models

Nursing is not alone in its high esteem for theoretical knowledge over practical knowledge and its strong reliance on formal models and the scientific paradigm. Formal models have their uses and their limitations. It is all important to recognize the difference between use and abuse. In staking out new terrain, in acquiring and charting a new course, whether it be for a profession, or for a new nurse, or for an anthropologist trying to understand a new culture, they can provide a map and a charter, a substitute for shared understanding through shared paradigms. As Bordieu writes:

> It is significant that 'culture' is sometimes described as a map; it is the analogy which occurs to an outsider who has to find his way around in a foreign langdscape and who compensates for his lack of practical mastery, the prerogative of the native, by the use of a model of all possible routes. The gulf between this potential, abstract space, devoid of landmarks or any priviledged center,... and the practical space of journeys actually made... or being made, can be seen from the difficulty we have in recognizing familiar routes on a map or town plan (Bourdieu 1979:2).

Whereas situational understanding is the understanding that accrues with concrete experience and a background of tacit and personal knowledge to guide behavior, it is this very background that is lacking for the

newcomer. The absence of this background partially explains the strong reliance on formal models and rational practices in this setting. And while these formal models and analytic practices are essential in moving the novice from beginner to competent stages, they are less appropriate for developing and rewarding and recognizing higher levels of clinical expertise. When formalism and rationality become the ideal, the implicit, unformalizable, intuitive and holistic traits of expertise can become obscured -- or even unrecognizable.

Anthropologists, ourselves outsiders and novices to a culture, must realize the limits of the formal models we often strive to construct and what kind of participation they best depict. We should be aware of the intellectualist tendency to translate the practical knowledge of informants into generative rules and principles. We must recognize that as outsiders, as novices to a culture, the questions asked and the answers they elicit reflect more inexperienced understanding than true expert or native, characterized by what Bourdieu calls, "learned ignorance." We should take him seriously when he states in his Outline of a Theory of Practice:

> So long as he remains unaware of the limits inherent in his point of view on the object, the anthropologist is condemned to adopt unwittingly for his own use, the representation of action which is forced upon groups when they lack practical mastery of a competence and have to provide themselves with an explicit and semi-formalized substitute for it in the form of a repertoire of rules, or a role, i.e., a predetermined set of discourses or actions (1979:2).

The rational, the formal, the theoretical are essential tools in understanding and coping with our world. They best be approached, however, with full knowledge of their strengths and limitations and in balance with an appreciation of practical knowledge.

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Guideline for Recording Critical Incidents

You have been asked by the AMICAE Project staff to describe critical incidents from your clinical practice in acute hospital settings. These incidents will serve as a basis for developing competency based exams for follow-through evaluation of new graduates for the local schools of nursing. They will also be used as the baseline material for a publication on the nature of applied nursing practice, with particular focus on the significance of experience in clinical practice in differentiation of the novice and experienced clinician.

The attached forms can be used to record your critical incident. First, however, some clarification of what is meant by critical incident is in order. It includes any of the following types of incidents.

What Constitutes a Critical Incident?

-An incident in which you feel your intervention really made a difference in patient outcome, either directly or indirectly (by helping other staff members)

-An incident that went unusually well

-An incident in which there was a breakdown (i.e. things did not go as planned)

-An incident that is very ordinary and typical

-An incident that you think captures the quintessence of what nursing is all about

-An incident that was particularly demanding

-An incident you have recently experienced that stands out in your mind for some reason or other

The Critical Incident: Example A

A. Personal Data:

NAME: (optional) DATE:

TITLE:

INSTITUTION:

AMOUNT OF TIME ON CURRENT UNIT:

AMOUNT OF TIME IN NURSING PRACTICE:

UNIT WHERE INCIDENT TOOK PLACE:

B. What to Include in Your Description of the Critical Incident?

- The context of the incident, e.g. shift, time of day, staff resources
- A detailed description of what happened
- Why the incident is "critical" to you
- What your concerns were at the time
- What you were thinking about as it was taking place
- What you were feeling during and after the incident
- What, if anything, you found most demanding about the situation
- What you found most satisfying about the situation

C. In the space below, please describe in detail the incident, addressing the questions outlined above.

Example B

Please use the space below to describe a critical incident from your nursing practice in which you recently participated.

1. In what way was this incident critical?

2. What were your concerns at the time?

3. What were you thinking about as it was taking place?

4. What were your feelings during and after the incident?

5. What, if anything, did you find particularly demanding about the incident?

6. What did you find particularly satisfying about the incident?

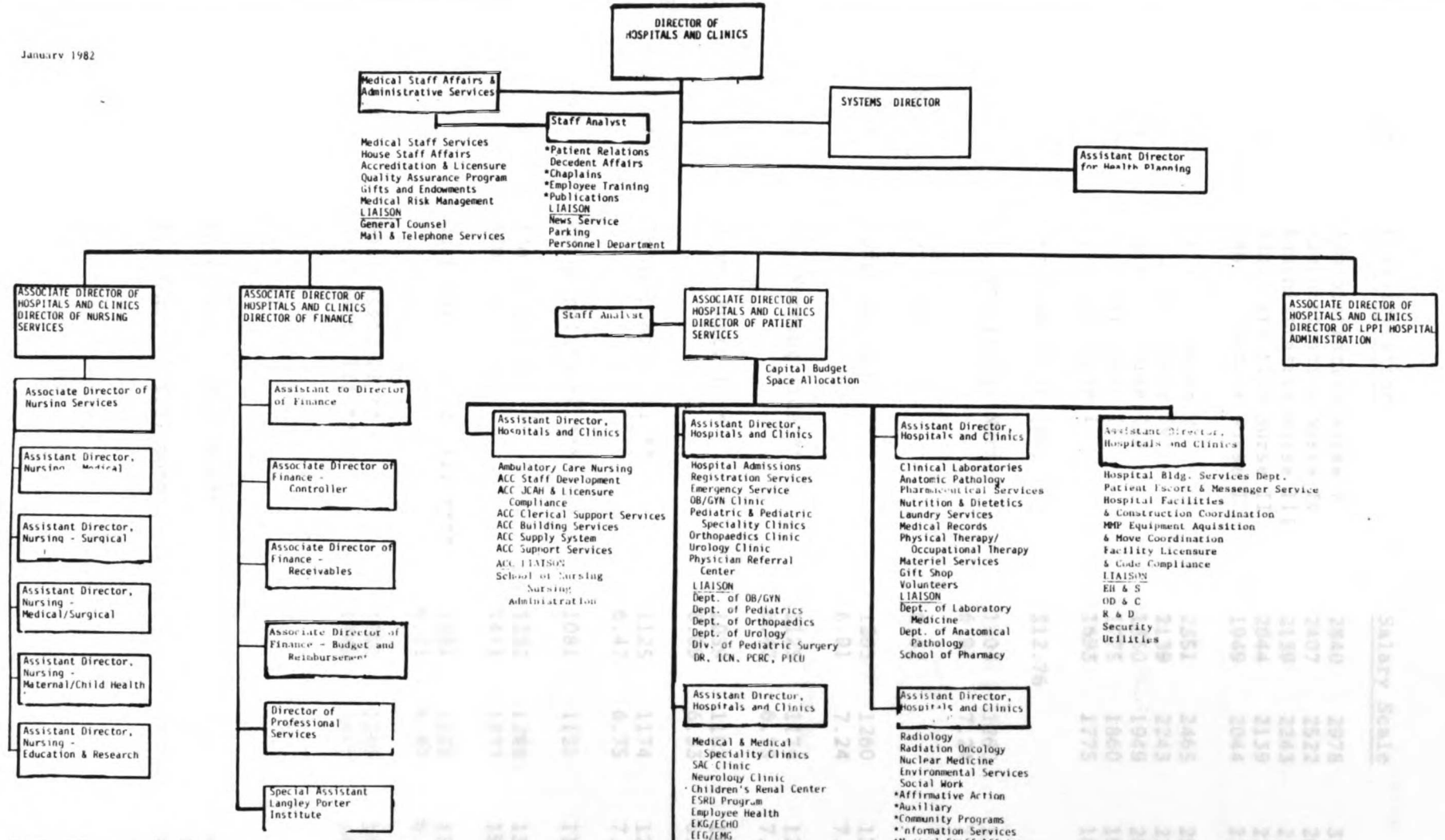
Example C: A TYPICAL DAY AT WORK

In the space below, please describe to us a typical day you have had recently at your work in an acute hospital setting.

Example D: AN UNUSUAL DAY AT WORK

In the space below, please describe a day at your work that was unusual in some significant way.

January 1982



*** Acts in the absence of the Director

* Staff to Director, Hospitals and Clinics

NURSING SERVICE SALARY SCALE

February 27, 1981

Code	Classification	Salary Scale				
9130	Administrative Nurse V	2840	2978	3120	3274	3432
9131	Administrative Nurse IV	2407	2522	2644	2773	2907
9132	Administrative Nurse III	2139	2243	2351	2465	2582
9133	Administrative Nurse II	2044	2139	2243	2351	2465
9134	Administrative Nurse I	1949	2044	2139	2243	2351
9136	Clinical Nurse V	2351	2465	2582	2708	2840
9137	Clinical Nurse IV	2139	2243	2351	2465	2582
9138	Clinical Nurse III	1860	1949	2044	2139	2243
9139	Clinical Nurse II	1775	1860	1949	2044	
9140	Clinical Nurse I	1693	1775	1860	1949	
9139	Per Diem Nurse (RN)	$12.76				
8916	Sr. Vocational Nurse	1203	1260	1317	1376	
		6.91	7.24	7.57	7.91	
8916	Per Diem--LVN	8.62				
8931	Surgical Tech. **	1203	1260	1317	1376	
		6.91	7.24	7.57	7.91	
8922	Sr. Nursing Aide **	1125	1174	1232	1288	1348
		6.47	6.75	7.08	7.40	7.75
8905	Hosp. Asst. I **	1059	1102	1149	1203	
		6.09	6.33	6.60	6.91	
8904	Sr.Hosp.Asst. II **	1125	1174	1232	1288	
		6.47	6.75	7.08	7.40	
4671	Principal Clerk ***	1081	1125	1174	1232	1288
4713	Adm. Asst. II	1232	1288	1348	1411	1477
4712	Adm. Asst. III	1411	1477	1546	1656	1693
9257	Unit Serv. Coord. III ****	1081	1125	1174	1232	1288
		6.21	6.47	6.75	7.08	7.40
9252	Hosp.Asst. II **	1203	1260	1317	1376	1442
9251	Hosp.Asst. III **	1348	1411	1477	1546	1618

Shift Differential

RN's:

Evenings:	$1.12/hr.	$195/month	**	.40/hr. or $69/month
			***	.22/hr. or $37/month
Nights:	$1.65/hr.	$287/month	****	.45/hr. or $78/month

Acuity Form Sample: Evaluation Form of the Level of Nursing Care Required

NEEDS	INTERVENTIONS		VALUE
HYGIENE AND COMFORT	Hygiene care: autonomous patient		2
	Hygiene care: partial bath (bed, sink, tub)		4
	Hygiene care: complete bath (0-4 years)		3
	Hygiene care: complete bed bath		7
	Hygiene care: complete tub bath (c. pres) (q.d.)		9
	Hygiene care: complete tub bath (c. pres) (ibid. & more)		13
	Mouth care	(q. 3-4h)	1
	Mouth care	(q. 2h & more)	3
	Facial shave		2
	Hair wash (bed/sink)		3
	Rubbing and positioning	(q. 3-4h)	5
	Rubbing and positioning	(q. 2h. & more)	12
	Up and/or ambulate with help	(bid-tid)	4
	Up and/or ambulate with help	(qid)	7
	Life up in bed and/or to wheelchair	(bid & more)	9

APPENDIX C: Materials given to Newly Hired Nursing Staff

OBJECTIVES OF THE FLOOR ORIENTATION

PURPOSE: The following objectives have been written to clarify the minimal expectations to the new orientee during the first two months of orientation.

It is expected that the new orientee will communicate his/her learning needs to the assigned preceptor on an ongoing basis throughout employment.

LOG: As part of your orientation you will maintain a daily log. Record the 1) types of patients for whom you care; 2) difficulties encountered; 3) three accomplishments of the week; 4) one thing you find satisfying about your job (weekly);and 5) learning need/goal for the next week.This log will be open to your preceptor and administrative Nurse III. From this we can get a sense of "where you're at" and you will have an ongoing record of your accomplishments for self-evaluation.

SKILLS LIST: A skills list has been given to you. Please reveiew it and check off how you rate yourself now. During your orientation, as you perform these skills successfully, have your preceptor check off your skills list upon demonstration of skills. Keep this list up to date during the next six months. *Items must be demonstrated within 8 weeks. Items marked ** are skills of which you must be aware at 8 weeks. Also notice when you have read the procedure before performing the skill.

PROCEDURE & PROTOCOL LIST: Review this list. As you read a procedure and or protocol note this on your sheet as you care for a patient who has a certain diagnosis and you read the MONP - keep this list up to date.

COMMON MEDICATION & SOLUTION LIST AND PRE-TEST: Review and see if you can answer the questions. This is for your own learning.

READING LIST: Articles you must read either before the appropriate class or before the end of orientation.

EVALUATION: Following your first 8 weeks of orientation you will receive your primary evaluation based on the CN II job description. From this, you and your preceptor will write a contract to be reviewed by the AN III. This contract will be for the next 3 months to prepare you for your Peer Review, which will take place at the time of your 5th month of employment.

SKILLS LIST

a. have done, need no supervision
b. have done but need supervision & guidance
c. need demonstration
d. have never done, need teaching

*must be able to do
**must be aware of ho

SKILL	a	b	c	d	DATE READ	DEMONSTRATED TO PRECEPTOR SUCCESSFULLY
catheterization, female **						
catheterization, male						
Incentive spirometer *						
CVP *						
gastrostomy tube						
ng tube *						
tube feeding						
TPN *						
prevention, pressure sores *						
IM & SQ injections *						
physical assessment, chest *						
chest tubes *						
chest physical therapy *						
suctioning, oral-trach, N-T *						
tracheostomy care						
blood administration *						
IV push medications *						
monitor IV *						
start IV *						
use volutrol *						
set up O_2, NP & MM *						
tap water enema *						
retention enema						
CPR *						
CPR, oral & rectal *						
BO, orthostatic *						

SKILL		a	b	c	d	DATE READ	DEMONSTRATED TO PRECEPTOR SUCCESSFULLY
ound isolation	*						
et to dry dressing	*						
et to wet dressing							
ound irrigation	*						
olostomy irrigation							
stomy appliance application	*						
itz bath	*						
ry sterile dressing							
enrose drain dressing	*						
agging a draining wound	*						
ch-mason dressing	*						
se bed scale	*						
se A/P mattress	**						
se egg crate mattress							
ematest stool/ng drainage	*						
est urine for sugar & acetone	*						
llect urine for UA	*						
llect urine for C & S	**						
llect sputum for C & S	**						
llect urine for 24° test							
llect wnd. drng. for C & S	**						
ine specific gravity c manometer	*						
ine specific gravity c refractometer	*						
movac care	**						
ckson Pratt care	**						
tube care	*						
AC's controller	*						
AC peristaltic pump	*						
AC volumetric pump	*						

SKILL		a	b	c	d	DATE READ	DEMONSTRATED TO PRECEPTOR SUCCESSFULLY
seizure precautions	**						
use of over bed frame	*						
use of foot board	*						
mouth care	*						
uses glyoxide	*						
ROM, active	*						
ROM, passive	*						
foley catheter care	*						
abdominal assesment							
IV site care							
Peri care							
use of abdominal binder							
use of PT walker							
skin graft care							
nutritional assessment of med surg pt.							
CAH rounds c AN							

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Common Meds and Solutions Used

Antibiotics

Septra
Keflex
Velocef
Penicillin
Clindamycin
Dixloxicillin
Naphcillin
Neo-mycin
Erythromycin
Ampicillin
Tobramycin
Gentamycin

Analygesics

Demerol
Talwin
Morphine
Percocet
Percodan
Tylenol and Codeine
Dilaudid
Phenergan
Methadone

Sleepers

Dalmane
Nembutal
Benedryl

Cardiac

Digoxin
Inderal
Aldomet
Lasix
HCTZ
Potassium
Nitropaste
Nitrobid

Which meds are compatible?
Did you check med compatibility chart?
Did you read medication procedure?

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G.I. Meds

Maalox
Amphogel
Lomotil
Titrilac
Cimetadine
Gaviscon
Compazine
Ducolax

Thyroid Medications

Thyroid Extract
Cytomel
Synthroid
Titrilac

Others

Regular Insulin
NPH Insulin
Dilantin
Narcan
Bilopaque
Mag Citrate
Calcium Cloride
Calcium Gluconate
Valium (read new material re: effect on respiratory compromise and wound healing.)
Mycostatin
Coaterzyme

Solutions

Dakins
Betadine
Hydrogen Peroxide
Normal Saline
Acetic Acid

Anticoagulants

Heparin
Coumadin

Steroids

Prednisone
Hydrocortisone
Solucortef

Preceptor _____

Nurse _____

Preceptor Checklist

This preceptor checklist was developed to help you assist the Clinical Nurses meet the objectives of orientation. Boxes are to be checked and dated when the Nurse completes the objective. Space is provided for comments, feedback to share with the nurse. This will help us have a running record of your progress.

Space is left for additional comments and objectives, so adapt this to the individual nurses needs. But remember, these are checklists to help you see that the new orientee meets the objectives of the floor orientation.

This completed checklist must be turned in to the Administrative Nurse III at preliminary evaluation.

OBJECTIVE	COMMENTS	DATE	APPROVED BY
Takes 2 nursing histories.	#1		
	#2		
Initiates & individualizes 2 NCP's based on above hx.	#1		
	#2		
Writes 2 days of soaat notes on above care plan.	#1		
	#2		
Adds, reuses & modifies 4 NCP's (other than ones initiated).	#1		
	#2		
	#3		
	#4		
Cared for 1 patient having major abdominal surgery, acuity rating of IV. (Note Diagnosis, acuity & number of days followed...)			
Cared for 1 patient on wound isolation. (Was proper isolation procedure followed.) Note when you read infection control manual.			
Read TPN Protocol	Read Protocol _____		
Attend class on TPN	Attended class _____		
Written TPN test completed successfully	Took test _____		
Dressing change done successfully x2 with supervision & using checklist.	#1 drsg D _____		
	#2 drsg D _____		

OBJECTIVE	COMMENTS	DATE	APPROVED BY
8) Prepared & sent patient to OR	Pre op checklist _____ Allergy band _____ I & O & medsheet _____ Activity record _____ Pre med _____ Valuables signed in _____ Nurses notes completed		
9) Received patient from PAR	Obtained report under supervision _____ Bedside ready _____ Meds transcribed correctly _____ Vitals sheet, med sheet, act record & I & O		
10) Admitted & oriented pt. to unit.	Name stickers _____ Pt. valuables _____ Valuables sheet _____ Pt meds _____ Knows visiting hours _____ Knows meal times _____ Call lights _____ Allergy band		
11) Discharged 1 patient from unit.	Medsheet _____ Activity record _____ Vital Sign sheet _____ Med drawer _____ Valuables sheet _____ Discharge note		
12) Transferred 1 patient from unit.	Gave report _____ Meds _____ Med drawer _____ Valuables checklist _____ Valuables drawer _____ Name stickers _____ Care plan complete before transfer in or out		
13) Participated in writing 1 teaching plan & implementation			
14) Writes a referral & makes the call.	Writes _____ Called _____		

OBJECTIVE	COMMENTS	DATE	APPROVED BY
15) Starts 3 IV's using protocol Dress IV site 3 times Uses correct tubing	Read protocol _____ #1 _____ #2 _____ #3 _____ Read protocol _____ #1 _____ #2 _____ #3 _____ Minidrip _____ Maxidrip		
16) I & O & Vital sign sheet correct x3, including totals.	Vital sign: 1 _____ 2 _____ 3 I & O: 1 _____ 2 _____ 3		
17) Followed pt. to OR & PAR			
18) Team lead x3-4 days			
19) Desk orientation	Admission (including admit/DC book) _____ Uses pt charge form _____ Uses floor charge form		
20) Demonstrate CVP reading ability after reading procedure	Protocol _____ Demonstration		
21) Demonstrate ability to care for patient with chest tube after reading procedure	Procedure _____ Demonstration _____		
22) Explain line of problem solving & follow them x 2	Verbalizes lines _____ Demonstrates x1 _____ Demonstrates x 2		
23) Demonstrates appropriate action during fire procedure			
24) Locate E care & do 1 check list, recite code blue phone #, participates in simulated code.	Crash cart check _____ Code blue # _____ Simulated code _____		
25) Goes to lunch daily & is ready for report 1 hour before end of shift, leaves work on time.	Lunch on time: #1 #2 #3 Ready for report: #1 #3 leaves on time: #1		

OBJECTIVE	COMMENTS	DATE	APPROVED F
26) Patient, rooms clean, check with Adm nurse x 4.	1 2 3 4		
27) Keeps log up to date			
28) Cares for a patient with skin graft or flap.			
29) Medication Administration	Transcribes correctly 1 2 3 Discontinues correctly 1 2 3 Knowledgeable about meds given 1 2 3 Narcotic count Counts stat med drawer Reorders stat med		

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SAMPLE: CLINICAL NURSE I.

Requirements: Current licensure as a registered nurse in the State of California.

General Description: A newly registered nurse, a nurse changing from one area of concentration to another, or a nurse returning to the profession after a prolonged absence who, under supervision, carries out routine patient care assignments, works in controlled patient care situations, and performs established nursing procedures for individuals or groups of patients.

Responsibility and Accountability: Responsible for all nursing care behaviors of clinical nurse I and accountable to clinical nurses II, III, or IV.

Behaviors:

I. Nursing Process

A. Assessment

1. Takes nursing histories from patients and/or others that identify common variables affecting care and serve as guides for the development of individual nursing care plans and that

a) provide baseline data pertaining to activities of daily living
b) reflect the physiological condition of the patient
c) reflect the psychosocial needs of the patient
d) reflect the perceptions of the patient and/or family of his health problem(s) and his expectations of the present hospitalization
e) provide information needed to begin discharge planning

2. Identifies common recurrent patient problems, symptoms, and behavioral changes in relation to

a) standards of care
b) individual patient needs

3. Obtains and reviews available data obtained by other members of the health team (medical history, physical examination, medical care plan, social worker's reports, and community referrals)

4. Identifies abnormal diagnostic data

SAMPLE: STAFF NURSE II

Requirements: Current licensure as a registered nurse in the State of California; diploma or associate degree with two years of recent clinical experience; or a baccalaureate degree in nursing with one year of recent clinical experience; or a master's degree in nursing with six months of recent clinical experience; or an equivalent of education and experience.

General Description: Under general supervision, the level II clinical nurse identifies and implements nursing interventions that have less predictable outcomes, and evaluates the results of these interventions for a given patient population; and in addition may perform the duties of a level I clinical nurse

Responsibility and Accountability: Responsible for all behaviors described in levels I and II job descriptions and accountable to clinical nurse III and/or IV.

Behaviors:

1. Nursing Process

   A. Assessment

      1. Takes nursing histories that identify less common variables
      2. Identifies common relationships in data collected in nursing interview
      3. Analyzes initial assessments and revises assessments based on patients' behaviors
      4. Validates data obtained by others by reviewing nursing care plans and nursing histories for a selected group of patients
      5. Evaluates nursing care by means of current assessment tools
      6. Interprets diagnostic data and incorporates it in the written assessment
      7. Identifies a wide range of patient problems, determines their common interrelationships, and establishes priorities for the nursing care plan
      8. Uses previous clinical experience and knowledge to anticipate potential patient care problems
      9. Assesses the needs of a specific patient population by

         a) making purposeful nursing rounds
         b) participating in clinical conference
         c) collaborating with physicians and other health care workers

      10. Assesses the competencies of personnel assigned to a specific patient group
      11. Uses and combines subtle cues to make subjective judgments about patients' needs

SAMPLE: STAFF NURSE III.

Requirements: Current licensure as a registered nurse in the State of California; a diploma or associate degree with three years of recent clinical experience, including at least one year in an area of concentration; or a baccalaureate degree in nursing with two years of recent clinical experience, including at least one year in an area of concentration; or a master's degree in nursing with one year of recent clinical experience, including at least six months in an area of concentration; or an equivalent combination of education and experience.

General Description: Under direction the level III clinical nurse works with increasing independence to set criteria for the quality of patient care, assesses the health needs of clients using specialized knowledge and skills and anticipates the outcome of nursing interventions; may perform the duties of a level I and/or II clinical nurse.

Responsibility and Accountability: Responsible for nursing care behaviors described in clinical nurse III job descriptions and accountable to clinical nurse IV.

Behvaiors:

1. Nursing Process

    1. Contributes to the development of individual patient and nursing care plans that

        a) identify complex patient problems that include subtle physiological and psychological changes in client behaviors
        b) identify the physiological, psychological, and environmental variables affecting the patient
        c) identify the interrelationships of these variables
        d) identify current coping mechanisms and their effectiveness
        e) identify patient support systems and their effectiveness

    2. Assesses the need for development of standards of care for a specific patient population

    3. Assesses the numbers and levels of personnel needed to provide nursing care for a specific patient population

SAMPLE: STAFF NURSE IV

Requirements: Current licensure as a registered nurse in the State of California. Master's degree in the area of nursing or related fields preferred with two years of recent clinical experience in the area of specilization. Baccalaureate degree in nursing required with six years recent clinical experience in an area of concentration.

General Description: Clinical nurseIV has in-depth knowledge of her speciality area and under general direction applies theories and concepts derived from the biological, natural, and behavioral sciences and related areas to her nursing specialty; and in addition may perform the duties of prior levels.

Responsibility and Accountability: Responsible for nursing care behaviors described in clinical nurse IV job description and accountable to the associate director for clinical practice

Behaviors:

1. Nursing Process

   A. Assessment

      1. Articulates a systematic view of man as an integrated being
      2. Utilizes a client-centered approach to assess specific needs of a particular patient population
      3. Uses knowledge of a variety of conceptual models in order to consider alternatives that explain and predict present or potential patient problems
      4. Selects and adapts models for meeting the needs of a specific patient population
      5. Uses specialized clinical knowledge to assess the needs of a specific patient population
      6. Uses a wide repertoire of assessment tools to determine the data base for a particular client population
      7. Modifies and adapts assessment tools to meet the needs of a particular patient population
      8. Develops assessment tools to meet the emerging needs of a changing patient population
      9. Assesses the social system of the work setting to identify directions for change in the delivery of nursing care services for a specific client population
      10. Assesses the needs for numbers and levels of personnel required to provide quality nursing care for a particular patient population in collaboration with the clinical nurse III

Table A. Nursing Through Constructs

CN II.	Takes nursing histories... a) which provide baseline data regarding activities of daily living... b) reflect the physiological condition of the patient, c) reflect the psychosocial needs of the patient; d) reflect the perceptions of the patient and of family of his health problem and his expectations of the present hospitalization; and e) provide information needed.....
	Identifies common recurrent patient problem symptoms and behavioral changes in relation to...individual patient needs
	Revises the initial nursing care plan to the changing needs of the patient
	Evaluates the response of the patient to his care plan
	Evaluates the response of the patient to nursing intervention
	Revises the nursing care plan to meet changing needs of the patient
	Collaborates with the patient/and or family to identify individual informational needs to assess learning readiness
	Uses teaching strategies, to meet individual informational needs that involve the patient and/or his family or other supporting people
	Communicates referrals to other members of the health team to meet specific learning needs of the patient and/or family
	Evaluates and revises the teaching strategies in relation to the patient and/or family
CN III.	Analyzes initial assessments and revises assessments based on patient's behaviors
	Plans teaching strategies, to meet individual informational needs that involve the patients and/or his family or other supporting people
	Evaluates and revises the teaching strategies in relation to the response of the patient and/or family
	Plans referrals to other members of the health team to meet specific learning needs of the patient and/or family

Table B. Patient Involvement

CN II.	Involves the patient and/or family in developing the nursing care plan
	Communicates a rationale for nursing intervention to the patient and/or family
	Collaborates with patient and/or family to identify individual informational needs and to assess learning readiness
	Communicates accurate information about the nursing care plan to the patient and/or family
CN III.	Contributes to the systematic development of individual patient and nursing care plans
	a) Actively seeking the opportunity to involve the family in patient care planning b) Initiating patient-family conferences
	Negotiates with patient, family and others to plan for discharge
	Utilizes data obtained from patient and family to evaluate patient care
	Observes changes in patient and/or staff behaviors and makes self available for problem solving
	Helps patients...identify problems and explores with them the consequences of alternative choices
CN IV.	Establishes contracts for nursing care with specific patients, stating mutual goals and expected outcomes

Table C. Nurse as Problem-Solver and Teacher

CN II.	Uses teaching strategies, to meet individual informational needs that involve the patient and/or his family or other supporting people
	Identifies and reports verbal and non-verbal communication problems of patient and/or family
CN III.	Identifies a wide range of patient problems, determines their common inter-relationships and establishes priorities for the nursing care plan
	Uses previous clinical experience and knowledge to anticipate potential patient care problems
	Observes changes in patient and/or staff behaviors and makes self available for problem solving
	Helps patients and/or staff identify problems and explores with them the consequences of alternative choices
	Identifies potential problems of patients and/or staff and intervenes appropriately
CN IV.	Uses knowledge of a variety of conceptual models in order to consider alternatives that explain and predict present or potential patient problems.

Table D. Nurse-Physician Relationships

CN II.	Obtains and reviews available data obtained by other members of the health team (medical history, physical examination, medical care plan, social worker's reports, and community referrals)
	Writes a nursing care plan, using the assessment data, that a) integrates the medical care plan
	Plans patient care with other members of the health team
	Implements the medical care plan as delegated
	Communicates referrals to other members of the health team to meet specific learning needs of the patient and/or family
	Interacts effectively with other team members to keep them informed of changes in the condition of the patient
CN III.	Assesses the need of a specific patient population by: ... c) collaborating with physicians and other health care workers
	Uses evaluation data in collaboration with other health disciplines to influence the revision of the total patient care plan
	Plans referrals to other members of the health team to meet specific learning needs of the patient and/or family
CN IV.	No direct or indirect mention

APPENDIX E: Summary of Themes and Meanings of the Clinical Program

Summary of Themes and Meanings:

One hears a recurrent set of themes in this project that coalesce within the concept "professional nurse." I have singled out 6, using the nurses terms in quotes when applicable. Under each theme I have grouped a set of meanings and their contrasts. These meanings were translated into language and practices which I list as well as some of the likely sources of the themes and meanings. The themes I identified are:

1) Patient-focus or "Clinical"
2) Autonomy
3) Growth
4) Rational:Scientific and Pragmatic
5) Differentiated
6) Formalized and Standardized

THEME: Patient-Focused or "Clinical"

Terms: "clinical nursing"; "patient-focused"; "return to bedside nursing" : "total patient care"; and psycho-social"

Meaning 1: The priority of patient care; the return to the bedside as a professional nurse; reward nurses for what they value

Contrasts with: Priority and prestige of nursing administration; the better the nurse, the farther from the bedside; "nursing the system"; "nursing the desk"

Practices: Clinical Ladder

Meaning 2: The patient is the client of the nurse, not only the physician and the hospital; the nurse/patient relationship is autonomous, primary and unmediated; the nurse is accountable to the patient

Contrasts with: A group of nurses with a group of patients

Contrasts with: A group of nurses with a group of patients or team nursing; the patient as the client only of the physician; the nurse as assistant in that relationship, not finally answerable to the patient

Practices: Primary nursing
Dissemination of decision-making to the individual practitioner
Nursing Care Plans
Consumer on Peer Review

Meaning 3: The patient is an autonomous partner in his/her care and should guide and participate in this care as much as possible. The nurse/patient relationship as interdependent

Contrasts with: The patient as passive recipient of care; the nurse as surrogate mother who nurtures dependence of the patient

Discourse and Practice: Consumer on Peer Review
Statements in Job Description that stress inclusion of patient
Use of terms in job descriptions such as "does with"
Emphasis on inclusion of the family in patient care

Meaning 4. Nursing care should address the whole person, not just the disease; nursing should address psycho-social dimensions of illness

Contrasts with : Predominant focus on physiological domain; disease oriented

Discourse/Practices: "Total patient care"
"psycho-social" dimension included in Models of Care and Job Descriptions
Primary nursing

Sources: Model of private duty nursing in history of the profession
The physician model of autonomous professional practitioner
Consumer movement of the 60s and 70s
Women's movement
Movement toward clinical nursing within nursing

THEME: Autonomy

Terms: autonomy; "accountability";

Meaning 1. Nursing as separate but equal with medicine: Control over the conditions of nursing practice; the development of a domain of nursing and a knowledge base separate from medicine

Contrasts with: Nursing being dependent, inferior and determined by medicine

Practices: The process of nurses designing the clinical ladder, and the job descriptions alone with the exclusion of hospital administrators and physicians

the minimal mention of the physician in the job description
the development of a nursing forum in Peer Review
the creation of nursing authorities and resources in the clinical ladder to whom nurses could turn to and which parallels the medical hierarchy matching power with power, competence with competence

emphasis on collaboration vs subordination with physicians
development of nursing's own "knowledge base" through nursing histories , care plans, and research

Meaning 2. Nurses, separate and equal from physicians are equal among themselves: Egalitarianism and Democratic governance go hand in hand with autonomy. Each nurse is separate and equal before each other.

Contrasts with: Authoritarian nursing structure
Centralized decision-making

Practices: decentralization of nursing service and the pyramid decision-making tree dispensed with

dissemination of decision-making down to the level of the individual nurse
Peer Review
Nursing Care Plans
Dispanding of the nurse supervisory system in exchange for differentiation of levels of competence
Clinical ladder that supposedly allows for all to advance if they want to
The reliance on rational-legal authority as vested in standardized criteria embodied in formal models such as job descriptions

Meaning 3: Individual responsibility
a. emphasis on making asssements, individual judgement; thinking not obeying;
b. being personally responsibile for outcomes of professional acts; being accountable
c. emphasis on self-evaluation and individual responsibility for growth

Practices: assessments are solicited and rewarded in the job descriptions and care plans
model of independent practitioner
primary care nursing

Meaning 4. Individualism: career orientation; the individual stands alone before his or her own career which she needs to pursue through a path of growth

Practices: career ladders
emphasis on individual growth and satisfaction in peer review and job descriptions

Meaning 5: Autonomy of the patient; implied in the emphasis on the nurses' separation from the patient

Practices: emphasis on patient participation in job descriptions; emphasis on a collaborative relationship

THEME: Growth

Meaning 1: Nursing should be a career, marked by upward mobility

Contrast with: nursing as "just a job" in which one does not develop

Practices: emphasis on growth and development of the nurse in the job descriptions, Peer Review
clinical ladder which provides an avenue for advancement and reward for increased competence

Meaning 2: Nursing is a series of unfolding capabilities

Contrast with: nursing as a finite set of tasks to be learned

Practices: career ladder based on job descriptions of expanding capabilities

Meaning 3: Self-actualization of nurses; nurses should grow and develop

Contrast with :nurses and nursing as stagnant

Practices: emphasis on growth and development in job descriptions and Peer Review process
reward for increased competence,

Meaning 4: Nurses should set goals that they achieve; nurses as sucessful, ambitious

Contrast with: nurses as being not achieving

Practice: Peer Review: goals are set that are measurable and documented
Job descriptions written so that they could be quantifiably evaluated, so growth could be documented

Meaning 5: Nurses' growth should be self-directed

Contrast with: nurse as employee and passive respondant

Practice: Emphasis on self-evaluation, writing of one's own goals

Sources: Women's movement
Self-actualization movement of 60s and 70s
Professional model (mostly of physicians)
Nursing education
Middle class values

THEME: Rational: Scientific and Pragmatic

Meaning 1: Deliberate, purposeful, pragmatic nursing. Nursing has outcomes that can be planned for, achieved, and measured; nurse as problem solver, goal-oriented

Contrasts with: Nursing as being; nursing as only expressive not instrumental; nursing as nurturing; nursing as natural or habitual

Practices: Nursing Process
Nursing Care Plans
Models of Care

Meaning 2: Nurse as acting on the basis of rational, conscious, objective thought proceeses

Contrasts with : nursing as based on emotions, habit, intuition, obedience; nursing as subjective; nurses knowing only how, not why

Practices: SOAP charting
Care Plans

Job Descriptions reward for theoretical knowledge
Emphasis on thinking and writing skills

Meaning 3: Nursing is a scientific discipline

Contrasts with: nursing as a technical discipline; nursing as derivative of medicine; nursing as second nature

Practices: research
emphasis on empirical basis of knowledge
image of nurse as collector of objective data and analyzer of this

Meaning 4: Nursing is learned and based on acquired competence

Contrasts with : nursing as natural, feminine

Practice: emphasis on academic requirements and reward for
emphasis on deliberateness and rationality vs intuitive and natural

Meaning 5: Nursing should know why they do something and should act on the basis of clinical judgement

Contrasts with: nurses knowing only how, emphasis on technical skills

Practices: emphasis on nursing theory and theoretical knowledge
reward for bacclaureate degree
Care plans and job descriptions requiring knowing the rationale for actions

Meaning 6: Nurses' own senses and judgement should be their authority

Contrasts with: medical sense and judgement as authority

Practices: increasing nursing knowledge base

Meaning 7: Nursing as explicit and literate

Contrasts with: nursing as primarily oral and implicit and natural

Practices: emphasis on writing skills
Nursing Process
Care Plans
Nursing histories

Meaning 8: Nursing is cognitive

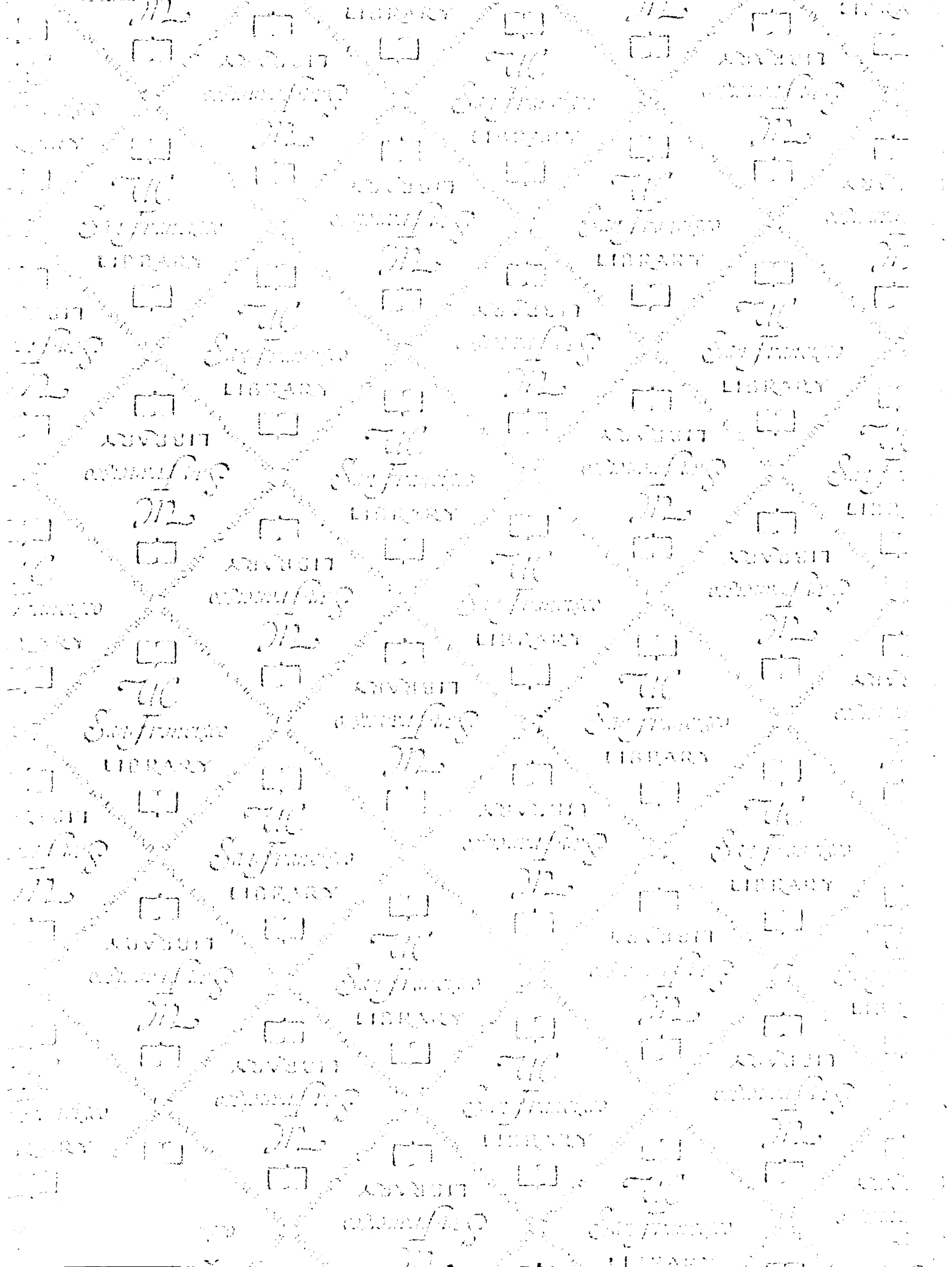
Contrasts with: Nursing as just emotional or technical

APPENDIX F: Summary Table of Dreyfus Model of Skill Acquisition

Taken from Putting Computers in Their Place: The power of Intuitive Expertise in Management and Education, Hubert and Stuart Dreyfus, in press, page 29.

SUMMARY TABLE OF THE DREYFUS MODEL OF SKILL ACQUISITION

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