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THE NURSED PASSAGE: A THEORETICAL FRAMEWORK FOR
THE NURSE-PATIENT PARTNERSHIP

A thesis presented in partial
fulfilment of the requirements for the degree
of Doctor of Philosophy
in Nursing at
Massey University

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ABSTRACT

This study focused on nursing in action. The research goal was to identify nursing-relevant dimensions within a person's experience of being a hospital patient undergoing elective surgery. In order to discover and conceptualise the underlying processes which are present as patients are nursed through this experience, an open question was posed - What is happening here? A qualitative research method was the most appropriate means of discovering an answer to this question.

The particular method chosen was the grounded theory approach developed by Glaser and Strauss. Data were collected in five surgical wards of a large city hospital over a period of five months. The research participants were twenty-one patients and the nurses involved in their care. Primary sources of data were interviews and the nursing records. These were augmented by field notes and accounts of observed incidents relating to the care of each patient.

Using the inductive strategies of the grounded theory method, numerous descriptive concepts were generated during data analysis. These were ordered within an

integrating social process derived from anthropology. By this means a grounded theory in the form of a theoretical framework - the Nursed Passage - was developed. Within this passage the patient is the passagee and nursing is translated into action through the agency of the nurse.

The Nursed Passage is a patterned partnership with three key elements. Firstly, the temporal element, characterised by ongoing movement and constant change, is conveyed in the sequence of phases or stages. Secondly, the participative element is portrayed as a patterned relationship in which both nurse and patient are actively involved in progressing the patient through the passage. Finally, the contextual element recognises complex factors within the nursing environment which have an impact on the shape of the relationship between patient and nurse.

This theoretical framework, generated from the reality of nursing as it occurs in one setting, assigns a specific shape to the encounter between nurse and patient. It identifies the contribution nursing alone can make to optimise each patient's hospital experience. In this way it both complements and facilitates the work of medical and other colleagues with whom nurses work. Thus, it serves to revalue nursing in terms that can maximally utilise the registered nurse's knowledge and skill for the benefit of all concerned, but particularly the patient and the nurse. Consequently, it has potential value for nursing practice, education and research.

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INTRODUCTION

This thesis recounts the first phase of a voyage of discovery, one that is still in progress. The need for the journey arose from the author's growing sense of unease about aspects of nursing practice within the hospital setting. Of particular concern was how qualified nurses at staff nurse level were adapting to their changed role following the removal of students from the work force. The end-point of the journey to date is a conceptual mapping of the process of nursing in action. This takes the form of a theoretical framework depicting the nature of the collaboration between nurse and patient during the latter's experience of hospitalisation for elective surgery.

Part of the justification for the transfer of nursing education, from the hospital to the general education system within technical institutes, was the concept of an all qualified nursing work force. This concept became reality when the resiting of basic nursing programmes commenced in 1973. Previously, within a hospital ward, nursing students had been the primary 'doers' while the registered nurses acted largely in a supervisory capacity. Now the staff nurse was to be the 'doer' of the nursing

work force. As the change progressed the lack of an articulated theoretical base upon which to shape this new role became increasingly apparent.

As a nurse teacher, closely involved in developing learning programmes to prepare nurses for the changed working environment, the researcher had been keenly aware of the conceptual deficiency. If it was to be corrected, such fundamental questions as the following had to be addressed: What is, could be, or should be the role of the newly registered nurse in a setting where nursing is primarily given by registered nurses? What do students need to learn - about themselves, about patients, about nursing, about the nursing role, and about health and illness?

During this same period, the author was aware of, and shared, the nursing profession's anxiety about the high mobility and low retention rate of staff nurses at a time when, because of the new staffing pattern, they were required in increased numbers. It was anticipated that resolution of this problem could be assisted by a better understanding of the nature of nursing in action. This could then be used to enhance nursing care with probable benefit for the patient and encouragement to the registered nurse to remain in practice.

Reflections on personal experiences had a major influence on the development of this study. Memories were recalled of many situations where nurses had seemed unable to move beyond their preoccupation with tasks and 'see' what was

happening to a patient and what nursing, through them, could offer. Two examples serve to illustrate this.

✓The first had occurred during a previous field study. Two nurses, one shortly after the other, approached a patient who had recently experienced an abortion at about 16 weeks gestation. Standing some distance from the patient, both asked the question: "Are you okay?" After receiving a nod from the patient, both left the room. However, concern for her pallor and air of apprehension led the researcher, taking on the role of nurse, to approach the patient for a closer look. Her pulse was high, her blood pressure low. On lifting the bedclothes the researcher discovered a large pool of fresh blood coming from the vagina. The patient admitted she didn't feel well at all. When asked why she hadn't said anything to the nurses she replied: "I didn't like to bother them. They're so busy." Action by the researcher led to immediate medical intervention and the patient was taken to the operating theatre within a few minutes. In this situation the patient seemed to consider the nurses' apparent 'busyness' to be more important than her own needs. At the same time the nurses were failing to use their nursing wisdom as they approached the patient. Thus, they didn't 'see' the evidence that all was not well, in spite of the lack of ✓congruence between the patient's words and behaviour.

The second example came from an experience when the ✓researcher was working in a surgical ward during a period of 'refreshment' away from her teaching role. She was

assigned a patient who was considered a 'problem' and a cause of concern to the charge nurse. Examination of the nursing documentation revealed that no patient problems had been entered on the care plan while the nursing notes only mentioned that the elderly lady was incontinent and "seems upset". She was ready for discharge after surgery for a perforated gastric ulcer.

Talking with this lady, and observing her and her behaviour while giving assistance with daily hygiene, led to the identification of a significant number of problems which were amenable to nursing action. Discussion with the patient led to confirmation of the following problems: grieving for the death of her only sister four weeks before in geriatric hospital; guilt that she had not visited her sister in the week before she died; no living relatives; loneliness; fear of going home to a large house where she feels afraid; incontinence at night; deafness; constipation; uncertainty on her feet; painful neck and shoulder; continuing indigestion and dysphagia; inability to shower/bath and dress herself; broken skin along her thoracic spines; excoriation under both breasts; marked oedema of ankles and feet; painful lower legs with very dry, pigmented and fragile skin; oral thrush; inadequate food intake; and nurses continually putting sugar on her porridge - the only food she enjoyed but which she couldn't eat with sugar!

✓ Experiences like these caused the researcher real concern. Information which could lead to beneficial nursing action

was available but the registered nurses were not 'seeing' it. Yet more questions were generated and required an answer: How do nurses perceive the patient? How do they perceive their work? How do they decide what nursing the patient requires? Do they value, and respond to, individual differences in patient situations? How can nurses be assisted to approach the patient in a spirit of enquiry with their accumulated nursing knowledge and skills ready for application at every moment?

These questions and subsequent reading caused the focus of interest to centre on the patterning of the nursing encounter between nurse and patient. Increasingly, the author found herself unsatisfied by the existing published conceptualisations of nursing. Indeed, questions about what actually happens in the interaction between nurse and patient increased and became more fundamental as reflection progressed. Finally, the decision was made to undertake a study of nursing in action in order to discover the phenomena that are within the domain of the nurse. In the familiar nursing setting of the surgical ward data would be gathered from a group of patients and nurses while the former were undergoing planned surgery. The question to be answered was - What is happening here?

Within the surgical ward, and throughout the hospital setting, nursing care often appears to be based primarily on the medical model of care with its main focus on the diagnosis of a pathological problem and the associated medical intervention. Any definition of nursing using

this model ascribes to the nurse a primary role of assistant to the medical staff. Consequently, nursing is perceived to be a subordinate service rather than an independent profession with its own work to perform for and with the patient. Confirmation of nursing's own contribution to patient care within the hospital setting is dependent on the generation of research-based models which identify a specific nursing perspective. In this way the patient's need for nursing, and the nursing response, could be separated from, but interrelated with, his need for medical care.

During the current period of rapid change in the New Zealand health service, when issues related to nursing - the service and its personnel - are constantly under scrutiny, this distinction is of critical importance. If the 'assisting' perspective holds sway then nursing is devalued and the justification for a qualified nursing work force is open to argument. One New Zealand nursing leader argues that

. . . specification of a central core of nursing articulated universally and applied consistently may move nursing from a defensive position implicit in the medical model, thereby focusing attention on the nursing role (Salmon, 1982, p.121).

Another New Zealand nurse shares her regret that many nurses view the assistive role as the "crux of their practice" and goes on to point out that such a perspective of practice is often unwitting, whereas

"...the nurse of quality knows that nursing is an entity of itself, not controlled by other professionals, which must be given due importance and due time to practice" (Nightingale, 1983, p.22).

Unfortunately, although nurses 'of quality' see nursing as having an independent service to offer to any person whose health and wellness is threatened, identification of specific nursing dimensions to aid translation of this ideal into practice has proved difficult and elusive. It became apparent to this researcher that there has been a paucity of theoretical research investigating phenomena as they occur within the challenging arena of nursing practice. This observation is given support in the current nursing literature. For example, Kim points out that there has been "little systematically presented empirical evidence in nursing", and this means that "theories based on inductive generalisations have not been well developed" (Kim, 1983, p.178). Similarly, after reviewing twenty-two reports of studies of adults undergoing elective surgery, Johnson concludes that "more theoretically oriented research is required before a description of the processes of coping with surgery can be developed" (Johnson, 1984, p.128). She believes that there would be significant value for nursing practice from sound theoretical research in this example of a "stressful health care experience" (Ibid, p.130).

While nursing's development as a profession is enhanced by the development of nursing theory, this only has value when it can be translated into beneficial action for the

patient. Although medicine is widely considered to have the major role in the treatment of illnesses, the multiple dimensions of a patient's illness experience go far beyond the medical scope of practice. If those aspects of the patient's situation which can benefit from nursing can be identified, this would give nurses a mandate for independent action within a specified scope of practice. Such a defined role would not only be of value to the patient but would also complement and facilitate the work of medical and other colleagues with whom nurses work.

Against this background, a field study was developed to examine the experiences of patients as they undergo planned surgery. The giving and receiving of nursing care in this context is particularly amenable to study as a total experience. In contrast to emergency admissions, both patient and nurses can be interviewed before, during and after the surgery. Also, the length of time each patient is in hospital is usually predictable and expected to be of short duration. Yet, during this time, the patient's nursing status changes dramatically as he passes from independence at admission to total dependence during the surgery, then through the recovery period back to increasing independence as the time for discharge approaches. It is as if this one experience is a microcosm of nursing as each patient rapidly passes through the full range of states which nursing can encounter in any setting.

From this study a grounded theory emerged, albeit one in

the early stage of its development. In the terminology of the chosen research method, it is a "discussional" grounded theory - a systematic description of the properties of each of the conceptual categories generated from the data. These concepts or constructs have been integrated within the organising framework of a social process derived from anthropology - the concept of passage. In this form the research outcome is a theoretical or conceptual framework rather than a developed theory and will be referred to in this way throughout this study. This issue will be amplified in Chapter 3 as part of the critical discussion of the method.

Passage, the integrating social process which shapes the theoretical framework, is derived from its anthropological use to describe the many developmental and situational transition experiences associated with life events. The Nursed Passage is conceptualised as a multidimensional process representing the patterned transaction between nurse and patient by means of which the patient is helped through a health-related event, such as surgery.

Within the Nursed Passage three distinct elements can be identified. Firstly, the passage has a temporal element reflected in an identifiable beginning and end. Four distinct stages or phases have been described: The Beginning; Settling In; Negotiating the Nursed Passage; and Going Home. The transition from the Beginning to Settling In coincides with the patient's admission to

hospital and into a state of being nursed. Discharge from hospital marks the end of the passage although nursing may continue after the person's return home. The Negotiating phase co-exists and interrelates with both Settling In and Going Home. It is possible that a post-discharge phase could be identified after further research.

Secondly, there is an interactive element which reflects the reality that nursing occurs within a patterned relationship between the nurse as the agent of nursing, and the patient as the passagess who needs to be nursed through the health-related event. Both patient and nurse are perceived as being active throughout the passage with both being ascribed their own pattern of work to perform. It is this mutual work which characterises the partnership.

Thirdly, there is a contextual element characterised by three specific factors within the nursing setting which can be seen to exert an influence on the relationship between nurse and patient throughout the passage. The first factor is the perception by nurse and patient that nursing is continuous despite its episodic nature; the second is the sanctioned interpersonal closeness between nurse and patient even though they are strangers; and the third is the reciprocal good will which is present. Each of these factors contains a paradoxical element which reflects the complexity of the immediate nursing context of the Nursed Passage.

Each patient's passage is different despite sharing an

overall pattern with others progressing through the same experience of being nursed. Patients differ with respect to the internal and external conditions which exist during the passage. They vary in the life experience they bring to this particular event. Their available individual resources are also unique. Thus, the dimensions of patient work identified in each stage of the passage exist for all patients but the situational performance is variable and may or may not lead to a beneficial passage.

In the same way, nurses vary in their personal qualities as well as the accumulated nursing wisdom they bring to each patient encounter. As nurses work to ease the way for a patient who is working through each moment of a nursed passage, every nurse will demonstrate some variation in her work from that of her colleagues. Not all nursing action will have a positive outcome for the patient's passage. Although nursing wisdom is available, a nurse may fail to select and/or perform the nursing actions which would optimally progress a patient's passage.

In the final analysis, it is in the interests of all concerned to complete each passage as quickly and effectively as possible within the circumstances which prevail. Responsibility for that is inevitably shared by patient and nurse. It is a collaborative endeavour between people who are, in fact, strangers brought together for a single purpose. The effectiveness of their collaboration is dependent on the outcome of the

negotiation processes in which nurse and patient are involved as nursing is given and received through each stage of the passage.

This account of the research study and its theoretical outcome follows an orderly sequence. The reader is guided through the preparatory stages in the first three chapters. In Chapter 1 an introduction to the nursing background against which the research problem was developed and studied is presented with selective use of nursing literature. Chapter 2 contains a discussion on qualitative research in nursing followed by an introduction to the grounded theory method chosen for this research. Chapter 3 presents the research protocol, its application in the field, the amount and type of data obtained, and concludes with a description of the process by which the theoretical outcome was attained.

Chapter 4 begins the presentation of the Nursed Passage. This chapter takes the form of an overview of the theoretical framework which was generated using the processes of the grounded theory method. Each of the constituent concepts is introduced and defined but without reference to the data from which it emerged. The overview precedes rather than follows the more detailed discussion in order to provide the reader with an insight into the total framework.

There are then five chapters, Chapters 5 - 9, during which the properties of the various concepts within each stage of the passage are explored and supported by anecdotes

from the data. Chapter 5 presents the Beginning - the first stage of the passage which occurs prior to the patient's admission to hospital. In Chapter 6, the second stage - Settling In - is discussed with the focus on the work of both patient and nurse. Chapters 7 & 8 contain the detailed discussion on the critical third stage - Negotiating the Nursed Passage. The work of the patient is presented in the first of these chapters, and the work of the nurse in the second. Finally, in Chapter 9 the discussion moves to the last stage - Going Home - and includes a description of the work of both patient and nurse.

Chapter 10 completes the presentation of the theoretical framework with the focus moving to the three paradoxical determinants identified within the nursing setting which directly impact on the shape of the passage.

In the concluding chapter, Chapter 11, the research findings are summarised and this is followed by a discussion of the possible implications of the Nursed Passage for nursing practice, education and research.

The Nursed Passage offers a new way of looking at what happens during the nurse-patient encounter in the setting of the surgical ward. Even in its present form, the framework challenges the nurse to think anew about her practice; the nurse administrator to rethink the organisation of nursing care; the teacher to visualise new ways of presenting nursing to those entering the profession; and the researcher to devise studies to expand

and confirm the emerging theory.

As with any study of this nature, the work is incomplete. Such a voyage of discovery often raises more questions than it answers. As the writing progressed, further development of the framework took place and this evolutionary process will continue.

The inevitable unfinished nature of this kind of theorising is acknowledged by Meleis when she comments:

At some point, a project needs to be abandoned so that others in the field will have a chance to play with its ideas in order to modify, extend, refine, or refute their own; . . . The reader is urged to consider that this project is intentionally an incomplete-completed project, a temporarily abandoned project that represents the thinking and the analysis of one author, seen through her own "wide-lensed glasses" at a certain point in time (Meleis, 1985, p.4).

CHAPTER 1

THE CONTEXT OF THE STUDY

In this chapter references drawn primarily from nursing literature are used to support a discussion on three separate aspects relevant to the practice of nursing. All three, namely the New Zealand setting, the nature of nursing and the patient's experience of hospital and nursing care, influenced the development and conduct of the study.

Introduction

This research took place in New Zealand at a time of change in nursing education and nursing service within a changing national health service. It was sited in a large general hospital which was feeling the impact of these changes. After a century of involvement in the preparation of nurses for registration the hospital was closing its three year general and obstetric nursing programme. Increasing numbers of graduates from the replacement comprehensive nursing programme, offered at the local and other technical institutes, were joining the staff. The proportion of nurses with post-basic nursing

qualifications from universities and technical institutes was also increasing.

Nationally, the consequences of this removal of employee/students from the hospital work force has necessitated the development of new patterns for staffing nursing units. Issues related to the employment and retention of registered nurses in the hospital nursing service have come to the fore, as has the nature of the role of the nurse in the new context. Other countries also are experiencing, or have experienced, the consequences of similar changes in nursing education. A survey of the international nursing literature revealed considerable discussion on the existing conceptualisations of the nurse, the patient and nursing (For example: Johnson, 1968; King, 1971; Levine, 1969; Orem, 1971; Parse, 1981; Roy, 1976; and Rogers, 1970).

All of these issues helped to shape the nursing context in which this study took place. The further discussion of this, with reference to selected literature, will be organised into three sections: i) the changing pattern of nursing in New Zealand; ii) the theoretical basis of nursing practice; and iii) the experience of hospitalisation.

The Changing Pattern of Nursing in New Zealand

Since the early 1970s changes in nursing education have dramatically altered the nature of the hospital nursing service. Registered nurses have discovered that their

previously predominant supervisory activities in relation to students have been reduced and replaced by a role as a bedside or 'hands on' nurse. In this role they become the model for nursing students and, as such, establish the standard to which these neophytes will aspire after graduation. Two particular aspects of the New Zealand situation have significance for the study and its outcome: the closure of hospital-based nursing programmes; and the role of the registered nurse in an all-qualified work force.

Closure of Hospital-based Nursing Programmes

Controversy and change have been, and continue to be, persistent themes in nursing education. Since 1973 the nature of basic nursing education, the type of registration attained, the status of the students, the site of the schools and the conditions of learning have undergone a revolution.

Prior to 1973 a nurse gained registration through one of three types of three year nursing programmes - general and obstetric, psychiatric or psychopaedic. Schools of nursing were operated by hospital boards which had the primary function of providing a regionally based health service funded by central government. During their training students were employees of the hospital board, receiving wages in return for providing the majority of the bedside nursing in hospitals. Formal education took the form of study days and/or study blocks interspersed

with an employment-based rotation through a range of hospital wards.

In 1969, the Review of Hospital and Related Services identified a number of major problems in the existing system of preparing nurses for registration. These included: too many schools; small schools with inadequate learning experiences; inadequate supervision of students on the three nursing shifts; priority given to service needs over the students' learning needs; failure of more than half of the students to complete the nursing programme; and a shortage of qualified nurse tutors (Department of Health, 1969, p.41-43).

By the early 1970s the New Zealand Nurses' Association was seeking governmental action to transfer nursing education into the system of general education. A major review of nursing education ensued and, together with concerted action by nurses throughout New Zealand, eventually led to a decision to introduce change (Carpenter, 1971; Department of Education, 1972; New Zealand Nurses' Association, 1973, 1980). On 2 November 1972 the then Minister of Health announced that pilot three year student-based programmes leading to registration as a nurse would commence in 1973 in two technical institutes.

After that initial announcement, decisions on increasing the number of schools offering the new programmes were made on an ad hoc basis annually in the midst of continuing confusion and controversy. In reviewing the impediments to progress in New Zealand nursing, a national

workshop reported that the

. . . continued use of students has served to distort the role of the registered nurse who, once qualified and deemed competent to provide nursing services, tends to become increasingly involved in non-nursing activities. . . . but the surest way to ensure that nursing skills are utilised is to remove unqualified persons (students) from the service setting (Nursing Education and Research Foundation, 1977, p.8).

Finally, by the time of the opening of the Annual Conference of the New Zealand Nurses' Association in 1979 the Minister of Health was able to confirm governmental commitment to the total transfer of nursing education to technical institutes.

The transfer . . . is now almost 30% complete. The question which remains is not which way, but at what pace the transition is to proceed (New Zealand Nurses' Association, 1980, p.11).

Despite this affirmation, it was not until the mid-1980s that the completion of the transfer of basic nursing education from hospitals into the system of general education seemed to be an achievable reality. By that time the majority of the separate three year programmes offered by hospital schools of nursing had closed or were working towards closure. Increasing numbers of technical institutes were offering the new integrated three year programme leading to registration as a comprehensive nurse.

In these new nursing schools, curricula were designed using the available conceptual frameworks of nursing to

prepare graduates with the knowledge and skills required to function effectively in the changing nursing scene. Of necessity, the absence of proven models meant that teachers were required to develop new ways to interpret nursing for their students as they prepared them for a working life of 'hands on' nursing within a professional nursing service. Nursing wisdom borne of experience, combined with creativity, were the essential attributes of nurse educators until the first curricula they developed for the new situation could be confirmed or rejected by systematic study. From the outset, the expectation was that the nurses who graduated from these new schools with a new broad nursing registration would be able to exercise the individual responsibility and accountability required within a changing nursing work force.

As the first class of comprehensive nurses prepared to commence practice the author, in the role of teacher, described the goal of the programme.

What we have striven to do is to produce a nurse acceptable in the New Zealand setting, able to adjust to the changing pattern of health care delivery, wanting to continue to give patient care after graduation (Christensen, 1976, p.24).

Role of the Registered Nurse in an All-qualified Work Force

The traditional reliance on employee/students to provide much of nursing's work had led to a strongly hierarchical organisational pattern in which nursing was described as a list of tasks and duties. These were distributed among

the members of the nursing team according to the present knowledge and skills level of each person. "Rigid rules and routines [were] established to avoid errors" (Carpenter, 1971, p.18). Much of the work of the less numerous registered nurses was management of the unit and supervision of the unqualified students. Indeed, the author recalls a conversation in 1973 with a final year nursing student in a hospital programme who had stated: "I don't really want to pass my exams because I won't be allowed to be a nurse any more!"

Concern over the consequences of this situation for patients, who were being nursed by students during critical life events, and for registered nurses, who were not able to use their considerable knowledge and skills in bedside nursing, led the Board of Health to conclude that "professional nursing services should be supplied by those qualified to provide such services" (Board of Health, 1974, p.21). This conclusion had already been reached by nurses. For example, a member of the Professional Services Committee of the New Zealand Nurses' Association in 1972 had given her support to a qualified nursing service.

Let the nurse having responsibility for the care of the sick, not be the one under stress of learning the fundamentals of care. Let her be the qualified nurse. Confident that she has been well prepared to practise the skills of this, her chosen career (Burgess, 1972, p.5).

However, the advent of a qualified nursing service was to have considerable implications for nurses and patients. A

new front person, the registered nurse, would be at the patient's bedside - nursing. Thus, the staff in most nursing situations would comprise a collegial group of registered nurses requiring limited supervision. This significant change in the pattern of nursing service led to "an upsurge of interest in the methods of delivering nursing care and in the preparation of nurses" (New Zealand Nurses' Association, 1976, p.8).

In preparation for the arrival of new graduates from student-based comprehensive programmes, nurses within the hospital nursing service "now turned their thinking towards clinical practice" and became "more and more interested in the quality of the service they provide for their clients" (Pitts, 1980, p.3). A system was required that would encourage the fullest application of the nursing knowledge and skills possessed by each registered nurse in the nursing team. Due attention had to be given to ensuring that those nurses who were now to give nursing care would "have the opportunity for the stimulation and satisfaction that goes with intellectual and professional growth" (Shaw, 1974, p.5). There was concern that nursing knowledge had "reached a utilitarian plateau" which would impede "the vital, overflowing and expansive kind of care that brings delight to both the person requiring the nurse's care and the nurse herself" (Salmon, 1982, p.19).

This reciprocal linking of the degree of delight experienced by the nurse with the degree of vitality in

her nursing was timely. However, a 1984 policy statement on nursing education suggested that "preoccupation with the minutiae of daily work" was still preventing "a wider, more constructive and effective nursing approach" (New Zealand Nurses' Association, 1984, p.49). Career satisfaction is largely dependent on the way in which each nurse views, and is helped to view, her 'daily work'. Therefore, it seems essential that nurses who are about to embark on life as a registered nurse have access to at least one research-based theoretical model of nursing which reflects both the potential and the reality of nursing practice. In this way their accumulating nursing knowledge and skill can be maximally utilised and continually challenged so that they will experience personal and professional satisfaction in a 'hands on' nursing role.

Against the background of this dynamic restructuring in New Zealand nursing, there remains a genuine concern that nursing's survival is under threat if its theoretical basis is not enhanced through research.

[There] exists today an unprecedented need for clarification of the uniqueness of nursing practice, lest over-riding forces in contemporary society lead to the disintegration of nursing as a distinct profession (Salmon, 1982, p. 111).

Such unease at the continuing lack of a sound theoretical basis and a facilitating practice environment has continued despite the dramatic changes in nursing education and the organisation of nursing service.

We have reformed nursing education - taken it out of the hospitals into educational institutions, reduced some of the medical domination, revised and revamped curricula, and sweated over philosophies. All were necessary actions, but I'm not sure they are sufficient conditions for nursing to self-actualise (Chick, 1983, p.43).

Theoretical Basis of Nursing Practice

In a dramatic account of her own hospitalisation for major surgery, Johnson, a nurse educator and theorist, suggested that nurses should remember that "our knowledge doesn't necessarily represent the 'whole truth'" (Johnson, 1972, p.133). Even the knowledge base currently available to nurses is considered to lack a "validated" shape that identifies it as an independent profession (Roberts, 1980). At the present time, there is an urgent need to develop a system of nursing knowledge "that will increase the percentage of rational and explained acts in the total repertoire of what the nurse does in nursing" (Kim, 1983, p.119).

Nursing's long history and rich diversity of setting and action leaves little doubt that nursing 'exists', although its theoretical basis is inadequately articulated. This means that practice is derived from experience and tradition rather than being based on research-based nursing theory.

Further discussion on this point will focus on an examination of three relevant issues: nursing's origins in maternal nurturance; nursing as a situation-specific

activity; and the developing theoretical basis of nursing practice.

Nursing's Origins in Maternal Nurturance

There is a linguistic link between nursing and the act of nourishing that assists in understanding the nature of nursing. "The idea of nursing as the suckling of an infant is ancient. Thus, the activity of nursing can be considered as an integral, essential, part of human life and development" (Weatherston, 1979, p.366). By the 19th century the meaning of nursing had broadened to encompass the activities associated with the maintenance of health among family members and their care in times of illness that were almost exclusively performed by the women of the family. At that time Nightingale found it necessary to write "some hints" so that "every woman" would be able to teach herself "how to nurse" (Nightingale, 1859, p.v). However, in this major work she clearly recognised a separate role for a skilled nurse which was distinct from the nursing component within the social role of "every woman".

In the first premise to her science of caring in nursing Watson confirms that nursing arises from the health-related needs of people as they pass through the various developmental phases and circumstances associated with human life in a social group.

Caring (and nursing) has existed in every society. Every society has had some people who have cared for others. A

caring attitude is not transmitted from generation to generation by genes. It is transmitted by the culture of the profession as a unique way of coping with its environment. Nursing has always held a caring stance in regard to other human beings (Watson, 1979, p.8).

The thread of compassion and care, with its emphasis on enhancing the well-being of a child or an ill person, that has its origins in the general nurturing role of mother has been retained, through the efforts of Nightingale and many others, as an essential characteristic of nursing today. But, separation of the role of nurse from the 'natural' female role has not been easy with many people still seeming to believe "that nursing consists of simple tasks which anyone could perform" (Roberts, 1980, p.33).

Although many have devalued nursing in this way, others have acknowledged the historical context and, furthermore, suggested that this association with the concept of nurturant caring actually empowers nursing.

Despite our periodic raillery about the word 'nursing' and the perceived stigma attached to its designation, our occupation is well-named. Nursing is nurturing, nourishing, fostering, caring. Nursing is caring: both the attitude and the activity. . . Nursing is caring for those who need to be nurtured in relation to their health status, wherever, as long and as frequently as they need it, until that need is removed or revised by recovery, independence or death (Styles, 1982, p.230).

These characteristics are highly abstract with both objective and subjective components that are difficult to describe in terminology unique to nursing. Nurse

theorists face the problem of distinguishing between the person-to-person caring in both a "chance kindly act and [a] professional service" (Wiedenbach, 1964, p.20).

Nursing as a Situation-Specific Activity

In the 1950s and 1960s it was common practice for definitions of nursing to focus on the activities undertaken by nurses. Nursing was thought to be definable as a context-free list of what nurses do. An example of this approach was a major study sponsored by the California Nurses' Association in 1953 which identified 439 separate nursing functions. However, in recognition of the rate of change in nursing practice - new procedures, discarding of old ones - the report concluded: "Some will question whether this effort has been worthwhile . . . whether this information will remain timely enough to be useful" (Simmons and Henderson, 1964, p.229-233).

Lists of disparate activities fail to reflect the reality of nursing as it is selectively applied to individual patient situations. In criticising this approach Simmons and Henderson regretted the fact that the "patient appears, for the most part, a passive and background figure, sometimes nearly the forgotten man" (Ibid, p.233). If, instead of focusing only on nursing functions, attention is given to their purpose, there is a critical change in emphasis to involve the exercising of nursing judgement in relation to the status of the

recipient of nursing. The dynamic impact of such situation-specific nursing activity is affirmed by Weatherston.

The nurse who cares for a person paralysed by a stroke, by dressing her and washing her, is not nursing. Nursing would involve helping the person wash and dress herself, if at all possible. . . . Quality of life is valued, thus we help the person regain independence, and help create a sense of well-being (Weatherston, 1979, p.369).

Such a view of nursing accepts that there are a range of activities which are essential to human living. The assumption is made that the 'normal' human state is independence in the performance of these activities. This self-care ability may be influenced by a multitude of internal and external challenges throughout life. Associated with each activity is a range of performance criteria and a point at which the person requires assistance to accomplish the activity. In her wellknown statement on the uniqueness of nursing, Henderson suggests that nursing has a specialised role in decision-making and action related to this aspect of human living.

[The] unique function of the nurse is to assist the individual, sick or well, in performance of those activities contributing to health or its recovery (or peaceful death) that he/she would perform unaided if he/she had the necessary strength, will or knowledge. And to do this in such a way as to help him/her gain independence as rapidly as possible (Henderson, 1966, p.15).

This view that nursing focuses on the ability of the patient to fulfil the requirements of daily living is

shared by others, including theorists King and Orem.

The dynamics of nursing can be described as a constant restructuring of relationships between the nurse and the patient to cope with existential problems and to learn ways of adapting or adjusting to changes in daily activities (King, 1971, p.103).

Health derived or health related limitations for engagement in continuing care of self or care of dependents is the reason why human beings can benefit from nursing (Orem, 1978 tape).

With the focus of nursing moving to the status of the patient, nursing can be clearly perceived as a relationship. To nurse means to be involved with people (MacQueen, 1974, p.12; Gruendeman, Casterton, Hesterly, Minckley and Shetler, 1973, p.30; Toynbee, 1977, p.121). This relationship is characterised by a mutual sharing in which the nurse uses the "special knowledge" called nursing to supplement the patient's present ability (MacQueen, 1974, p.18; Stevens, 1979, p.261; Rubin, 1969, p.44).

Therefore, the relationship the nurse establishes with each patient is significant. Indeed, Peplau believes that this association is ". . . often more telling in the outcome of a patient's problem than are many routine technical procedures" (Peplau, 1952, p.6). Because of her belief that the impact of the person of the nurse on the nurse-patient encounter is underestimated, King gave priority to the person-to-person relationship in her theory (King, 1971; 1978).

As a nurse I am one of the most critical variables in that nursing situation and it is time we recognised our critical variability and how we influence the situation (Ibid, 1978 tape).

Kaperick describes nurses as "people helpers" and goes on to suggest that each nurse has

. . . many tools to work with and yet the most important one is her self. How she uses herself is the key to really helping people. How she lives her life with the patient from the time they are together, be it minutes, hours or days, will determine whether both parties grow as people or whether it was a waste of time (Kaperick, 1971, p.23).

Such descriptions are confirmation that the nurse person is the effective instrument required to translate nursing into action relevant to each patient's situation. Skill in judgement as well as performance are critical factors in achieving an optimal nursing outcome.

Outsiders have not traditionally associated 'thinking' with nurses and nursing. "A good nurse historically has been measured from the neck down: busy hands and busy feet" (Manthey, 1980, p.35). Indeed, the 'good' nurse was one who could model herself on the experienced nurses she learned from and perform the 'tasks' of nursing as she saw them performed. Today's "new emerging culture of nursing" means that "emphasis is being placed on the creative 'thinker' of nursing practice and less emphasis is given to the continuous 'doer'" (Leininger, 1970, p.72-73).

If the need for nurses to undertake situational decision-making within a person-to-person relationship is

recognised, the way is open for the theoretical confirmation of nursing as an independent activity. However, there continues to be difficulty expressing nursing's independence in a way that identifies it as a separate discipline in a collaborative relationship of equality with other health related disciplines, particularly medicine. "For any real improvement to occur, the public must make a distinction between what the physician has to offer and what the nurse has to offer" (Ashley, 1976, p.131). It is this close association with medicine, particularly in the hospital setting, which "has been detrimental in establishing a separate identity for nursing" (Mundinger, 1980, p.8).

Over recent years more and more procedures for patient management - diagnostic, remedial and monitoring - have become available to hospital-based medical care. Many of these, their performance but not the decision-making to prescribe their use, have been delegated to nursing. This occurs primarily because of the nurse's continuing presence with the patient in contrast to the intermittency of medical visits. While some have seen the performance of these as enhancing the status of nursing, this development can be viewed as the antithesis of what nursing needs at this time.

. . . . nurses are being encouraged to undertake more and more medically related tasks such as venepuncture, haemoglobin estimation and first assessment visits. To the extent that they enter the domain of diagnosis and assessment, they are increasing their relative subordination, as there can be no equality of knowledge

and responsibility in medical decision making; . . . Conversely, to the extent that nurses maintain their focus on nursing care and development of expertise, they move away from subordination to doctors and towards professional independence and autonomy (McIntosh and Dingwall, 1978, p.123).

Peplau identified the nurse's perception of her independence in situational decision-making as a key issue in the consolidation of nursing as a separate discipline.

In each situation, the readiness of nurses to think for themselves and to share in the determination of what can be done to meet patient needs, or their readiness to permit others to make all decisions and govern all of their actions, is an important factor in defining nursing and what it can do (Peplau, 1952, p.16).

While it is not valid to charge either nurses or nursing with intellectual subordination, there is considerable potential for nursing to be perceived as being dependent on medicine. This arises from nursing's poorly defined theoretical base; from the conditions under which nurses have been socialised into the profession; and from the perceived lack of control over her own work experienced by the individual nurse. Coser could be speaking of today's surgical ward as well as those of the 1960s when she expressed her belief that the nurse's

. . . own feeling of freedom to make decisions, along with the new philosophy of self-help inherent in post-operative care, encourages her to let patients make as many little decisions about themselves as physical conditions permit. . . . Independent nurses help make independent patients (Coser, 1962, p.144).

The Developing Theoretical Basis of Nursing Practice

The 1960s and 1970s saw the publication of a number of theoretical models which ascribed nursing-relevant dimensions to the patient. For example, Johnson conceptualised the patient as a behavioural system; Rogers as an energy field; Orem as a self-care agency; and Roy as an adaptive system (Johnson, 1968; Rogers, 1970; Orem, 1971; Roy, 1976). These, and other nursing models of the patient, were attempts to conceptualise the human being in a way which would permit the identification of patient states which could be beneficially affected by nursing intervention.

Identification of problem or deficit states associated with a particular theoretical perspective would then allow the nurse to plan nursing actions which could be expected to ameliorate the patient's situation. Nursing could then be viewed as a process. One of the first nurses to speak of the nursing process described it as comprising the interaction of three elements: "(1) the behaviour of the patient, (2) the reaction of the nurse and (3) the nursing actions which are designed for the patient's benefit" (Orlando, 1961, p.36). Gradually, however, the innumerable interpretations of the nursing process came to be assigned steps which closely linked it with problem solving activities performed by the nurse, or the scientific method: data gathering; diagnosing; planning; implementing; evaluating (e.g. Yura and Walsh, 1973; Zimmerman and Blainey, 1970; Carrieri and Sitzman, 1971;

American Nurses' Association, 1973; New Zealand Nurses' Association, 1981).

The linking of a conceptual model of the patient with the problem-solving method known as the nursing process led to an extension in descriptions of nursing. Now there was a way of identifying when nursing was needed and a format for translating the interpretation into a planned nursing response. This theoretical control over decision-making in relation to patient care was seen as having the potential for elevating nursing to the status of an independent discipline.

The nursing process enables a nurse to realise her potential as an independent decision-maker who has command over competencies which heretofore were not used in carrying out predominantly assistance-type functions (Mauksch and David, 1974, p.3).

When situational decision-making is identified as a characteristic component of nursing theory, it requires each nurse to develop a strong personal nursing identity. She is ascribed the responsibility for maintaining the currency of her nursing knowledge and skills to provide a valid theoretical basis from which to select appropriate nursing strategies for application in individual nursing situations.

Judgement is personal in character; it will be exercised by the nurse according to how clearly she envisions the purpose to be served, how available relevant knowledge is to her at the time, and how she reacts to prevailing circumstances such as time, setting and individuals (Wiedenbach, 1964, p.27).

There is evidence that "the public image of nursing is gradually changing from the traditional 'bed-pan servant' to an intellectual nurse with diverse skills and talents" (Leininger, 1970, p.73). This infusion of a theoretical basis into nursing practice is associated with an increasing recognition that nursing theories need to include recognition of nursing's concern with the patient's 'immediate present' (Rubin, 1969, p.44; Greene, 1979, p.62; Stevens, 1979, p.262).

Nursing time is essentially the 'now'. It is the actual moment or period, day or night, when the nurse is in contact with her patient The nurse's area of responsibility makes her focus not only on the physical immediacy of the patient but also on his immediate conceptions (Wiedenbach 1964, p.15).

Continuity and immediacy are very difficult ideas to convey in a theory. Some recent attempts at theorizing have attempted to meet this challenge by the use of gerundial form for concepts (Roper, Logan and Tierney, 1980; Parse, 1981). At the Fifth National Conference in 1982 Roy reported on a theoretical framework developed by a group of nurse theorists which included nine conceptualised patterns of human functioning using the gerundial form: "Exchanging; communicating; relating; valuing; choosing; moving; perceiving; knowing; and feeling" (Roy, 1984, p. 28).

This present, continuous focus in nursing is consistent with the concept of nursing's purpose as assisting a person through the whole of a health-related event by

assisting them through the many moments which comprise the experience. Nursing requires a theoretical shape that encourages its practitioners to harness the full repertoire of nursing's knowledge and skills in each patient encounter while remaining sensitive to its relevance in the context of the patient's total nursing-relevant experience.

The Experience of Hospitalisation

The hospital can be viewed as a place characterised by the inevitable presence of tension, of role conflict, and of culture clash between the nurse and the patient (Congalton and Najman, 1971; Taylor, 1970). It is also commonly perceived as a place of fear of the known and the unknown, with the consequent distress even posing a potential challenge to the health of the person who becomes a patient (Salmond, Powell, Gray and Barrington, 1977, p.45).

If, as suggested by Taylor, "a hospital is designed to care for sick persons while cures are attempted", then both fear and hope are associated with becoming a patient in hospital (Taylor, 1970, p.7). Paradoxically, there may be circumstances when hospitalisation, and even surgery, are welcomed by the patient.

Having had to cope with very debilitating symptoms, such as acute gallbladder spasms, the patient is happy to be in the hospital even though he is anxious to some degree. He is grateful that that he will soon be relieved of his aggravating symptoms (Gruendemann et al., 1973, p.13).

Most people still regard it as an experience to be avoided.

Nobody likes to enter the hospital, even if its going to make him better, and we all know why. Checking into a hospital means putting your trust in strangers, in an alien place (Gots and Kaufman, 1978, p.1).

Hospital staff and patients necessarily view the hospital from different perspectives. For the hospital staff it is their place of work "where the crises of patients and their families form the basis of everyday routines"; for the patient it may be a matter of life and death (Rosenthal, Marshall, Macpherson and French, 1980, p.13). Indeed, the perspectives are so different that a nurse may not find her nursing knowledge of real value if she changes her role and becomes a patient herself (Johnson, 1972, p.133).

In the setting for this study the hospital becomes the patient's temporary home while he undergoes surgery. He leaves his familiar surroundings and withdraws from full expression of his usual social roles. On admission he enters into a number of new relationships including that of patient to the nursing staff but the upcoming surgery, and thus his role as patient to the surgeon, has pre-eminence. "In the eyes of the patient all other activities are naturally subordinate to this primary purpose" (White, 1972, p.12).

Despite the primacy of the surgery, and therefore the surgeon, it is possible to argue that admission to

hospital is actually necessitated primarily by the need for nursing care during the medical intervention and its consequences (McClure and Nelson, 1982, p.59). In this view, discharge would then be a consequence of nursing no longer being required although this decision usually remains clearly in the control of medical staff.

Dependency is a state often associated with the role of hospital patient, particularly when the admission is for surgery. Customary autonomy is temporarily forfeited as the patient recognises his dependence on the expertise of others and "hands over to other people the right to make decisions about his body" (Levitt, 1975, p.498; Taylor, 1982, p.209). This willingness to relinquish control and trust another person because of their specialised knowledge is not, according to Remen, an unusual event.

In times of specific need we frequently choose to trust others whose training and expertise prepare them to act on our behalf better than we might be able to ourselves, given the circumstances. We form many relationships in this way; with lawyers, architects, accountants, electricians and many others, physicians and nurses among them. Forming such relationships is a responsible choice, a legitimate means of acting to get our needs met (Remen, 1980, p.215).

Acceptance that this willingness to trust an expert is a common occurrence in a society with a large number of specialised roles, permits consideration of the proposition that, in such circumstances, the patient's role would be more appropriately perceived as a complex one with co-existing elements of autonomy and dependency.

This leads to the possibility that the patient possesses an expertise which is the counterbalance to the patient's dependency on the expertise of others. Such a view is illustrated by the following two quotations - from a nurse and then a doctor.

The patient is unequal to the nurse in ability to make generalized professional judgements. On the other hand, the patient is also an expert in something: he is an expert in knowing his own body, his own responses and experiences. He is an expert in the particularization that is himself (Stevens, 1979, p.260).

Professional and patient bring with them into the setting of illness two different sorts of information which are relevant to the task at hand. Both need to be willing to educate and be educated by the other, as neither can take responsibility for doing his or her part in the recovery of health without the information which the other has (Remen, 1980, p.216).

In the considerable literature on the role of the patient in hospital a valuable insight is gained from the personal reflections of people who have been recently in the role. One nurse spoke of the difficulty she experienced in becoming a patient and even found herself withholding significant information, particularly her feelings and reactions, from the staff, thus she did not always get appropriate nursing assistance (Johnson, 1972, p.127). From the experiences of 200 patients, Levitt discovered that "widespread humour and tolerance" were often facades used to avoid "such feelings as anxiety, fear or depression" (Levitt, 1975, p.497). In a study of patients who have survived a severe illness, Smith found that the external demeanour of patients may not reflect what is

going on inside.

A person who is attractively dressed in robe and slippers, surrounded by flowers and cards, may give the impression of requiring little from the nurses. One can be anxious and lonely among the flowers; one can be ill-informed about self-care though surrounded by greeting cards (Smith, 1981, p.89).

An insight into how nurses can gain access to the patient's real feelings comes from Johnson's belief that she wanted a nurse with whom she "felt comfortable" before she would be willing to share herself, even in the presence of troublesome feelings (Johnson, 1972, p.132). A high level of competency in, and appropriate use of, nursing skills are also highly valued by patients and, thus, engender trust and comfort (Ibid, p.132; Taylor, 1970, p.65).

Finally, in a study of the value placed on specific nursing activities by nurse and patients, White found that patients gave priority to skills related to "personal hygiene and physical comfort", and only valued the nurses' work in the here-and-now circumstances associated with the hospital experience. She concluded that

. . . for most patients, hospitalisation is but a brief moment in a lifetime . . . Instead of talking so globally about meeting patient's needs nurses should concentrate on the things they really can do to make illness in the hospital a more tolerable experience (White, 1972, p.12).

The literature on the meaning of hospital for patients raises a number of issues relevant to this research study.

There are constant reminders that each patient's experience is a personal one and a nursing-relevant theoretical perspective must allow for the expression of that perplexing, and challenging, individuality.

Hospitalisation may be experienced as lonely or boring for some, and busy, interesting and curious for others. It may mean a loss of identity, or a feeling of worth (Wu, 1973, p.70).

Summary

In this chapter selections from the extensive nursing and related literature have been used to discuss the context of the study. Changes in nursing education and nursing service in New Zealand since 1970, current theoretical concepts about nursing practice, and aspects of the meaning of hospitalisation for the patient have all been described. Both the literature and the researcher's experience sensitised her to the field before and during the study. However, the theoretical outcome emerged from the data although its links to nursing's heritage are apparent.

Chapter 2 will discuss the decision to use a qualitative research method. This will be followed by an introduction to the particular method chosen for this study.

CHAPTER 2

THE RESEARCH METHOD

In this chapter selected references from the literature will be used to discuss the value of using a qualitative method to study nursing. Following this, the particular method chosen for this study, namely grounded theory, will be introduced. A brief criticism of this research approach is included.

Introduction

Over recent years there has been increasing interest in the use of qualitative research methods to study nursing. Justification for this approach can take the form of criticism of quantitative methods and/or espousal of the cause of qualitative methodology. Elements of both approaches will be apparent in the discussion that follows. However, the advocacy for qualitative field research, and the grounded theory method in particular, will be limited to its appropriateness for this study and the resolution of the questions with which the researcher was concerned. Thus the value of the approach has been emphasised and an effort has been made to avoid

involvement in the general area of criticism of methodologies which has become a "well-established form of professional recreation" (Hill, 1970, p.16).

This study was planned to be an exploration of nursing in the hospital setting. There would be no manipulation of events, no experimentation, and no predetermined hypotheses. Rather, the researcher planned to enter the natural setting ready to observe and to attach meaning to what happens when a patient is being nursed through the experience of planned surgery.

. . . to discover the elusive, vague, and still largely unexplored nature of human care necessitates exquisite participant observations, interviews, documentations, and other research skills and techniques mainly associated with qualitative types of research (Leininger, 1985, p.xi).

All of these strategies were used to gather data from the experiences of patients and nurses as they interact in "the private, intimate world of human care" (Watson, 1985b, p.345). The question to be posed in this field was: What is happening here? Such a question involves the researcher fully in the process of data gathering and analysis and the consequent induction of a meaningful interpretation of what is happening. The grounded theory approach to the discovery of theory was chosen as the most suitable method for this field research.

The following discussion on the research methodology has been organised under three headings: i) qualitative research in nursing; ii) the nurse as researcher; and

iii) the grounded theory method.

Qualitative Research In Nursing

Qualitative research permits the researcher to explore a problem area in its natural setting. Support for the use of a qualitative method suggests it allows the researcher to "move close to a social setting and bring back an accurate picture of patterns and phenomenological reality as they are experienced by human beings in social capacities" (Lofland, 1971, p.59).

Nursing is concerned with "the dynamic whole that is a human being with whom the nurse interacts in practice" (Omery, 1983, p.49). There is a recognition that multiple and complex phenomena are operating in the transaction between nurse and patient. Identification and description of each are possible but their interrelatedness is an essential component of a theoretical representation of the reality of nursing.

Further support for the consistency between a qualitative approach and the focus of concern of nursing comes from Tinkle and Beaton.

At its most basic level, nursing is a relational profession. It exists by virtue of its commitment to provide care to others. If the concerns and perceptions of the recipients of nursing services are considered unimportant factors in nursing research, then nurses may indeed be providing nursing care that is more meaningful to themselves than to patients (Tinkle and Beaton, 1983, p.31).

This view is shared by Munhall when she proposes that

. . . qualitative research methods, particularly in theory development, may be more consistent with nursing's stated philosophical beliefs in which subjectivity, shared experience, shared language, interrelatedness, human interpretation, and reality as experienced rather than contrived are considered (Munhall, 1982, p.178).

The final example of support for a qualitative approach to be introduced here comes from Swanson and Chenitz who, after defining qualitative research as "a systematic study of the world of everyday experience", go on to state:

Qualitative research provides a way to construct meaning that is more reflective of the world of practice because its methodology, like its subject, is more organic than mechanistic and, therefore, more suitable to the domain of professional nursing. Scientific discovery in nursing will come with the generation of theory that explains client situations from a perspective that is uniquely our own. Qualitative research provides avenues for these discoveries (Swanson and Chenitz, 1982, p.245).

With the goal of the research being the discovery of new insights, the outcome is uncertain during much of the process. The researcher must remain open to the significance of the data despite the possibility of moments of panic when facing masses of data with no outcome in sight. The presence and validity of such a feeling is confirmed by Deutscher.

It is scary because the research outcomes are unpredictable. The nightmare of every qualitative researcher, novice or experienced, is 'What if I don't find

anything?' The fact that one is always able to find something because there is always something there is not reassuring (Deutscher, 1975, p.vi).

However, two previous experiences of fieldwork using qualitative methodologies had prepared the researcher for the challenges inherent in the use of such a research approach (Christensen 1971; 1972). In depth analysis of the nursing literature reaffirmed the value of using a discovery method to answer the broad research question - What is happening here?

The Nurse as Researcher

The use of a qualitative method involves entry into the field to gather data on the experiences of people as they occur. Therefore, the researcher becomes a participant and does have an impact on people and events. The degree of influence depends on the extent and type of participation by the researcher in the field. Four distinct roles, each of which is characterised by a different mix of observation and participation, have been suggested by Junker and these can be summarised as follows:

1. Complete Participant - here the researcher becomes a complete member of the group under study and observational activities are completely concealed from the members of the group.
2. Participant as Observer - the researcher does not totally conceal observation activities, but such activities are subordinated to participation activities which give the researcher entry to the field.

3. Observer as Participant - the observation activities are publicly known from the beginning and sanctioned by those in the field, giving the researcher access to the field but perhaps influencing the 'openness' of members in giving information to the researcher.
4. Complete Observer - an almost imaginary role in which the researcher has complete freedom to observe without any influence on the activities or group under study (Junker, 1960, p.35-38).

In this study the role adopted by the researcher was primarily that of 'observer as participant'. There was full disclosure to all concerned that a research project was underway and that the researcher was a nurse herself. As a nurse, the researcher was familiar with the setting. In this respect the nature of the research is different from that in which a social scientist enters a field with which he has had no previous experience.

Nursing needs nurses as researchers in order to ask and investigate the questions of significance to the profession (Schlotfeldt, 1972, p.484). However, the role of nurse researcher in a field study is not an easy one.

. . . being a nurse and a researcher can present difficulties, especially when the researcher explores nursing problems by participant-observation. How does the nurse researcher live with both halves of her hyphenated self as she studies practice in the only place it can be studied, the field of practice? (McBride, Diers and Schmidt, 1970, p.1256)

On the one hand the nurse researcher may avoid the "'culture shock' experienced by a non-nurse on entry to the field" and may be "sensitive to certain aspects of nursing behaviour which a non-nurse may not notice"

(Byerly, 1976, p.148). Conversely, the nurse's professional orientation may confine her 'openness' to what is happening as she interprets events and the data within an a priori framework. In addition, the researcher's nursing experience may lead to her being used by subjects as a "source of advice on how to solve problems", "a sounding board, and sometimes as an object of catharsis" (Ibid, p.149). Despite potential difficulties, advocates for increasing the use of qualitative research in nursing, suggest that the nurse researcher should acknowledge the value of the joint role and, indeed, use it to enhance the quality of the research (Quint, 1969; Fagerhaugh and Strauss, 1977).

Entry into the field to collect data does mean that the researcher becomes involved in the everyday life of the people involved. Relationships develop between the researcher and the people in the setting which will influence the study. According to Zigarmi and Zigarmi, both subject and researcher can feel the unidirectionality of the relationship if the researcher is "always taking" and the subject "always giving" (Zigarmi and Zigarmi, 1979, p.26). The subjects will be interested in the research activities and, therefore, it is important for the researcher to accept the responsibility of reciprocating on a person-to-person basis (Wax, 1960, p.93). As a nurse, the researcher is able to establish a relationship with both patients and nurses which will not only preserve the humanity of the encounter but may also contribute to the success of the research.

The major instrument for the collection of data is the investigator himself. Thus, the successful employment of the method of participant-observation is predicated by one's ability to establish rapport and relationships of mutual trust and respect with his informants (Ragucci, 1972, p.487).

Initially, there may be some uncertainty in the mind of a researcher concerning the issues of objectivity and bias arising from the participant-observer role combined with the role as nurse. Such inner uncertainty may be fuelled by comments from others who, according to Agar, will seek to understand the research in the light of the traditional quantitative perspective by asking such questions as: "What's your hypothesis?" "What's the independent variable?" "How can you generalise with such a small sample?" (Agar 1986, p.70) Zigarmi and Zigarmi agree that this can be a real cause for concern to the researcher who is seeking to use the processes of discovery to attach meaning to the activities occurring within a particular social setting, such as nursing.

The pressure the ethnographer experiences to do good, credible research, is felt throughout the time it takes to do the study. . . In part, the dilemma the ethnographer experiences stems from wanting to do a credible, significant study, yet doubting his/her ability to contend with the constraints and limitations of a qualitative research methodology and to cope with problems related to bias, influence and sampling (Zigarmi and Zigarmi, 1979, p.32).

However, Lofland offers a word of advice on this issue: ". . . in doing a qualitative study, do not try frontally to play the quantitative game. The games are different"

(Lofland, 1971, p.62). Not only is the researcher who uses a qualitative method acting according to a different set of rules, but the field role of 'observer as participant' gives the researcher increased opportunities for gaining insights and attaching meaning to events.

Because the researcher is involved, a range of modes of awareness can be used in data collection. Empathic and intuitive awareness, for example, are deliberately and purposefully employed (Oiler, 1982, p.179).

The research problem as stated - What is happening here? - required a methodology that would permit examination of the complex multivariate phenomenon of nursing in action in its natural setting. Having explored the issues associated with the conduct of qualitative research as a nurse researcher and accepting the appropriateness of this approach for this study, the next step was to identify the particular methodology to be used in the study.

The Grounded Theory Method

Glaser and Strauss formulated their methodology for the discovery of theory from the systematic collection and analysis of data in 1967. The method arose from their own experiences doing fieldwork among dying people. In the intervening years a literature has developed in amplification and support of the method. Some of this is used to support the following introduction to the grounded theory approach.

Grounded theory "has rules and procedures which, if

carefully followed, produce an analysis of a social context which has both accuracy and applicability" (Stern, 1980, p.23). This discussion will focus on these 'rules and procedures' - as they have been developed by Glaser and Strauss. However, the originators of the method are sure that theirs is not the definitive statement. In their major exposition of the method they state:

And so we offer this book, which we conceive as a beginning venture in the development of improved methods for discovering grounded theory (Glaser and Strauss, 1967, p.1).

Glaser confirms this openness to modification and extension of the method in his later work when he recounts the experiences others have had with the method since 1967.

Others have done more by trying to take grounded theory in a new direction. This latter was a goal of ours in *Discovery* when we affirmed that the book was for openers, and that others could take the method in any direction they wished (Glaser, 1978, p.158).

He goes on to identify the common aspirations of non-sociologist researchers who have used the method.

All had wanted to discover what the problem is, what processes account for its solution and have tried to get away from the preconceiving nature of other methodologies, where hypotheses are derived from literature and then experimented upon, verified and/or surveyed. . . . More and more people wish to discover what is going on, rather than assuming what should be going on, as required in preconceived type research (Ibid, p.158-9).

The method, as developed to date, had appeal for several reasons. First of all, the strategies have been documented as a step-by-step process that gives the novice considerable assistance during a very complex process. Second, it supports the researcher seeking to generate theory in a situation where there is a dearth of theory, as in nursing practice. Third, the approach can be viewed as a liberating experience that gives the researcher freedom to be fully involved in creative research and theory-building guided by a facilitating approach which supports modification and extension of its processes.

Discussion of the research approach has been organised into five sections: formulation of the research problem; generation of a grounded theory; use of literature; criticism of the method; and use of the method in this study. Of necessity, this discussion is brief. For an indepth explanation the reader is referred to Glaser and Strauss (1967) and Glaser (1978).

Glaser and Strauss consistently use the term 'theory' or 'grounded theory' to refer to the outcome of a study using their method. While this term is retained in the discussion, the Nursed Passage at its present stage of development is more accurately referred to as a conceptual or theoretical framework.

Formulation of the Research Problem

In the grounded theory approach the researcher has an identified general area of concern which requires

investigation. The goal is to build a theoretical analysis of the data which will at least describe, but may also explain what is happening and even have a predictive quality.

To date, . . . the grounded theory approach has been used primarily to develop rich substantive analyses. A theoretical analysis at the substantive level, though more modest in scope and power than formal theory, gives the analyst tools for explaining his or her data as well as tools for making predictions (Charmaz, 1983, p. 126).

Within the method there is no "preconceived framework of concepts and hypotheses" to prescribe the specific data for collection (Glaser, 1978, p.44). Rather, the "grounded theory study is done to produce abstract concepts and propositions about the relationships between them" (Chenitz and Swanson, 1986, p.8). When the researcher is a nurse rather than a sociologist, the problem to be investigated represents an area of professional concern to the researcher in her role of nurse.

This nursing perspective on the problem for investigation is a legitimate extension of the grounded theory method which advocates "complete openness" to the data (Glaser, 1978, p.158). Stern gives support by asserting that the "strongest case for the use of grounded theory is in investigations of relatively uncharted waters, or to gain a fresh perspective in a familiar situation" (Stern, 1980, p.20).

Generation of a Grounded Theory

A key aspect of the grounded theory method is the interrelationship between the collection, coding and analysis of data. Theoretical sampling, the label assigned to this complex process, is the

. . . data collection for generating theory whereby the analyst jointly collects, codes, and analyses his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges (Glaser and Strauss, 1967, p.45).

During the period preceding entry into the field the researcher makes initial decisions on the kind of data to be collected. Many kinds of data are considered relevant and such activities as interviewing, observing and reading documents may proceed simultaneously. Concurrent analysis of the early data may lead to decisions to collect additional data using any method appropriate in the setting.

Different kinds of data give the analyst different views or vantage points from which to understand a category and to develop its properties; these different views we have called slices of data (Ibid, 1967, p.65).

Coding and memoing are two key activities in theoretical sampling, with both commencing as soon as data collection begins. Soon after it has been collected the field data is analysed line by line in an attempt to understand what is happening.

Two different types of coding are used: substantive and

theoretical (Glaser, 1978). Substantive coding attempts to capture in conceptual form the substance of the data gathered from the field. As the data are analysed line by line the analyst attempts to look at it from every angle. It is a process of breaking the data down into meaningful conceptual units which seem, according to the intuition and insights of the researcher, to explain what is happening in the data. No assumptions are made that any variables are significant until they emerge from the data as meaningful codes. The labels assigned to the codes arise from the within the data, and often use the actual words of informants.

Theoretical coding, the second form, refers to the conceptualization of the relationship between the substantive codes to form an integrated theoretical representation of the data. "They, like substantive codes, are emergent; they weave the fractured story back together again" (Ibid, p.72). Although several theoretical codes may fit the same data, Glaser advises the analyst, in any one work, to focus on the development of only one integrative pattern - usually a process - to explain what is happening.

Since the theory must be grounded, verifying its fit and relevance requires patience in going over and over the data to be sure it works with ease, before a secure investment is taken in selective coding for a focus or a core variable (Ibid, p.61).

Memoing is an important activity associated with coding. As the researcher proceeds with the coding activity, paper

and/or tape recorder are always nearby in readiness of the immediate recording of ideas.

Memos are the theorizing write-up of ideas about codes and their relationships as they strike the analyst while coding. Memos lead, naturally, to abstraction or ideation. Memoing is a constant process that begins when first coding data, and continues through reading memos or literature, sorting and writing papers or monograph to the very end. Memo-writing continually captures the 'frontier of the analyst's thinking' as he goes through either his data, codes, sorts and writes. . . . The four basic goals in memoing are to theoretically develop ideas (codes), with complete freedom into a memo fund, that is highly sortable (Ibid, p.83).

As the data are closely examined, coded and analysed, any ideas that strike the analyst about the data, codes, relationships, concepts, and experiences within and outside the current research are recorded, separate from the data, and kept for regular referral and sorting. Glaser and Strauss view this process of thinking and reflecting on the data and the categories as they emerge during coding as of fundamental importance because the "root sources of all significant theorizing are the sensitive insights of the observer himself" (Glaser and Strauss, 1967, p.251). They propose a rule to be followed in the case of a flash of insight: "Stop coding and record a memo on your ideas" (Ibid, p.107).

Collection of data stops when the researcher finds that similar data are being collected over and over again so that there is no further development of the theoretical categories and their properties which are being generated

from the data (Ibid, p.61). This process, labelled theoretical saturation, indicates that the analysis is yielding a perspective on the data from which a theory can be generated.

At the beginning, there is more collection than coding and analysis; the balance then gradually changes until near the end when the research involves more analysis, with brief collection and coding for picking up loose ends (Ibid, p.72).

In addition to theoretical sampling, a second concurrent process is essential to the generation of a grounded theory. Glaser and Strauss have called this the constant comparative method (Ibid, p.101-115). Each code is compared with the coding of previous similar incidents. Memos are sorted, codes are grouped and, eventually, a core integrating category or social process will emerge which seems to explain the data. As the process of theoretical saturation occurs at the level of the coding, and the properties of the core integrating category or process become stabilised, the grounded theory begins to take shape.

According to the method, the emerging theory is ready for sharing when it "explains, with the fewest possible concepts, and the greatest possible scope, as much variation as possible in the behaviour and problem under study" (Glaser, 1978, p.125). At this point the theoretical outcome is tested by sharing it with the subject group.

The final test of accuracy comes from the subject group. If a theory fits, mouths drop open, eyes light up, and the audience, grasping the idea, fairly shouts its acceptance. 'That's it,' they say, 'that's just the way it is!' Or they may say, 'Oh of course' as in, 'Of course, who doesn't know that' (Stern, Allen and Moxley, 1984, p.376).

Glaser articulates a similar view but extends the test to a requirement that the people in the area of the study should see the grounded theory as "useful" because it "gives traction over action; it makes sense, by making theoretical sense of common sense" (Glaser, 1978, p.14).

Use of Literature in the Grounded Theory Method

Literature has a limited place in the grounded theory approach. Glaser and Strauss argue that a field study may be distorted by the widespread consultation of literature. They emphasise the power of literature in their argument that the library itself can be a rich source of data for the induction of theory.

When someone stands in the library stacks, he is, metaphorically, surrounded by voices begging to be heard. . . . people converse, announce positions, argue with a range of eloquence, and describe events or scenes in ways entirely comparable to what is seen and heard during field work (Glaser and Strauss, 1967, p.163).

These powerful voices speaking from literature are viewed with considerable caution. It is argued that an indepth literature review of the research problem may lead to an intrusion of concepts from the literature and a biased perspective on the collection and analysis of field data

that may prove to be a barrier to openness and discovery in the mind of the researcher (Glaser, 1978, p.31-32). The fear is that rich emergent categories will fail to be recognised and developed in favour of borrowed categories which have a poor and/or limited fit with the data.

An effective strategy is, at first, literally to ignore the literature of theory and fact on the area under study, in order to assure that the emergence of categories will not be contaminated by concepts more suited to different areas (Glaser and Strauss, 1967, p.37).

In her defence of the grounded theory method Charmaz contends that researchers can use the relevant literature appropriately "to expand and clarify the codes and to sensitize themselves to ways of exploring the emerging analysis" (Charmaz, 1983, p.117).

It is significant that Glaser and Strauss were primarily advocating the use of their method to sociologists. The tabula rasa ideal cannot be applied to researchers examining their own arena of professional practice. A nurse researcher cannot pretend that there is no background of experience and knowledge, as well as some familiarity with the literature and the nursing setting, to influence the research conduct and outcomes. This role has already been examined and the claim made that this dual role is a viable one that can be exercised in a study using the grounded theory approach. Therefore, the researcher who is a nurse, while always remaining 'grounded' in the field data and using this as the primary source for the emergent theory, will also acknowledge that

the study is 'grounded' within current nursing theory and knowledge.

Criticism of the Grounded Theory Method

Glaser and Strauss admit to using "frank polemic" in their presentation of the strategies of the grounded theory method, which was their response to the prevailing climate of opinion on the development of sociological theory in the 1960s (Glaser and Strauss, 1967, p.259). This enthusiastic advocacy of the method is continued by Glaser (1978) and is present in their other publications (Glaser and Strauss 1968, 1971; Fagerhaugh and Strauss 1977; Strauss and Glaser 1977). Since its inception the grounded theory method has been subject to criticism, usually by those who espouse another methodological approach. Several examples will be presented together with comments arising from the experience of its use in this study.

Oiler, defending the phenomenological approach, takes grounded theory to task for its assumption that there will be a discoverable process in the data (Oiler, 1983). Similarly, an advocate of the method has identified two potential pitfalls in its use: premature closure and failing to find a core variable to integrate the analysis (Wilson, 1985, p.423). She suggests the former often comes about when time constraints associated with deadlines lead to an end "to theoretical sampling and coding before the full range and variation for codes and

categories have been discovered" (Ibid, p.423). The latter leaves the researcher wondering "how to salvage the study" but a descriptive report is always an option (Ibid, p.423). In this study, both 'pitfalls' were experienced but time, effort, increasing familiarity with the method, and systematic analysis and re-analysis of the data associated with many creative insights, ultimately led to an integrated theoretical outcome. The researcher's experience confirmed the need to clearly understand the method in order to ensure the investigator is not left with "mountains of data" with no sense of direction (Simms, 1981, p.359).

In a paper dealing with the problem of rigour in qualitative research in nursing, Sandelowski speaks of the potential hazards associated with involvement with activities and personnel in the field that await a nurse as researcher.

The researcher in qualitative inquiry is more likely to have direct access to subject's experience, but may also be unable to maintain the distance from those experiences required to describe or interpret them in a meaningful way (Sandelowski, 1986, p.31).

Each researcher requires considerable wisdom to maintain an appropriate degree of detached closeness, as distinct from total objectivity, in any field study using participant observation. Glaser and Strauss give emphasis to the difficulty in their call for the field researcher to be "sufficiently immersed in the world to know it", but to have "retained enough detachment to think theoretically

about what he has seen and lived through" (Glaser and Strauss, 1965, p.7). This involvement is clearly carried through into the development of theory which, they contend, emerges from the analyst's perceptions, personal experiences, and "hard-won analyses" (Ibid, p.6). Thus, the generation of theory from field data requires the creative but measured involvement of the researcher through all stages. The grounded theory method openly challenges those who suggest that complete objectivity is possible in any study involving the actions and thinking of a person occupying the role of researcher.

The root sources of all significant theorizing is the sensitive insights of the observer himself. . . .the researcher can get - and cultivate - crucial insights not only through his research (and from his research) but from his own personal experiences prior to or outside it (Glaser and Strauss, 1967, p.251-2).

. . . the so-called 'emergence of categories' involves a complex interplay between 'what's going on out there' and 'what's going on inside' the researcher's head (Fagerhaugh and Strauss 1977, p.311).

While grounded theory is considered to be a qualitative methodology, both qualitative and quantitative data, indeed any data, can be used to develop a grounded theory (Glaser and Strauss, 1967). Thus, the criticism of the data used to generate the theory will primarily be specific to each study rather than to the method itself. However, the grounded theory approach is clearly considered a qualitative approach in the controversy between quantitative and qualitative research strategies.

Graphic criticism of the method comes from Ford who questions the ability of the researcher to capture 'reality' in a grounded theory.

Those RABBITS [scientists] are horribly mistaken who rely upon so-called procedures of induction . . . for the discovery of 'true' theories. These methods can lead no one to discover anything. . . . he has 'discovered' nothing; what he has done is to link observations together in a haphazard way and then invented a FAIRY TALE [connection of ideas in the form of an explanatory story, or theory] to explain them (Ford, 1975, p.139-140).

Glaser and Strauss defend the inductive mode of theory generation and counter such criticism by asserting that "discovery cannot be stopped, but breaks through both verifications and preconceived conceptual schemes" although it is often not developed in such circumstances (Glaser and Strauss, 1967, p.185). Critics are also answered, if not satisfied, by the method's "final test of accuracy" - the ability of those in the field to identify their reality with the grounded theory emerging from the research process (Stern et al., 1984, p.376).

The qualitative/quantitative controversy has a large literature and cannot be covered adequately in a study such as this. Nor can attention be given to the related debate on the issues of validity, reliability and bias in field work, participant observation, and case studies. However, the conflicting perspectives are acknowledged and the decision to use a qualitative approach for this study was made with an awareness of the arguments for and

against the method. Indeed, interest in using a qualitative approach in general, and the grounded theory approach in particular, was fuelled by the controversy!

Finally, it is necessary to justify the description of the research outcome as a grounded theory in the face of potential criticism. According to its originators, a grounded theory may be either "discussional" - systematic description of concepts - or "propositional" - presentation of a set of propositional statements (Glaser and Strauss, 1967, p.115). In both cases they refer to a group of emergent conceptual categories organised within an integrating framework. Glaser and Strauss consider the discussional type is "often sufficiently useful at the exploratory stage of theory development" but can, if required, be further developed into the propositional form (Ibid, p.115). Thus, grounded theories may vary considerably in their degree of development.

This argument in support of the use of the term 'theory' to describe the discussional form will not be convincing for readers who hold a more traditional definition of theory or who have no personal experience with the methodology. Consequently, the description of the Nursed Passage as a grounded theory will be open to criticism. However, it does meet the criteria for labelling as a grounded theory of the discussional type. Conceptual categories have been generated; a framework which fits the data has been used to integrate the concepts; statements have been made to claim the existence of both the

categories and their placement within the overall framework. It is a theory that describes the various elements within the process of giving and receiving nursing. As yet, it lacks propositional statements which posit formal relationships, particularly of cause and effect and prediction.

Consideration of some of the perplexingly confusing nursing literature on theory, conceptual models, theoretical models and frameworks fails to yield a universally acceptable alternative label for the Nursed Passage (Dickoff, James and Wiedenbach, 1968; National League for Nursing, 1978; Stevens, 1979; Riehl and Roy, 1974; Chinn and Jacobs, 1983; Walker and Avant, 1983; Fawcett, 1984; Meleis, 1985). Following a similar investigation, Meleis decided to "relegate most of the differences to semantics" and concluded that "the final choice of label is a personal matter", although the term "'theory' is sufficient to describe the conceptualisations that have been proposed by our theorists" (Meleis, 1985, p.96).

After considerable reflection, the decision was made to acknowledge the terminology of the method - 'grounded theory' - while accepting that the Nursed Passage is a theory still in the process of development. At this stage it is closely related to a theoretical or conceptual framework when this is defined as a network of interrelated concepts representing an abstraction induced from reality. Support for this interpretation comes from

Glaser and Strauss themselves who use the terms "analytical framework" and "theoretical framework" in their discussion of an emergent grounded theory (Glaser and Strauss, 1965, p.6). Therefore, using this precedent, the terms 'theoretical framework' or 'conceptual framework' as defined will be used synonymously to describe the outcome of this study.

Using the Grounded Theory Method

In retrospect, the method was appropriate for the study and its use was continually challenging, although the experience was prolonged with many moments of frustration approaching despair.

The process of theoretical sampling - concurrent data collection, coding and analysis - was difficult to sustain. Initially all went well. Eventually, a judgement was made that the case studies being collected were showing a sameness that seemed to indicate that little new information was being collected. In addition, the time available for data collection was drawing to a close. When the fieldwork ended multiple codes had been identified by the process of line-by-line substantive coding, but an integrating concept was not yet evident.

After the conclusion of data collection, the data were worked over and over again during the process of analysis. Connections were sought between events, between subjects, between codes. The search for meaning in the data continued as an interplay between the general and the

particular as ideas for integrating a variety of concepts were tested and discarded. Finally, an integrating social process emerged that synthesised the codes into an integrated theoretical interpretation of the data. Confirmation for the evolving theoretical framework and its constituent concepts was found within the data.

Discovery of this framework required far more time and effort than anticipated. There is no doubt that, "as with any research methodology, the living process is less orderly than its written description" (Stern, 1980, p.23). The amount of data was extremely large and required the development of a management system to control it. Transcription of the taped field data took many months. Once an integrating category was identified, a re-analysis of the total data was undertaken with the focus now on validating each constituent category within the emerging theoretical framework. Confidence in the grounded theory approach was increased when this process confirmed the fit between the codes and the data.

Finally, as previously stated, the concurrent nursing work of the researcher meant that the reading of nursing literature was maintained throughout the study. During the life of the research there was a continuing interaction between the professional self and the researcher role. Substantive and theoretical codes were reflected upon from a nursing perspective and placed in the context of current nursing theory and practice. As a consequence the process of theory generation was much more

complex and less isolated from external bias than that suggested by Glaser and Strauss. While this may be criticised from a purist methodological perspective, it is necessary for the nurse researcher to have confidence that the theoretical outcome is identifiable as nursing and expands current nursing knowledge.

Summary

In this chapter the research approach has been presented and discussed with reference to relevant literature. After an explanation of the value of qualitative research for nursing and the issues raised when the researcher is also a nurse, the key elements in the grounded theory method, as proposed by Glaser and Strauss, have been described. Attention was given to some of the criticism of the approach, including the use of the term 'theory' to describe the outcome. The chapter also included a brief account of the experience of using the method in this research.

Chapter 3 begins the account of the actual conduct of the research with a presentation of, and discussion on, the protocol.

CHAPTER 3

CONDUCT OF THE RESEARCH

This chapter introduces the protocol which was developed to permit the systematic collection of comprehensive and diverse qualitative data. The strategies developed to conduct interviews, gather information from written records and undertake participant observation - a variety of "slices of data" - are described (Glaser and Strauss, 1967, p.68).

Introduction

The field work took place over a five month period. Coding and analysis commenced with entry into the field and continued long after data collection concluded until the emergence of an integrated theoretical interpretation which fitted the data - the Nursed Passage.

This chapter will summarise the research process which led to the generation of this theoretical framework under the following headings: i) the research problem; ii) the research setting; iii) entry into the field; iv) the study population; v) the field experience; v) summary of the data; and vi) generating the grounded theory.

The Research Problem

The problem for examination was expressed as a general question - What is happening here? This open question would be in the mind of the researcher as she entered the familiar setting of the surgical ward to observe the giving and receiving of nursing. A number of patients would be followed through their experience of receiving nursing while undergoing elective surgery. From these case studies would come a fresh interpretation of nursing in action based on a range of data systematically collected in the field.

The Research Setting

The setting for this study was a regional teaching hospital of about 900 beds situated close to the centre of a city. Five surgical wards were chosen for data collection, namely three general surgical wards, an ophthalmology ward and a genito-urinary ward [see glossary in Appendix 2].

Both the ophthalmology and genito-urinary wards are situated within a three-storey block opened in 1944. There is a T-shaped corridor from which doors open into one, two and four-bedded rooms. The three general wards are situated in a recently opened multi-storey block. One, four and six-bedded rooms open into the outside of an m-shaped corridor with the four-bedded room in each ward being used primarily for patients in the immediate post-operative period after major surgery.

During the study two wards were staffed by a charge nurse heading a team primarily composed of staff nurses with some enrolled nurses. One of these wards was using primary nursing while the other used a combination of cubicle nursing and task assignment [see glossary in Appendix 2]. Three wards were staffed by a charge nurse with a team of staff nurses, hospital-based student nurses and enrolled nurses. These wards used a combination of cubicle and team nursing. Three of the wards had students from the nearby technical institute school of nursing during the study.

Entry into the Field

Permission to undertake the study was given by the nursing administration within the hospital and, with their support, the proposal was forwarded to, and approved by, the hospital's Research Ethical Committee. This committee commented on its lack of familiarity with the research method.

A date was established for commencing the study in each ward in succession. The study was discussed with the charge nurse and the nursing staff in the ward. Morning and afternoon staff were addressed at a prearranged time during the changeover period of 2.30 - 3.30pm. Nurses who were not present at that meeting received a personal explanation if they were assigned to nurse a patient in the study. All five charge nurses were interested and enthusiastic about the research. Variable amounts of

interest and enthusiasm were shown by other nursing staff although no overt opposition was encountered at any time.

The last step before making an appointment to meet each patient was to discuss the study with the potential subject's surgeon. No difficulties were encountered in gaining the support of the surgeons although the qualitative methodology proved difficult to explain. One commented that the study seemed to be a case of "Clayton's research - the research you do when you're not doing research!" This proved to be a real-life reminder of the qualitative-quantitative controversy!

The Study Population

The study population comprised a group of patients undergoing planned surgery and the nurses responsible for their care.

Patients

Patients were chosen from the list of people waiting to be admitted to the five surgical wards.

Consistent with the goal of studying the situational reality of the surgical experience, there were minimal qualifying criteria for participation in the study. These are listed in Table 1.

Twenty-one patients comprised the study population. A small number were followed concurrently in each of the five wards in succession: three in each of the first two

TABLE 1: CRITERIA FOR SELECTION OF PATIENT PARTICIPANTS

On the waiting list for elective surgery

Resident within the local region

Able to speak English adequately enough to respond during interviewing

Sixteen years of age or over

Willing to participate in the study

wards; four, five and six respectively in the remaining three wards. Persistent post-operative complications experienced by two patients caused the researcher to spend much more time than anticipated in the second ward. This led to some anxiety as the Christmas period with its associated closure of waiting list admissions drew nearer. Consequently, the number of patients followed concurrently was increased. However, in retrospect, it was recognised that three was the optimal number with a methodology which required simultaneous data collection and analysis. Any increase above this number meant that less time was spent with each patient with a consequent reduction in the breadth of data. More time was required for interviewing, leaving less time for participant observation of activities as they occurred. Analysis, in the form of coding and memoing, was fitted in between visits during the day but was primarily an overnight activity.

Selection was consistent with the protocol for seventeen of the twenty-one patients. Admissions scheduled for the first day on which the researcher would enter the ward

were considered for inclusion in list order. Only one such person was excluded because of her inability to converse in English. The remaining seventeen were willing to participate in the study. In addition, three waiting list admissions who were already in the ward but were also on the operating schedule for the following day were included. All three met the criteria for participation in the study.

In one ward the charge nurse specifically asked if a patient could be included in the study. She was concerned about this man and was seeking assistance from the researcher, as nurse. Although admitted urgently for observation the previous week, he was scheduled for surgery on the same day as the waiting list patients in the study. In the face of this specific request, this patient was included. Consideration was given to excluding the data on this patient from the analysis but the flexibility of the research approach permits such situational amendments to the protocol to be made. So, these data were retained.

The study was fully explained to each patient and questions were answered prior to agreement to participate being obtained in writing. A copy of the consent form is included as Appendix 1. No attempt was made to conceal the nature and purpose of the research. Confidentiality of name was assured and patients knew that their experiences would be included as part of a dissertation. Although an astute reader could discover the name of the

institution, the wards and the dates of the study, and individual anecdotes are used to illustrate the theoretical presentation, anonymity has been preserved. The total experience of each patient has been merged in the analysis of the field data.

Table 2 summarises the characteristics of the patient group.

TABLE 2: CHARACTERISTICS OF THE PATIENT GROUP

Total No:	21		
Sex:	15 Men 6 Women		
Marital Status:	15 Married/Partners 3 Single 2 Widowed 1 Divorced		
Age:		<u>Men</u>	<u>Women</u>
	Under 20	0	1
	20-39	2	1
	40-59	6	1
	60-79	7	3
Range		24-78	19-79
Mean		56	52
Occupation:	Cafeteria Assistant	Chef	
	Clerk (Retired)	Clerk - Executive	
	Clerk - Supervisor	Housewife	
	Housewife (R)	Journalist	
	Managing Director (R)	Marketing Manager	
	Minister's Wife (R)	Office Manager	
	Painter/Paperhanger (R)	Personnel Officer	
	Plumber	Policeman (R)	
	Real Estate Salesman	Sales Manager	
	Shoemaker (R)	Shop Assistant (R)	
	Storeman (R)		

The proportion of men was unexpected but reflects the situation at the time of the study. Similarly it was surprising that all the patients were Pakeha [of European

descent]. The age range for both men and women was large although only four were under 40 years of age.

Table 3 lists the types of surgery experienced by the patients in the study. The number of similar operations performed during the period of data collection is also included. This number is listed alongside each operation.

TABLE 3: TYPES OF SURGERY INCLUDED IN THE STUDY

	<u>In Study</u>	<u>Total</u>
Block Dissection of lymph nodes	1	3
Blocked Gortex Graft	1	3
Bowel Resection	1	20
Carotid Endartarectomy	2	14
Cataract Extraction	1	57
Gastrectomy	2	7
Inguinal Herniorrhaphy	1	27
Injection of Oesophageal Varices	1	7
Keratoplasty	1	2
Mastectomy	2	12
Parathyroidectomy	1	3
Sphincterotomy	2	9
Thyroidectomy	1	6
Trabeculectomy	1	8
Transurethral Resection	2	26
Ureteroplasty	1	1

Fifteen of the patients entered hospital the day before surgery; two were admitted two days before; and four spent four to six days in the ward prior to surgery. The time spent in hospital after surgery varied from two to twenty days. Ten had been discharged by the fifth day, another six had gone home within ten days and only one was hospitalised for more than fifteen days.

Nurses

Individual nurses participated in the study in one or more

of three ways according to the nature of their association with the patients in the study. Firstly, at the end of each nursing shift the nurse who was identified as being primarily responsible for nursing the patient during the past eight hours was interviewed. Eighty-two different nurses were interviewed during the study. The five charge nurses were also interviewed. Some baseline data on the nurses who were interviewed was collected and is summarised in Table 4.

TABLE 4: CHARACTERISTICS OF THE NURSE GROUP

Total No:	87	
Status:	5	Charge Nurses
	55	Staff Nurses
	5	Enrolled Nurses
	22	Students
Working hours:	68	Full-time
	19	Part-time
Registration of qualified staff:	3	General Nurse
	45	General/Obstetric Nurse
	12	Comprehensive Nurse
	5	Enrolled Nurse
Training School of qualified staff:	34	Local Hospital Board
	6	Local Technical Institute
	14	Other NZ Hospital Boards
	6	Other Technical Institutes
	5	Overseas
Students	20	General/Obstetric programme
	2	Comprehensive programme

Secondly, copies were made of all nursing records maintained on each patient subject during his hospitalisation. The primary records were the nursing history, nursing notes, and nursing care plan. Finally, nurses could participate in the study by their involvement

in incidents of interaction between patient and nurse, and social interaction between nurses in the presence of the researcher. These were recorded as field notes.

The Field Experience

For data collection purposes, the patient's surgical experience was divided into three stages: Stage 1 - before admission to hospital; Stage 2 - the period of hospitalisation; and Stage 3 - after discharge from hospital. The protocol for each stage will be briefly discussed.

Stage 1 - before admission to hospital

In the protocol, a home visit prior to admission was planned for each patient. This visit had three purposes. First, the researcher would explain the study and ensure the person understood what was required of him before¹ inviting him to complete the consent form. Secondly, the relationship between the researcher and the subject would be initiated prior to the stress of admission to the hospital. Thirdly, data collection would commence at this time using three methods: interview, observation, and diary.

1

As the majority of patients were men, the masculine pronoun is used when referring to the patient group. However, when individual patients are being discussed the relevant personal pronoun is used. As the majority of nurses were women, the feminine pronoun is used for general discussion of the nurse group. References to individual nurses use the relevant personal pronoun.

Interview

This was planned to be an open-ended but focused conversation between the researcher and the patient which would be recorded. A copy of the interview protocol is presented in Appendix 3. It was the researcher's intention to commence each interview with a common initiating question and thereafter listen as the person spoke, exploring issues as they arose. At all times the researcher would attempt to remain sensitive to the person's willingness and ability to discuss each topic.

This first interview was planned to collect data on the person's perception of his world. It was anticipated that the conversation would naturally lead - at an early or late stage - to a discussion on the person's health status and history including the forthcoming surgery.

Observation

During the visit the researcher planned to note the environment in which the person lived, his physical appearance and verbal/non-verbal behaviour patterns. The guide for these observations is presented in Appendix 3.

Diary

At the conclusion of this first visit the person was to be given a notebook in which he was invited to keep a diary from then until the final visit after discharge from hospital. The person would be requested to record

anything concerning the upcoming experience that he would like to share with the researcher.

Despite this plan, the first experience with Stage 1 visits precipitated a major change in the protocol. Dynamic changes occur in patient loads within individual wards and the anticipated lead time between notification and admission did not prove to be reality. In the first ward, the researcher obtained the names of three anticipated admissions two days prior to the event. One could not be contacted, another was willing to receive a home visit and one felt it would be better, for the researcher, if the visit was made at his workplace. These two visits, hastily arranged for the day before admission, and the events on the day of admission led to a change in protocol. This experience is recounted in order to explain the circumstances that led to the change.

On arriving for the home visit the door was opened by a charming elderly man - the patient - who immediately, while leading the way into his lounge, commenced to share personal information relevant to the study. With the tape recorder still in her bag and the consent still unsigned, the researcher was graciously entertained with afternoon tea and social conversation intermingled with the desired interview information. Almost every topic the researcher had anticipated covering during a spontaneous recorded interview was covered. Finally, after completion of the formalities relating to the explanation of the research and the signing of the consent form, the tape recorder was

prepared for use. At this point the man picked up the recorder, took some time to prepare what he wanted to say and gave a six minutes 'speech' in which he recalled the events leading up to the need for the surgery. The visit lasted nearly two hours; the actual recording lasted only six minutes and lacked spontaneity.

Later that day a visit was made to the place of work of the second patient. Although this gentleman continually gave the assurance that all was well, work colleagues kept on entering his office for advice. In this setting the researcher felt intrusive and uncomfortable. The resulting conversation was affected by the circumstances in which it took place.

On the next day, when these two men were admitted to hospital, the researcher consulted the charge nurse concerning the next waiting list admission. She replied: "The corneal graft is in. He's being done tomorrow." With that she walked out of the office and entered a four bed cubicle, researcher following behind. On approaching a bed on which a man was sitting reading a magazine she said: "This is __, she's a nurse and is doing a survey. She would like to speak with you." At this point the charge nurse smiled and left the room. This man proved to be the third person from the original list with whom contact had not been possible prior to admission. As this was the beginning of the research and the other Stage 1 interviews had raised unexpected problems, the researcher decided to try undertaking the first interview on

admission. The researcher's diary note records: "I was so pleased I did because I had an excellent conversation with him."

Thereafter, the Stage 1 interviews were carried out in the hospital as soon as possible after admission. In this environment the preliminaries were soon completed and recording the interview was quickly underway. The initiating questions opened up the conversation and permitted the patients an opportunity to shape their own individual responses. Some immediately spoke of issues relating to the surgery, others started with an account of their childhood. The observation schedule was completed after each Stage 1 interview. Diaries were given to the first three subjects but were not used. Patients reported that they saved up any comments until the researcher's next visit. Thereafter, diaries were given to subjects at the time of discharge but only one entry was made.

Stage 2 - the period of hospitalisation

As the focus of the study was on the actual experience of hospitalisation, most data were collected during this second stage in the form of: patient interviews; nurse interviews; patient observation; nursing documentation; and participant observation.

Patient Interviews

Each patient was to be interviewed three times a day, at the end of the nursing duties at 7am and 3pm and the

settling of the ward at 9pm. During each visit a focused but open-ended interview was recorded. The tape recorder was small and had a built-in microphone. It was placed on the bed during the interview. Although most patients initially seemed a little uneasy with the recorder this was much less evident in later interviews.

During each interview the patient was invited to speak of his perceptions of, and reactions to, his current situation and the events of the previous eight hours. A protocol was prepared for the interview and this is presented in Appendix 4. As planned, the exact wording of the initiating question was determined by the circumstances and the patient's status. Most commonly, the conversation did commence with the question: "How have you been since I saw you last?" Although the interviewer guided the duration and scope of each interview, the major determinant was the patient's condition. There were occasions, mostly in the immediate post-operative period, when it was not possible to interview the patient.

Thrice daily visits were maintained throughout the hospitalisation of the first two patients. At the time of their discharge, the remaining patient in that group was independent and waiting to be discharged in a few days so the visits were reduced to once daily in mid-afternoon. By this stage the researcher was finding the fieldwork with concurrent transcription and analysis extremely exhausting. Six to nine hours a day in the ward, divided

between three visits, together with the concurrent coding and analysis associated with the research method had a cumulative effect. It became evident that the planned protocol could not be maintained throughout the months available for the fieldwork. Consequently, the pattern of daily visits was revised. Three visits daily were made during the immediate perioperative period and then the number was reduced to two and, in some cases one, as the patient's condition stabilised and change was less dynamic. The mid-afternoon interview was retained throughout the patient's time in hospital.

Nurse Interviews

Nurse interviews coincided with patient interviews. The nurse identified as being primarily responsible for nursing the patient during the duty was interviewed. Each conversation was recorded and commenced with the question: "Can you tell me about ____ and the nursing care he/she has required this duty?" This question sought to ascertain the nurse's perception of her role, the nursing care given during the preceding eight-hour period, and the status of the person as she perceived it at the end of the duty. A copy of the protocol is presented in Appendix 5.

Originally, the intention was to interview only registered nurses. However, in the second ward a number of nurse students were encountered. It transpired that the care of a patient could be assigned to a student who was only nominally under the supervision and guidance of a

registered nurse. Therefore, at the end of the duty, the nurse student was identified as the person 'responsible' for the patient during the duty. The protocol was changed to allow interviews with students in such circumstances.

Early in the study it became apparent that the climate set by the charge nurse may be an important factor in the nursing care offered to patients. This was particularly evident in the variations in the format used for nursing documentation in each ward. Therefore, it was decided to include an interview with the charge nurse towards the end of the data gathering in each ward.

Observation

During each visit to the patient, the researcher was sensitive to the general condition of the person and his behaviour. The schedule included as Appendix 5 was used to guide these observations.

Nursing Documentation

Duplicate records of the nursing documentation on each patient - nursing notes, nursing history and nursing care plan - were made. In addition, a record of the patient's pain medication and sedation was maintained as these became important topics in the interviews with nurse and patients. Copies of the two nursing history formats in use are presented in Appendix 6; the two nursing care plan formats are presented in Appendix 7.

Participant Observation

In the field, the researcher wore a uniform with nursing insignia to identify her as a nurse. Her data gathering activities were acknowledged at all times as was her status as nurse. As discussed in Chapter 2, she primarily occupied the field role of observer as participant.

During the field work the researcher participated in informal interaction with the nursing staff. Comments on the nursing of the patients in the study were noted. Notes were also made of visits made to the patient by nursing and medical staff while the researcher was present.

Planned events involving the patient and a nurse, such as preoperative teaching or a procedure such as wound care, were included in the study by agreement with the nurse and the patient concerned. It was not possible to observe exactly the same critical events for each patient because several patients were followed at a time and there was considerable variation between patients. Participation in planned nursing procedures proved to be more difficult than anticipated. A decision was made to collect specific data on the quantity of nursing contact. The total nursing activity involving two patients over a seven hour period was observed. This confirmed the impression that nursing contact time was considerably less than had been assumed in planning the protocol.

One hundred and twenty eight incidents directly relevant

to the nursing of the subjects were recorded and considered in the analysis.

Instances arose where participation as nurse was appropriate. Such interventions were limited as far as possible but included verbal assurance, counselling, information giving, and activities to maintain safety and patient comfort. These primarily occurred during recorded interviews. Activities of this kind were noted and considered as data, as well as being notified to the patient's nurse if the nurse researcher considered this was appropriate.

Stage 3 - after discharge from hospital

Following discharge - at a convenient time for the patient - a final interview took place in the person's home. Once again, this interview took the form of an open-ended but focused discussion between the researcher and the patient subject. It included discussion of the person's memories of the surgery, the hospitalisation and the nursing he received as well as his perception of his present health status. During this visit it was necessary to end the relationship with the person and allow him to ask questions about any aspects of the research with which he was concerned. A copy of the interview protocol is presented in Appendix 8.

One patient required two home visits. On the first, this elderly man, who had already been readmitted because of a post-operative haemorrhage, was again in considerable

distress caused by severe pain and bleeding. Soon after that visit further surgery was required to remedy the problem. A repeat visit was made after his return home. Another patient had already been readmitted to hospital at the time of the Stage 3 visit and, as her life-threatening illness was progressing and the future was uncertain, the interview was recorded in hospital. One patient requested that the interview be held while he underwent renal dialysis in the hospital outpatient unit.

Summary of the Data

The data - from written records, field notes and interviews - are summarised on Table 5.

TABLE 5: SUMMARY OF DATA

Population:	Patients	21	
	Nurses	87	
Interviews:	Stage 1	19	In hospital
		1	At home
		1	At work
	Stage 2	288	Patient
		285	Nurse
	Stage 3	20	At home
		1	In hospital
		1	In outpatient unit
	Charge Nurses	5	
Documentation on each patient (if used):	Nursing Notes		
	Nursing Care Plan(s)		
	Nursing History		
	Medication Record		
	Observation Record		
	Fluid Balance Chart		
	Nursing Referral to District Nurse		
	Medical discharge summary		
Incidents:	128 recorded in field notes		

Generating the Grounded Theory

On the third day of data collection the field diary contained the following entry:

"Analysis is starting! Thinking about a behavioural category of CONFORMITY - RETENTION OF CONTROL - SELECTIVE CONFORMITY based on"

A multitude of substantive and theoretical codes were recorded and explored. Continuous memoing occurred from the outset. The data were worked in a variety of ways including:

Line by line coding and memoing of all data

Comparison of content and coding of each type of data in each stage across the patient group

Comparison of content and coding of each type of data within each case study

Memoing on each substantive and theoretical code with reference to the data

Sorting of the memos and further memoing as codes were grouped and sorted in a variety of ways

Reduction of the codes into more abstract concepts confirmed by links to data

Organisation of concepts within an integrative framework followed by a line-by-line recoding of the data in relation to the emergent theory.

By a process of synthesis the myriad of substantive codes were gradually reduced and developed into fewer concepts with a greater degree of abstraction although their links to the data were maintained. As this analytical work of discovering meaning continued there was a search for an

integrating framework - a core category or process - to link the concepts into an interpretation that fitted the field situation from which the data were obtained.

Some six months after the completion of data collection the following diary note was made:

"I had a Eureka experience tonight at about 6.40pm. Believe it or not, I was lying reading in the bath!! It was a little too cold to go running down the streets but the joy in my heart brought tears of gratitude and almost bewilderment to my eyes. What was the Eureka? Well, I was reading Glaser and Strauss' 'Status Passage' and, in fact, was only on page 3 when I suddenly realised this was my focus. I am interested in the Nursed Passage, that is the patient's experience of needing and receiving nursing."

Initially, an attempt was made to apply Glaser and Strauss' theory of Status Passage to the substantive data collected from the field (Glaser and Strauss, 1971). However, the fit between that specific theoretical interpretation of passage and the data was not a comfortable one. Instead, the anthropological concept of passage, as originally proposed by van Gennep, was adapted and extended to provide an integrating framework for what was emerging from the data (van Gennep, 1960). In his classic description of rites of passage, van Gennep likened the life of an individual within his society to the pattern of the universe.

The universe itself is governed by a periodicity which has repercussions on human life, with stages and transitions, movements forward, and periods of relative inactivity . . . For groups as well as individuals, life itself means to

separate and to be reunited, to change form and condition, to die and to be reborn, to wait and to rest, and then to begin acting again, but in a different way (Ibid, p.3; p.189).

From this perspective life is viewed as a "series of passages" from one age group to another, from one social status to another, from one place to another, and so on (Ibid, p.2). van Gennep, a Flemish anthropologist writing in the first decade of this century, proposed the concept of passage as a theoretical interpretation of initiation ceremonies within indigenous communities. However, the concept of passage with its rites performed by passagee and agent, and its prescribed processes of change, can be broadened to include other critical life experiences. Glaser and Strauss provided the cue for the derivation of this social process in their discussion of a number of passages described in the research literature (Glaser and Strauss, 1971, p.6-7). These include the experiences of having tuberculosis and poliomyelitis, recovery, going through medical school, and being a mental patient. Their own research among dying patients generated a passage of dying (Glaser and Strauss, 1968). Such examples, although the terminology in each is different, provide analogies for the application of the concept of passage to nursing.

The specific properties of the Nursed Passage arise from the nursing setting rather than being imposed from the literature. Glaser and Strauss' suggestion that researchers explore for multiple properties characteristic

of the particular passage being described, rather than focussing on a single or few derived properties and perhaps neglecting significant data, has been followed (Glaser and Strauss, 1971, p.1-11).

As discussed in the previous chapter, the study led to the emergence of a grounded theory in the discussional form. It is a research-induced theoretical or conceptual framework. At this point the theory of the Nursed Passage requires further research before it can be developed confidently into the propositional form.

The challenge facing the researcher was to write the theoretical outcome in a way that would persuade practitioners that it could be relevant to their practice; that the time required to understand it would be worthwhile; and that there would be personal and professional rewards in its use. With this in mind, care has been taken to use terminology which is readily understandable by the practising nurse. Indeed, one of the key tests for a grounded theory is the degree to which people in the field can relate it to the reality of their everyday world. Thus it has to be presented in a form which "makes its fit and relevance easy to comprehend" (Glaser and Strauss 1967, p.32). This is achieved through the use of descriptive terms for the concepts and also by means of the constant use of anecdotes to illustrate the direct link between the theoretical outcome and the reality of nursing as revealed in the data.

Summary

In this chapter the discussion has focused on the protocol which was developed for this field study. A summary of the field data has been given. The chapter concluded with an account of the process by which the theoretical framework emerged from the data using the strategies of the grounded theory method.

Presentation of the Nursed Passage will commence in Chapter 4 with an overview of the whole theoretical framework.

CHAPTER 4

THE NURSED PASSAGE: AN OVERVIEW

This chapter presents an overview of the Nursed Passage. It is presented at this stage in order to assist the reader to see the whole - the end product as it were - before embarking on a more detailed discussion of each of the major components in the six chapters which follow.

Introduction

The outcome of this research, the Nursed Passage, is a socially sanctioned process in which nurse and patient work together to minimise the effects on the patient of the disturbance caused by the presence of a health-related problem together with its associated treatment regimen. In the hospital setting the Nursed Passage is one passage within the patient's total experience of undergoing planned surgery. As the patient lives through the experience as a whole then each passage in which the patient is involved has an impact on, and is impacted upon by, the other concurrent passages. In particular, the actions of the medical staff - the surgery and its medical management - have a major influence on the shape of the

Nursed Passage because of the effect they have on the patient. Indeed, it is their actions that cause the patient to need nursing.

Each participant, that is the patient as passagee and the nurse as agent of nursing, has a specific pattern of work to perform during the passage. For the patient, this work derives from a personal need to survive the ordeal caused by the problem, entry into hospital and the surgery. By contrast, the work of the nurse is shaped by the nature of nursing's specialised assistance and the ability of the individual nurse to select appropriate nursing strategies to ease the path of the patient through the experience. Thus, the relationship between the agent and the passagee is unidirectional with the work of both focusing on the patient.

The passage actually commences before the patient's admission to hospital with the experience conceptualised as the Beginning. After admission, when the nurse and patient meet each other for the first time, three stages or phases have been identified: Settling In - a period of transition characterised by separation from the 'old' and incorporation into the 'new'; Negotiating the Nursed Passage - the ongoing process during which patient and nurse work together to cushion the impact on the patient of the disturbances associated with hospitalisation and surgery; and Going Home - the period of preparation for the transition from the now familiar 'new', being a patient, back to 'old', the changed home situation

incorporating the impact and continuing effects of the surgery. Negotiating the Nursed Passage coexists with each of the other phases. The exact times for the completion of Settling In and the commencement of Going Home are not specified but the changed behaviour of nurse and patient confirms the presence of each phase.

Each phase has its own characteristic pattern of work for both nurse and patient. Success in accomplishing the tasks confronting the patient during the passage is not guaranteed. However, the theory has not been developed to the stage where propositional statements can be made to link the work of the nurse with that of the patient and the patient's progress through the passage. At this point only the patterns of work of agent and passagee within the immediacy of the patient's situation during the phases of the passage have been defined.

The final component of the grounded theory is the inclusion of three specific Contextual Determinants, identified in the nursing situation, which influence the behaviour of nurse and patient during the Nursed Passage.

A summative model of the Nursed Passage is presented in Table 6. It depicts the centrality of the concept of passage and the relationship between the conceptualised patterns of work of both patient and nurse in each phase of the passage. The Beginning and the Contextual Determinants are shown in their relationship to the key phases of the process identified as the Nursed Passage.

TABLE 6: THE NURSED PASSAGE

THE WORK OF THE PATIENT			
Surfacing the Problem	Becoming a Patient	Managing Self Centring on Self Harnessing Resources Maintaining Equanimity	Maximising Readiness
Preparing for Intervention	Suspending Social Roles	Affiliating with Experts Acquiescing to Expertise Fitting In Retaining Autonomy	Making Arrangements
Interpreting the Experience	Revealing Self	Surviving the Ordeal Enduring Hardship Tolerating Uncertainty Possessing Hope	Discovering Requisites
		Interpreting the Experience Monitoring Events Developing Expertise	Resuming Control
THE BEGINNING	SETTLING IN	NEGOTIATING THE NURSED PASSAGE	GOING HOME
	Admitting	Attending Being Present Ministering Listening Comforting	Appraising
	Appraising	Enabling Coaching Conserving Extending Harmonising Encouraging	Supplementing
		Interpreting Responding Anticipating	
THE WORK OF THE NURSE			

CONTEXTUAL
DETERMINANTS

Episodic Continuity

Anonymous Intimacy

Mutual Benevolence

A brief introduction to each of the concepts within the five parts of the grounded theory will be presented in sequence: i) the Beginning; ii) Settling In; iii) Negotiating the Nursed Passage; iv) Going Home; and v) the Contextual Determinants. Encountering these in isolation from the data which gave them life may be confusing. However, as stated, the purpose of this overview is to set the scene for what follows in Chapters 5-10.

The Beginning

The concept of the Beginning represents the patient's experience with a health-related problem from initial awareness to admission to hospital for surgery. Its duration may be anything from days, perhaps even hours, to years.

This period preceding entry into the Nursed Passage is a time of adaptation to the changed situation and preparation for the upcoming experience. Three theoretical constructs were developed from the field data to identify the nursing-relevant work of the patient during this initial experience: Surfacing the Problem; Preparing for Intervention; and Interpreting the Experience.

Surfacing the Problem

This is the process in which the patient acknowledges the existence of a problem; adapts to the presence of the

problem; makes a decision to to seek medical assistance; undergoes an experience of diagnosis and testing; receives information on the medical diagnosis; and, finally, accepts the recommendation that surgical intervention is required.

Four different patterns for surfacing the problem were identifiable in the data:

Evolution - the gradual development of a problem, which is not life-threatening, to the stage where non-urgent surgery is the recommended intervention to alleviate its effects;

Crisis on Evolution - the development of a long standing problem to a critical state which is now potentially life-threatening and urgent surgical intervention has become necessary;

Anticipated Crisis on Evolution - the evolution of a problem to a stage where urgent surgical intervention is required to reduce the risk of either sudden death or fear-inducing debility; and

Crisis - the sudden presentation of a proven or possible malignancy, associated with pain, suffering and death, which requires urgent surgical intervention.

Preparing for Intervention

The patient takes steps to get ready to enter hospital and seeks to equip himself with the resources to withstand the

consequences of the problem and the impending surgery.

Interpreting the Experience

Throughout his experience with the problem a patient analyses events as they occur and synthesises them into a meaningful whole. From this whole he extracts a selection of details which he forms into a personalised account of events.

The Beginning is presented in more detailed form, with illustrations from the field data, in Chapter 5.

Settling In

Settling In is the transition experience in which the patient enters hospital and comes into contact with nursing within the Nursed Passage. Both patient and nurse have their own pattern of work to perform during this phase. This work is summarised in Table 7.

TABLE 7: SETTLING IN

The Work of the Patient

Becoming a Patient
Suspending Social Roles
Revealing Self

The Work of the Nurse

Admitting
Appraising

The Work of the Patient

The patient has the task of settling into the role of patient within the Nursed Passage. This work of Settling In, together with the work of the nurse, also facilitates the patient's accomplishment of the related tasks of becoming a patient to the institution, to the medical staff and other health groups within the hospital.

Three separate but interrelated patterns were developed from the data to explain the work of the patient as he settles in: Becoming a Patient; Suspending Social Roles; and Revealing Self.

Becoming a Patient

The patient takes action to make the transition into the patient role. This process is assisted by learning at the time of admission, the patient's previous experience with the role, and the work of the nurse.

Suspending Social Roles

As he moves from home to the hospital, a patient lays aside his usual range of social roles and responsibilities for the duration of his hospitalisation and recovery from the surgery. This may have involved considerable preparation beforehand.

Revealing Self

On admission the patient is required to expose himself, in

word and body, to others, especially nurses and medical staff, and to permit them to perform intrusive procedures.

The Work of the Nurse

The nurse has two major tasks to perform during Settling In: Admitting and Appraising.

Admitting

The nurse undertakes a routinised set of tasks on behalf of others - hospital administration, medical staff, and other hospital services - to accomplish the patient's admission to hospital. Although these are delegated functions, they are given a nursing perspective and have become an integral part of the work of the nurse.

Appraising

Specific nursing-generated activities are performed by the nurse to establish a nursing-relevant information base about the patient to guide decision-making by nurses during the passage.

A discussion on Settling In is presented in Chapter 6.

Negotiating the Nursed Passage

The major work of negotiation through the Nursed Passage commences at the time of admission to hospital and continues until the patient goes home. It co-exists with, and supports, the work associated with Settling In and

Going Home.

Nurse-patient collaboration is required to help the patient make his way through the Nursed Passage as effectively as possible. It is a dramatic moment-by-moment process as the patient faces the dynamic internal and external challenges which continually confront him while in hospital.

Patient and nurse each undertake their own complex range of activities during this phase. These are listed in Table 8.

TABLE 8: NEGOTIATING THE NURSED PASSAGE

The Work of the Patient

Managing Self	Affiliating with Experts
Centring on Self	Acquiescing to Expertise
Harnessing Resources	Fitting In
Maintaining Equanimity	Retaining Autonomy
Surviving the Ordeal	Interpreting the Experience
Enduring Hardship	Monitoring Events
Tolerating Uncertainty	Developing Expertise
Possessing Hope	

The Work of the Nurse

Attending	Enabling
Being Present	Coaching
Ministering	Conserving
Listening	Extending
Comforting	Harmonising
	Encouraging
Interpreting	
Responding	
Anticipating	

There is no one-to-one link between the various activities which comprise the work of nurse and patient. The work of

both is an integrated matrix in which each individual activity affects the whole. In each nursing encounter the nurse selects from the full range of work strategies the most appropriate combination of actions to assist the patient to progress through the passage.

The Work of the Patient

The work the patient seeks to accomplish during the passage arises from his total situation. It is assigned as the work within the Nursed Passage because nursing either has, or shares, the responsibility and has nursing strategies available to assist the patient with this work.

Four major constructs were generated from the data to describe the major areas in the work of the patient associated with negotiating the Nursed Passage: Managing Self; Surviving the Ordeal; Affiliating with Experts; and Interpreting the Experience. Each one has a number of sub-concepts.

Managing Self

The patient attends to himself and uses the self-management strategies he has learned through his life to prepare for and endure the experience of undergoing surgery. This work has three identifiable sub-concepts:

Centring on Self - the focus on self which permits the patient to maximise his energy on getting through the experience;

Harnessing Resources - the patient's efforts to control his situation through the use of learned self-management strategies; and

Maintaining Equanimity - the patient's work of striving to attain a state of composure, serenity and quietude within himself, and particularly in the way he presents himself to others.

Affiliating with Experts

In hospital the patient receives specialised assistance from a number of experts. In order to maximally benefit from this the patient has to learn strategies for interacting with these hospital staff. Three sub-concepts amplify this patient task:

Acquiescing to Expertise - the selective submission of the patient to the experts on whose specialised skill and knowledge he is dependent;

Fitting In - the willingness, and ability, of the patient to adapt to the routines and practices associated with being a hospitalised patient; and

Retaining Autonomy - the patient's selective retention of independence in thought and action while receiving care from experts.

Surviving the Ordeal

The patient undertakes work aimed at enduring the

experiences associated with hospitalisation and surgery. Three sub-concepts expand this aspect of his work:

Enduring Hardship - the efforts made by the patient to withstand such experiences as the pain, discomfort and inconvenience associated with the surgery;

Tolerating Uncertainty - the actions taken by the patient to cope with the lack of certainty which exists in relation to such issues as the nature of the problem, the outcome of the surgery, and his lack of specialised knowledge which limits his decision-making concerning himself and his circumstances; and

Possessing Hope - the patient's ability to anticipate a future in which there is an improvement in his condition which may be minutes, hours, days or even weeks away.

Interpreting the Experience

This represents the continuation of the patient's work, commenced with the Beginning, of analysing events as they occur and synthesising them into a whole which is personally meaningful. In addition to the constant processing of experiences and information the patient begins to use his increasing knowledge. This is reflected in two additional dimensions in this work:

Monitoring Events - the patient uses his increasing knowledge base to form opinions on his progress, the work of staff and occurrences in the environment; and

Developing Expertise - the patient progressively processes information and becomes increasingly wise about his situation.

Chapter 7 contains a detailed presentation on the work of the patient as he negotiates the Nursed Passage.

The Work of the Nurse

The work of the nurse is dynamically variable and situation-specific as she uses nursing strategies to ease the path of each patient through his individual passage. Each individual nursing action may encompass more than one type of nursing work in the way it is used for a particular patient in a single nurse-patient encounter.

From the data five theoretical constructs were developed to specify different types of nursing work: Attending; Enabling; Interpreting; Responding; and Anticipating.

Attending

Nursing work takes place during moments of contact between nurse and patient as, in a sense, the nurse accompanies the patient through his passage. Thus, attending denotes the first essential work of the nurse - being there for the patient. It has four sub-concepts:

Being Present - the work of spending time with the patient in order to nurse him in the immediacy of his ongoing passage;

Ministering - the selective application of nursing knowledge and skills through the agency of the nurse to meet the identified situational needs of the patient;

Listening - the nurse's work of concentrating on what the patient is saying and taking heed of this; and

Comforting - the effort made by the nurse to soothe, ease the discomfort, and induce a state of well-being in the patient.

Enabling

This encompasses the empowering dimensions of the nurse's work whereby the patient is assisted to attain the means, opportunity ability to act within his present circumstances. Five different sub-concepts were identified within this construct:

Coaching - the guiding, motivating and teaching work of the nurse;

Conserving - the actions of the nurse which assist the patient to protect, preserve and carefully manage his resources;

Extending - nursing's work in helping the patient to extend the scope of his present activities relevant to his current situation;

Harmonising - nursing activity undertaken to facilitate the attainment and/or maintenance of a beneficial state of synchrony within the patient or between the patient and

his environment; and

Encouraging - actions taken by the nurse to inspire the patient with the confidence and the courage to hope, to take action, to make decisions, to accept help.

Interpreting

The nurse uses a number of intellectual activities to continually attach meaning to the patient and his situation. These include observing, monitoring, analysing, translating, contextualising, synthesising and decision-making. Interpreting exists as a separate planned activity as well as being an integral part of every nursing action.

Responding

Throughout the passage the nurses maintains a state of readiness to take action in response to a perceived change in the patient or his circumstances. This work includes the incidental responding which occurs within each nursing episode as well as a planned, longer term nursing response.

Anticipating

The nurse is constantly challenged to use her knowledge and experience in order to visualise the patient's immediate and/or longer term future and initiate nursing activities to forestall a negative situation and/or

facilitate a beneficial outcome.

The work of the nurse related to Negotiating the Nursed Passage is discussed in detail in Chapter 8.

Going Home

As the passage progresses both patient and nurse undertake new work specifically associated with preparing the patient for the transition out of the Nursed Passage. Time is a significant variable in this phase. There is an intrinsic sense of healing and progress which triggers the patient to begin his preparation for going home. The final decision is usually made by the medical staff, often in consultation with nurses. However, this may not be confirmed until the actual day of discharge. Thus, both patient and nurse may have little time to complete their work.

The work of patient and nurse during the final phase of the Nursed Passage are summarised in Table 9.

TABLE 9: GOING HOME

The Work of the Patient

Maximising Readiness
Making Arrangements
Discovering Requisites
Resuming Control

The Work of the Nurse

Appraising
Supplementing

The Work of the Patient

The patient engages in a number of tasks which prepare him for the transition from hospital to home. There are four separate but interrelated aspects to this work: Maximising Readiness; Making Arrangements; Discovering Requisites; and Resuming Control.

Maximising Readiness

The patient readies himself as far as possible, in action and thought, to leave the hospital and return home as soon as the time and day are confirmed.

Making Arrangements

Prior to going home the patient takes steps to prepare his family for his return home, and to make appropriate plans for actually going home as soon as the decision is made.

Discovering Requisites

The patient has the task of ascertaining the nature of the measures prescribed by medical and other staff which will facilitate his continued recovery after he leaves hospital.

Resuming Control

As the passage draws to an end the patient resumes maximal self-care after sharing this control of himself with experts while in hospital.

The Work of the Nurse

During the Going Home phase the nurse seeks to use specific nursing strategies to assist the patient to achieve an optimal transition out of the Nursed Passage. Nursing is particularly concerned with ensuring that the person is as ready as possible to leave the hospital and to maintain himself, or receive appropriate assistance, on his return to his own environment. Two concepts were developed from the data to reflect the different aspects of the nurse's work at this time: Appraising; and Supplementing.

Appraising

The nurse establishes an information base on the patient's potential for self-care after leaving hospital and identifies areas where immediate and longer term support will be required.

Supplementing

Nursing actions are undertaken to give specific supplemental assistance as the patient prepares to leave hospital. Arrangements are also made for specific assistance from nursing and other community services when the patient goes home if nursing judgement indicates this is a necessary adjunct to self and family care.

Going Home is presented in a detailed discussion in Chapter 9.

The Contextual Determinants

The Contextual Determinants are those factors within the nursing context itself which exert a specific influence on the shape of Nursed Passage. Analysis of the data led to the identification of three determinants: Episodic Continuity; Anonymous Intimacy; and Mutual Benevolence.

Episodic Continuity

This is the paradox in which nursing is perceived by both the nurse and the patient as being continuous although it is actually episodic in nature. On examination, nursing is revealed as a series of episodes in which the nurse and patient come into purposive face-to-face contact for only short periods of time - usually minutes or even seconds.

Anonymous Intimacy

In this second paradox nursing is characterised by a degree of sanctioned interpersonal closeness despite patients being nursed by a constantly changing group of nurses, and nurses being faced with an ever-changing group of patients as passages are completed and new ones commence.

Mutual Benevolence

This construct refers to the reciprocal good will with which both patient and nurse enter the Nursed Passage, and which each seeks to maintain throughout the relationship.

The Contextual Determinants of the Nursed Passage are presented in a theoretical discussion, illustrated by excerpts from the field data, in Chapter 10.

Summary

During this chapter the theory of the Nursed Passage has been introduced and its component parts identified. A diagrammatic representation of the whole passage was presented to indicate the way in which the phases of the passage relate to each other. It also demonstrates the essential complementarity of the work of patient and nurse.

This overview has been brief and presented without support from the rich data which generated the theoretical framework. Each concept is vitalised when it is linked to the reality of the practice setting through the use of anecdotes. Chapters 5 - 10 will present an expanded discussion on each part of the Nursed Passage together with supportive excerpts from the field data.

Chapter 5 commences this more detailed presentation with the Beginning.

CHAPTER 5

THE BEGINNING

This chapter commences the discussion which will ground each concept in the data from which it emerged during analysis. It seeks to portray the pre-hospital experience of the patient in relation to the onset of the problem and his preparation for admission.

Introduction

For the person involved, admission to hospital for planned surgery is the continuation of an individual drama which began years, months, weeks or days ago. Eventually, it has culminated in the person readying himself to enter hospital following acceptance of the surgeon's recommendation that surgery be performed to alleviate a problem. This drama comprises a complex matrix of actions, reactions and meanings which, in their specific details, are unique to each person's situation. However, on further analysis, it is possible to distinguish nursing-relevant patterns which collectively mark the beginning of the Nursed Passage.

What happened during this prelude to admission has

significance for the shape of the passage which follows. Each of the concepts within this phase is discussed in some detail because they represent a potential new source for the formulation of a protocol for nursing appraisal during the Settling In phase. Throughout the discussion emphasis is given to aspects of the person's experience which are considered to have an impact on his performance, or work, as a patient.

Footnotes will be used to explain the origin of the terminology used in each component concept.

² The Beginning

The moment when a person acknowledges awareness of any sign or symptom that causes concern, for example, feeling pain, finding a lump, seeing unusual bleeding or noticing a discharge, is an intensely personal event. From then on, if the symptom persists and the person feels a need to seek advice or help, he becomes the central point of an ever enlarging circle spreading out to involve more and more people. The person and confidant(s) reflect on the situation, often referring to previous experiences which are perceived to be relevant. Advice and support are offered. Coping strategies are employed by the person in an attempt to control the symptoms and his own reactions

2

The term 'beginning' was coined after a dictionary search for a suitable word to reflect the fact that the Nursed Passage actually has its origins in the prelude period before admission. Its form is consistent with the gerundial terminology used throughout the framework to reflect ongoing process.

to their presence and perceived significance. All the time, as the circle enlarges, more and more information is received and meaning is attached to what is occurring. Eventually, after hours, days or months, medical personnel - the general practitioner, perhaps a physician, and finally the surgeon - enter the circle and, from then on, have a major influence on shaping events. Now there is an official interpretation of the problem. Eventually, the decision to operate is made by a surgeon and agreed to by the patient.

In the following discussion a theoretical perspective on the Beginning phase of the Nursed Passage will be presented. Three concepts which will have a major influence on the work of both patient and nurse during the upcoming passage have been developed from the field data: i) Surfacing the Problem; ii) Preparing for Intervention; and iii) Interpreting the Experience.

3 Surfacing the Problem

Unusual bleeding, a lump, a discharge, pain, indigestion, fatigue, loss of weight - all are possible triggers to perception of a problem. At this point the person is immediately involved in a process of decision-making concerning the response he will make to the occurrence. The outcome of this self-diagnostic process may be any of

3

The term 'surfacing' was derived from its dictionary meaning of 'emerging' or 'becoming apparent' following constant references by patients during interviews to their experiences of living with the problem (Collins, 1979).

the following decisions:

No problem exists

A problem may exist but it will not be acknowledged and no action will be taken

A problem exists but requires no action

A problem exists and vigilance is required to monitor it

A problem exists and actions are available to resolve the problem within the person's own resources

A problem exists and external consultation is necessary

Decisions made in such circumstances are influenced by the mode of presentation of the problem and the significance attached to specific symptoms. Certain phenomena produce an impact because they are perceived as life-threatening. Unusual bleeding, a lump or an unusual discharge which appears suddenly is likely to cause alarm and initiate immediate action.

"The trouble is the blood. . . . I can't see anything but the blood. The first time it happened it really frightened me."

.....

"About three weeks ago I noticed a lump here at the top of my leg . . . and I rang the hospital . . ."

.....

"I woke up in the morning and found the discharge and panicked."⁴

By contrast, symptoms such as indigestion, leg pain and those associated with the presence of a hernia may be tolerated for months, even years, before relief is finally

sought through the general practitioner. Indeed, it may even transpire that the decision by the doctor to suggest further action on a specific problem of this nature follows consultation on another unrelated matter.

"Nearly three years I have that. But wasn't so bad last year. This year start getting more heavy. . . . When I eating it sort of repeating and everything."

.....

"Well, my legs started to play up and I'd walk about a hundred yards and they would start to ache, and I put up with that for about eighteen months, and I thought I'd better go to the doctor and see if there is something wrong."

.....

"That's what I started off with - a leaky tap! And they knew the hernia was there, and they said 'Oh well, we'd better get that fixed.' . . . I've known its been there but it hasn't bothered me."

Because of nursing's focus on the person's moment-by-moment experience with the symptom(s) and the medical treatment regime, the pattern by which a problem surfaces is significant. There are four possible patterns associated with the surfacing of a problem: Evolution; Crisis following Evolution; Anticipated Crisis on Evolution; and Crisis.

5

Use of the terms 'evolution' and 'crisis' resulted from a dictionary search to discover terms which would reflect both the development of the problem through time and its present impact on the life of the person. Evolution is defined as 'a gradual development' which requires a degree of adaptation and adjustment but is not life-threatening. By contrast, Crisis is used to denote 'a sudden change for the worse' - a decisive event which presents a major threat to the person's outlook on, and expectation of, life (Collins, 1979). This crisis is 'situational' occurring 'as a result of some unanticipated traumatic event that is usually beyond one's control' (Hoff, 1978, p.12).

Each pattern has its own significance for the nursing care of a person throughout the subsequent hospitalisation and medical intervention.

Evolution

Nine of the twenty-one patients in this study presented a pattern of evolution which is characterised by the gradual development of a problem to the stage where non-urgent surgical intervention is recommended. While there may have been some initial apprehension about the meaning of the symptoms, fear of dire consequences has been alleviated following medical consultation. Despite the lack of a life or death crisis, a personal drama has unfolded as there has ensued an interplay between the problem and the world of the person into which it is intruding.

The evolutionary pattern has the following attributes:

Duration of months or years

Not presently associated with life threat

Use of personal strategies for adjusting to the presence of the problem, with variable success

Alliance with the doctor for conservative management of the problem, often associated with periods of remission

Referral to a surgeon as the problem persists

Period of waiting for surgery

There may be considerable diversity in the actual manifestation of the evolutionary pattern. Exerpts from

the Stage 1 interviews of three of the nine patients manifesting this pattern are presented to illustrate this variability. The evolutionary process is apparent in both the history of the problem itself and each patient's adaptation to its continued presence.

A person with a five year history of glaucoma -

"I don't think the illness in my eyes has made much difference to my lifestyle at all. . . . As long as I could put the drops in night and morning there didn't seem to be any problems. . . . According to Dr_ the pressure's increasing and he advised me to have the operation."

.....

A person with a history from childhood of urinary tract infections -

"I just get bad kidney infections - you know - I can hardly walk and things like that. Its so common I just know when its coming and when its gone - you know. I used to go to the doctor all the time at home and he would just say 'Oh yeah - problem child!' and feed me some more rubbish - antibiotics and stuff. . . . So that's why I thought I'd just come and get some more pills and that would be that. (Laughs) I didn't know that he was going to be on the ball!"

.....

A person with a six month history of rectal fissure -

"Yes, that's what it was - blood. I thought 'Oh my God, I've got haemorrhoids!' Doctor said no, I had a fissure and he put me on suppositories and ointment. That worked for a while and he thought I was healing up and I had a relapse for a while. I was getting more and more uncomfortable and then he decided to refer me to a surgeon . . ."

When a person enters hospital and tells a story of his experience which seems to fit the dimensions of the

evolutionary pattern, the nurse can recognise that this person has developed an expertise in his symptomatology. He has lived with the progress of the condition; he is probably aware of alternative treatment methods and may have been involved with one or more of these in alliance with his family doctor; he has learned ways of adapting his life style to cope with the effects of the symptoms and the demands of their conservative management; and he is looking forward to the relief from symptoms which is anticipated after surgery.

Crisis following Evolution

Six of the twenty-one patients in this study revealed a pattern of crisis following a period of evolution. Possibly over many years, the problem had surfaced according to the pattern of evolution. However, a critical turning point in the disease has caused a change in the pattern which now manifests itself as:

A recent change in a condition of long duration

Presence of a life threat

Personal coping strategies are of increasingly limited effectiveness

Previous alliance with the doctor for the conservative management of the problem

Urgency attached to referral to the surgeon

Urgency attached to admission for surgery

Each of the six crises following a period of evolution encountered in this study was unique and yet was

consistent with the nature of the health problem. The crisis could originate as a dramatic development in the problem itself, such as the haemorrhaging associated with the development of oesophageal varices arising from chronic liver disease. Alternatively, a crisis may be precipitated by a traumatic event in the life circumstances of the person himself which has influenced his perspective on, and the status of, an evolving problem. Examples of this are the way in which grieving and the effects of loneliness may aggravate a chronic gastric ulcer, or the onset of a crisis when a patient with evolving cataracts complicating poor eyesight needs to learn self dialysis for chronic renal disease.

In the following selections from interviews with two of the six subjects who demonstrated this pattern it is possible to grasp the dramatic nature of the crisis and its impact on the person.

A person with a oesophageal varices after a fifteen year history of pain and indigestion since removal of her gall bladder -

"I get terrible gastro. Real pain towards the liver. This is where it all started. Always tender. . . I take Aludrox most of the time now. . . .You do get the odd day when you could paint the moon but it will only last that one day and then you feel discomfort. . . . That pain has been there ever since the gall stones. I have never been one hundred per cent since then - whatever happened then. . . . Its the pressure that built up evidently that perforated the thing and caused the haemorrhage. . . I didn't expect it. I was having dinner. . . . I said 'I don't feel like dinner' so I stopped eating and I said to my family 'I'll go and lie down. I don't feel well.' I thought it was the

flu. I think it was 7 o'clock that night I said 'I think I'm going to be sick.' And I was absolutely amazed. I had had about three drinks of grape juice and I suppose that must have made the amount look more. We rang the ambulance. It was a whole bowl full. . . . Came top and bottom. . . . I got an urge to pass and it was all black there. The other part was red. . . . The ambulance man took my blood pressure and he said it was absolutely high. They just crept along the road. He was afraid to go over a bump, he said, in case I exploded. . . . After three or four days he [physician] went down the throat again and that is when he decided he wanted Mr _ [surgeon] to have a look at me. . This thing has changed everything. I just don't know when its going to happen."

This experience, consistent with the medical problem, illustrates the crisis induced by the onset of a life threat into a situation which has been evolving over many years. The patient's recognition of danger is evident in her words: "Time is running out really, isn't it!"

A person who had had a gastric ulcer for fifteen years and had been recently widowed -

"I live on my own now. My wife died this year. I'm a lousy cook, I'll say that. (Laughs) This has probably not helped me over the last few months. Possibly I've aggravated my ulcer in the process but, anyway, I'll make out. . . . Its been a good fifteen years since I was first diagnosed that I had an ulcer. That's when it started playing up. . . . She died on _ [date] and I suppose it was nerves. I don't know what aggravated it. I started losing weight. I think I look after myself alright. I can't cook but I found that you have to learn to do these things. Everything started up again as far as my problem was concerned and it just wouldn't settle down. I lost a lot of weight - about two stone. . . . I was sick so much, I think. . . . when I went to bed I would get a buildup of acidity and I finished up vomiting every night."

This man associated the critical deterioration in his physical condition with the recent death of his wife. An exacerbation of symptoms associated with his chronic gastric ulcer had ensued accompanied by persistent vomiting and marked loss of weight leading to real concern for his health.

As with the evolutionary pattern the person with this pattern of crisis on evolution has been living with the condition, often for a period of years. The impact of the chronic condition on his life may have been such that considerable adjustment in many aspects of daily living has been required. A variety of different treatment regimes may have been attempted requiring concentrated effort on the part of the person in an alliance with his doctor. His expertise in the symptomatology and progress of his condition is apparent. New dimensions of urgency and a feeling of threat are now present to influence the behaviour of the patient during the surgical experience.

Anticipated Crisis on Evolution

Examination of the stories recounted by the patients in this study revealed a particular pattern of evolution in which the nature of the gradual disease process was one which they knew could, indeed probably would, eventually culminate in a fearful event such as death, a severe heart attack or a debilitating stroke. In this pattern the evolutionary process is usually occurring within the walls of the person's arteries. In the two patients exhibiting

this pattern, the blood vessels supplying the brain were becoming increasingly narrowed and damaged by arteriosclerosis with the probability that this would eventually lead to a stroke. Other major vessels may be involved, particularly the coronary arteries.

Advances in medical science now make it possible to diagnose and to treat such progressive conditions before the threatened event occurs. Thus, people with this problem are able to visualise a possible future of death or debilitation if the condition is untreated and to decide whether to accept major surgery which may prevent a future crisis.

In practice, while a degree of urgency is attached to the need for this surgery, the actual waiting time for admission to hospital may be considerably longer due to the number of people on the waiting list for the same pre-emptive intervention. This may be perceived as paradoxical, even conflicting. While the waiting continues, the threat persists. Cessation of life or serious disability could occur at any time.

The pattern which focuses on the threat of a future crisis because of evolving arterial disease presents as:

Either - a life-threatening event such as a heart attack or minimal awareness of symptoms but evidence of generalised arterial disease

Possibility of life threat or disability without medical intervention

Personal coping strategies fully utilized to control uncertainty and apprehension

Degree of urgency attached to referral to surgeon

Urgency attached to need for surgery followed by a period of waiting of weeks to months for admission.

Extracts from the initial interview with one of the two people exhibiting this pattern is presented to illustrate the characteristic pattern.

A person with an eighteen month history of pain in legs during exercise -

"Well, my legs started to play up and I'd walk about a hundred yards and they would start to ache, and I put up with that for about eighteen months and I thought I'd better go to the doctor to see if there is something wrong. I'd walk a hundred yards and have to stop . . . then it would go away. Anyway it wound up that I have circulation problems. . . . He [general practitioner] sent me to Mr _ [surgeon] and they checked me, done me all over and advised me to have a test, which I did and it proved positive that I should have an operation. So here I am!"

This gentleman later confirmed that he had agreed to the surgery because of his fear of the threat posed by this condition.

". . . he [surgeon] says 'The blood goes up one side and down the other down there,' he says, 'and they are closing up, and,' he said, 'they will get to a stage where you will have a stroke.' So that convinced me. I says 'Well right - whatever, whenever.' That's about the operation. . . . If I was to have a stroke its going to be curtains. . . . I have seen a few people with them - not me!"

While the patterns of the two patients who manifested this pattern are similar, their personal circumstances, of real significance to nursing, were very different. One person

had experienced a recent family tragedy with continuing problems, while the other had previously experienced a heart attack, had been required to journey from a nearby town for the surgery and, because his children lived overseas and his wife could not drive, would have no family visiting during his hospitalisation. However, the nature of the probable future crisis and the strong desire to prevent it were almost identical.

When such a person is admitted to hospital for the planned surgery he will be anticipating the removal of a threat. The consequences of the threat becoming a reality are known to him by the experiences of others - perhaps sudden death, or a stroke, or a massive heart attack. All, in his view, are to be feared and prevented if at all possible. His decision to accept surgical intervention involves an intellectual decision as well as an emotional response. He has decided that, although he may not consider that he is currently experiencing any problems, the threat is serious enough to subject himself to major surgery.

Crisis

Four of the twenty-one patients in this study demonstrated a pattern of crisis. All were women. The crisis involved the sudden presentation of a possible malignancy. Perception of the future when cancer is a possibility includes visions of pain and suffering before inevitable death. Future plans are in turmoil. Uncertainty becomes

a prevalent feeling.

This crisis pattern presents as:

Possible or proven malignancy which has become apparent only recently

Awareness of a proven or potential life threat

Personal coping strategies fully utilised in an attempt to control apprehension over outcome of surgery arising from fear of cancer

Urgency attached to referral to the surgeon

Urgency attached to admission for surgery

A crisis pattern arises from the nature of the presenting problem as it imposes itself on the daily life of the person. All of a sudden there is a threat which might necessitate a rethinking of present and future plans. While there may be an already existing health problem the crisis-inducing problem is usually unrelated and may arise without warning. At the time of admission the future is uncertain. Hope is held that the surgery will remove the threat but it is also realised, with some apprehension, that the surgery itself may not achieve the desired goal.

Despite the similarity of the actual problem - cancer - and the acknowledgement of a sense of panic or shock, the individual circumstances of the person concerned cause variations in the story each tells of the experience. This is well illustrated in the following excerpts from interviews with two of the four women concerned.

A person with a discharge from the nipple -

"I woke up in the morning and found the

discharge and panicked - about a month ago. Rang up my doctor and Nurse said he was busy and couldn't take me till the next day unless it was urgent. So I said I don't know whether its urgent or not but I have a discharge from the nipple and I'm panicking. So she said 'Come at 12 o'clock.' . . . By 3.30 I was being interviewed in the hospital here. . . . He passed me on that quickly. Both doctors at the time said there was only a very small percentage of people that did have cancer that came and thought it was a possibility. . . . Last Thursday, the day of the operation biopsy, not the needle one, a few hours beforehand . . . they put a needle into where the spot showed in the x-ray . . and they left it there until they operated later in the day and took the lump out and had it examined and it was found to be malignant. So that's the stage I'm at now. . Everyone says I'm marvellous but I just can't believe I've got anything wrong with me because - I mean I know I have - but it hasn't sunk in. Because I feel so well. I'm still hungry - putting on a bit of weight if I'm not careful - and panic in between times of course."

This patient had been involved in repeated personal crises over recent months. In addition to the crisis induced by the presence of malignancy, admission to hospital created home management problems and continuing concern about her personal situation. During the conversation she raised the issue of a possible link between her personal stress and the onset of the malignancy when she stated "I would like to have asked if worry brings on cancer in any way."

A person with a history of Hodgkins Disease twenty years before and a melanoma two years previously -

"Then two years ago I had that melanoma which was a bit of a shock because I thought everything was going so well. About three weeks ago I noticed a bit of a lump here at the top of my leg in the groin and I rang the hospital and I came

to go to Mr _ [surgeon]. That was last Tuesday and the doctor there said he would have to put me into hospital this week and have it removed. That was another bit of a shock. I just felt I was getting over this foot. . . . It was just the shock of coming in when you think everything is going so well."

In this example the crisis represents an indication that the original cancer has spread from the foot. Despite her history, the crisis still came unexpectedly after a period of apparent recovery. The crisis is perhaps_ even more important in this situation because it comes after a lot of hard work and hope on the part of the person - following orders, adapting lifestyle, thinking through the issue of having cancer, appearing to have conquered it, beginning to look to the future and suddenly having to rethink everything as a new threat appears. Also, there is evidence of some continuing concern about the health of her husband and about his ability to cope in her absence. Her concern for her own frail mother, who was staying with her at the time of discovering the lump, added another complication.

All of the patients showing the crisis pattern in this study became aware of a visible lump or discharge. This is not always the first sign. Interviews with other patients suggest that many experience an initial pattern of non-specific 'unwellness' or another sign/symptom which could occur with a number of conditions. For example, two patients had experienced a feeling of lethargy and generally feeling unwell with the later sign of mild jaundice for months preceding admission. One other had

had constipation for two years despite many attempted remedies while another had abdominal discomfort with a feeling of being 'bloated'. As the picture persisted and intensified, further medical examinations raised the spectre of malignancy.

The crisis pattern by which a problem surfaces brings a person into nursing care at a time of 'panic'. A sense of urgency and crisis has been reinforced by the words and actions of the medical staff. The outcome, if the problem is left untreated, is feared. Surgery is seen as essential and welcomed in order to avoid the threat of pain, suffering and death, even though the surgery itself may be life-threatening and/or could alter the person's body image.

These four patterns refer to more than the actual development of a physiological anomaly. Rather, they reflect the integration of the problem into the daily living experience of the person concerned and include the actions and reactions of the person as the situation unfolds. The person entering the Nursed Passage as part of the process of resolution of the problem brings this experience with him.

6

Preparing for Intervention

When a surgeon makes a recommendation that surgery is

6 This term was developed following a dictionary search to find the most suitable description for the preparatory behaviour patients revealed in interviews.

required, and the patient agrees to this action, a period of planning for admission to hospital for surgery ensues. Plans are made in relation to home, family, job and other responsibilities; night clothes are checked and new ones may be purchased. There is a general preparation for a temporary withdrawal from the person's usual pattern of daily living.

In addition, the person readies himself for becoming a patient and undergoing surgery. This aspect of the preparation will be influenced by the pattern in which the problem surfaced. In particular, the presence of a perceived threat to life has an impact on the person's approach to the upcoming experience. Analysis of the initial interviews revealed that, during this period, each person strives to achieve a state of acquiescence, with equanimity and order within himself and his immediate world.

Acquiescence, in this context, is defined as 'agreement without protest' to a course of action involving personal suffering in order to achieve a goal perceived to be beneficial (Collins, 1979). It includes the belief that the right decision has been made as well as the development of confidence in the surgeon who will be responsible for performing the ameliorative action. During the Stage 1 interviews it became apparent that, associated with this acquiescence, there was a widespread distinctive quality of dignity, composure, serenity and calmness - that is, equanimity - which patients perceive

to be the appropriate state in which to approach the experience of hospitalisation and surgery. It seemed that most people had been able to attain this state as evidenced by their behaviour during interviews at the time of admission, even when in a crisis pattern.

For some people, as illustrated by the following examples, the willing acceptance of surgery was associated with the anticipation of relief from troublesome symptoms.

" . . . I just finished up vomiting every night. . . .they just have to do something about it the way it was going. Well, they did too because I would have finished up a physical wreck probably. . . . Fortunately, I hope or have been assured that they can make a new man of me!"

.....

"It appears there's a bit of tissue there that's causing the problem and the only way to get over it is to chop it out. . . . Whatever will be will be. If its got to be done let's get the darned thing over and done with."

Each person in the study seemed to be assured that the surgery was necessary and all but one appeared to have harnessed personal resources effectively to attain a state of composure in preparation for the surgical experience. The person who had failed to attain this goal before admission had an unusual prelude period exacerbated by the need to change her surgeon due to his illness. Her acknowledged anxiety about the possibility of cancer was heightened by the delays in medical appointments caused by the change. Finally, after pressure from her, and because of a cancellation, she was admitted at relatively short notice. According to her own account, this scenario left

her still unsettled at the time of admission.

"I felt that no one was looking after me and I was extremely anxious. . . . I had seen Mr _ [surgeon] for a couple of minutes and unfortunately he became ill and no one has seen me except this registrar and I just felt he was not up to it. I had no faith in him at all. . . . he's a couple of years older than me . . . when I came in here this morning I just freaked out."

Nursing action at the time of entry into the Nursed Passage was required to give specific assistance to this person [See Chapter 6].

The research data also revealed that the achievement of a state of composure was associated with a verbalised denial of worry or anxiety about the upcoming surgery by the majority of patients.

"I certainly have the greatest respect and no fears about Mr -."

.....

"It doesn't really worry me. I thought 'Oh well, you know what you're doing.'"

.....

"This time I'm not worrying - no. In fact, I might even be looking forward to it."

Some people may experience a specific fear or concern associated with the problem itself, as distinct from the surgery. During the initial interview, and as the relationship between subject and researcher continued through the experience, people were able to speak of specific concerns which they held as they entered hospital. In the following two examples, one man shared

his feeling of unease that the death of another person was making his surgery possible and an elderly lady spoke of her fears about cancer.

"I think one of the other things about this particular operation which I find - um, peculiar - it gives me a funny feeling - is that they term it - 'You've got to wait for suitable material!' - which means you've got to wait for someone else to be killed off. Okay - what will be will be. If they're going to die, they're going to die. But I still find it very hard to accept or - I suppose I accept it - but I find it hard to take the fact that, for my benefit, the whole thing relies on something unfortunate happening to someone else. Its not a pleasant feeling. . . . Its started now. . . I think probably a mixture of a bit of nausea, I suppose, and gratitude amongst it."

.....

"'Got to get rid of it' Mr [surgeon] told me. I was flabbergasted. I'm a bit nervous coming back here today. Stomach's a bit wiggly-wobbly."

For some the concern arose from their personal circumstances.

"When I found out I was sick my biggest alarm was how was I going to get on without me. . . So I'm worried from that point of view."

Rather than presenting overt anxiety, almost all subjects demonstrated humour during the initial interview when recounting their story. Some of the humour may be very informative to the listening nurse as it reveals past and present feelings and reactions by the patient. Three exerpts are given to illustrate this point.

"I live on my own now. My wife died this year. I'm a lousy cook, I'll say that!"

"He showed me the x-rays and said 'Oh yeah, you'll have to come into hospital,' and I thought 'Oh yeah, me and my big mouth!'"

.....

"The surgeon said 'You don't have to worry very much. They're doing this operation on the streets of Bombay with a bamboo stick so it can't be that bad. Mind you, it hurts a bit!' So that reassured me, so long as it's not done by those means in this hospital!"

The prevalence of this characteristic state of composure with good humour among the subjects in this study, as demonstrated during their first interviews with the researcher, suggests that persons who are about to undergo surgery perceive a social expectation that they present themselves in this way.

Although this image of a desirable state arose from the data, the nature of the research gives little explanation of the reason. It seemed to be important to people that others perceive them as being in control of themselves. Even if there is uncertainty or even fear underneath, the outward appearance of calm contributes to the maintenance of self-esteem within the person. If attainment of a state of composure is delayed and uncertainty and/or lack of equanimity remains at the time of admission, urgency is attached to overcoming this immediately after admission. This urgency arises from the patient's need to settle issues causing concern from prior to admission so that maximum resources can be focused on the surgery itself.

Interpreting the Experience

As each new experience unfolds a person attempts to attach meaning to each event and incorporates it, together with his reactions, into the integrated story of his life. Thus, there is a constant process of analysis and synthesis.

By the time the person enters hospital he has put his personalised interpretation of his experience in a form which he can share with others. From the multitude of experiences, reactions and feelings which contribute to the story he has selected what he considers to be the critical issues in order to recount it in turn to family or friends, the general practitioner, the surgeon, perhaps other medical staff and the nurse. Each time the story is told the person receives comments and reactions which will be interpreted and may become a part of the story for future telling. Thus, the story continues to change and develop, perhaps becoming more complex, perhaps containing less omissions, as more information is received.

In this study it quickly became obvious that there was considerable variation in the completeness of patient's accounts of their experience and in the expressed desire of each person to fill in the gaps even when these were recognised. Omissions in the story were often associated

7

This term was developed following a dictionary search to find the most suitable description for the analysing and information-sharing behaviour patients revealed in interviews.

with the intended action by the surgeon to remedy the problem. This is demonstrated in the following exchange between the researcher and one subject.

"And do you understand what you have come in for - what do you think you have come in for?"

"I don't really know."

"When you were talking it over with Mr [surgeon], did he explain it to you?"

"Oh he just showed me the x-ray and he says he's going to - I think something's blocked and he's going to unblock it."

"Mm."

"So that's why I thought it was only going to take a couple of days and I'd be home again."

"Did you think they would go in from below or . . .?"

"Well, no. I hoped from down here (points to mouth) but I really thought from below. I thought that might happen. I really didn't know."

"And you didn't want to ask?"

"No. I just thought 'Oh well, when I come here they'll tell me, I guess.' 'Cause its horrible people pestering you all the time. 'Cause, you know, there's people at work like that - What are you doing? What are you doing? - you know. It gets me riled. So I thought, just wait, he'll tell me."

"So you're quite happy with that?"

"Yeah. I don't care. I didn't even know how many days I'd be in for. I thought two."

"That's the sort of thing you should ask if you want to know the answer."

"Yeah."

"When the doctors come round they will probably ask you how much you know - and

then its up to you."

"Yeah. It doesn't really worry me. I thought 'Oh well, you know what you're doing."

This example illustrates the reticence of some people to actively seek information even when key questions remain unanswered and the story is incomplete. Such an open acknowledgement of ignorance was made by eight subjects in this study group during the Stage 1 interview and most of these seemed to be willing to accept that their lack of knowledge was to be expected. Indeed, the points of ignorance and the belief that this was to be expected were incorporated into the story. Knowledge and expertise are attributed to the medical staff. The following exchange illustrates this point.

"Well, they're going to do my neck first. I don't know what they do. And after a week or two they do the leg."

"Why do you have to have an operation on your neck?"

"I wouldn't have a clue. It's all to do with the circulation."

"So you've come into hospital expecting that you are going to have one operation on your neck and then, a little bit later, an operation on your leg. Is that right?"

"As far as I understand. They just give you the bare facts, I think. They don't go into detail."

"Would you like them to go into detail or are you happy with that?"

"Its all the same to me."

One person with a life-threatening condition showed a variation from this pattern by repeatedly expressing a

wish to know more about her situation. Even when sharing this with the researcher, this lady was always extremely composed, speaking very quietly and deliberately without overt anxiety.

"I don't know much about it. They don't tell you a lot. I often think they should tell you more."

"You don't feel you can ask?"

"Well, I have asked and I don't seem to get anywhere. They sort of shove you off. They do really! All they say is we must get you well and all the rest of it."

Later -

"I know very little about it even though I have had the experience but I wish they would tell you more. Dr _ [physician] put me before a panel of doctors in Ward _ and they were asking me about the gall bladder operation. I couldn't tell them much about it because Mr _ [previous surgeon] never explained much to me. I was quite content to let things lie. He [physician] said 'She has a very chronic liver complaint.' That's the first time I ever heard it was bad. I wish they would tell you that little bit more."

Paradoxically, this patient seemed sincere when she spoke of her high regard for the medical staff, particularly the physician with overall management of her disease, in spite of comments regarding her lack of knowledge.

"He has been absolutely wonderful to me. So interested. And he has done everything he could for me. As he said, 'We have got to get you well - well, as well as we can.'"

There was considerable variation in the terminology used to by each person to recount his story. Some used the medical terminology, others translated the story into

language that was personally meaningful. No pattern was found in the unstructured interviews in this study to account for the variation among the subjects. There was some evidence of 'wisdom' about diseases, tests, the hospital and staff that arose from continuing association with the health professions in the stories told by those who had a chronic disease and by those who had experienced previous surgical intervention for the same problem. However, there was no consistency among this group on the nature of the terminology used. Short excerpts from the stories of three people who had had considerable contact with health professionals in recent years are presented to demonstrate the variation in language.

A person with a breast lump -

". . . they operated later in the day and took the lump out and had it examined and it was found to be malignant."

.....

A person in hospital for a second corneal graft and a history of eye problems since childhood -

"He [doctor consulted while overseas] said there was a cut on the cornea. I asked him if it was an old one or a new one. He couldn't tell. I suspect it was an old one because it cleared up. . . . It appears there's a bit of bad tissue there that's causing the problem and the only way to get over it is to chop it out."

.....

A person with an eight year history of renal failure requiring home dialysis -

"He [surgeon] said those three things should be cured by this parathyroidectomy. . . . I take a lot of pills to lower the calcium level - Titalac, Cemetidine and others to try and lower it. They must have done because the levels today are good. I tried to explain to the doctor

that electrolyte levels taken after dialysis are never correct. She said they were good. I said you should take them tomorrow. That's the day when they settle down again and you'll see what they really are."

Analysis of the initial interviews in this study indicates that the way in which a person recounts the story of his experience and his expectations is very important. His demeanour, the language used, the way in which potential life threats or crises are discussed, the topics chosen for inclusion or given emphasis, the spontaneous expressions of 'not knowing' and reactions to this - all these give the nurse an invaluable insight into the world of the person as he perceives it to be at the time of admission to hospital and entry into the Nursed Passage.

Summary

Events which precede the person's entry into hospital and into the Nursed Passage proper have been portrayed in this chapter as the Beginning. Each person entering the state of 'being nursed' during hospitalisation for surgery has a Beginning experience which, in its component processes, is shared with others but which, as a synthesised whole, is unique.

Chapter 6 will discuss the Settling In phase - the first meeting between patient and nurse within the Nursed Passage.

CHAPTER 6

SETTLING IN

In this chapter the nature of the work required of patient and nurse during the patient's transition from home to hospital is described.

Introduction

By reporting to the Admission Office, completing and signing the admission documentation, a person presenting for elective surgery becomes an 'in-patient' of the hospital. Thereafter instructions are given on how to proceed to the assigned surgical ward. Entry into the ward, the domain of the nursing staff, symbolises entry into the Nursed Passage. Now begins a period of transition for the patient from a state of 'not being nursed' to a state of 'being nursed'.

Patients vary in their degree of unfamiliarity with being a patient in hospital, with the experience of surgery, and with receiving nursing. For example, five subjects in this study had had the same or a related operation in the same ward within the last two years. In contrast, this was the first admission to hospital for any reason for

three subjects. Between these two extremes lay the experiences of thirteen others, some of whom were familiar with other wards in the hospital as a result of their admission in recent years for other or related health conditions. Whatever his previous experience, each patient faces the task of adjusting to the new situation.

From the moment of the first encounter with nursing staff the patient begins the process of negotiating his own Nursed Passage with the specialised assistance of the nurse. The negotiating work of each participant is discussed in Chapters 7 and 8. However, there is also a separate but concurrent process of initiation into the Nursed Passage which has been entitled Settling In.⁸

There are two actors during the process of Settling In - the patient and the nurse. The work of the patient is to make the transition to becoming a patient - in relation to the hospital, the medical staff, other health professionals, as well as the nursing staff - and the work of the nurse is to facilitate this process. In the remainder of this chapter the conceptualised work of patient and nurse during Settling In will be presented with illustrations selected from the data to support each concept.

8

The term 'Settling In' was derived from the data. Nurses consistently used the term to indicate that the patient had completed the process of admission to hospital and into nursing care. A qualitative judgement on the patient's transition was implied in the nurses' use of the term, e.g. "Settling into the ward well", "Has settled well into the ward."

Settling In: The Work of the Patient

Having left his family, his home, his social world, and his usual pattern of daily living behind, each person entering hospital is assisted to become a patient, to adapt to his new setting and status, and to prepare for the upcoming experience of surgery, by entering into a state of 'being nursed'.

From the field data it was possible to identify three separate but interrelated patient areas in which the patient was working during this process of Settling In: i) Becoming a Patient; ii) Suspending Social Roles; and iii) Revealing Self. Each one will be discussed with supportive excerpts which are primarily drawn from patient interviews.

9

Becoming a Patient

While he is called 'patient' from the outset, a person 'becomes' a patient through a complex pattern of discovery and learning as well as a preparedness to open himself to the unknown. No matter how often a person has been a patient in the past, even in the same ward, there is always something new in each experience - new problem, new personal and family circumstances, new faces, new

9

This term was developed after a dictionary search. In this context the use of the gerundial 'becoming' reflects the process of transition being experienced by the patient during the period of settling in. The term 'patient' was chosen instead of 'client' because that was the terminology used by the patient, the nursing staff, and all others in the institution.

procedures, new decor, and many more.

From their first contact with the patient the nursing staff are easing his way into the role and its work by selecting, translating and sharing with him the information he needs to know as a patient. Helpful information includes the physical layout of the ward, the names of key personnel, how to order meals, and how to contact the nursing staff.

"I've only shown him around and just given him directions and just spoken to him . . ."

Some patients spoke of the value their previous experiences of being a patient were at this time. Such people already possessed some of the information required to settle into the ward and into the Nursed Passage.

"I'm finding it much easier. I know what's sort of going to happen I think knowing what the routine was is quite helpful."

However, a previous experience may actually impede the patient's attainment of settling in. For example, one patient had had the same operation in another hospital several years before and found his admission experience very confusing.

"When I had the other graft done they were so careful about infection and everything and when I come in here there seems to be a complete change of philosophy I'm assuming I'll stay here, in this bed, this cubicle - I'm assuming at this point - which I find quite strange after the other two experiences. But everyone to his job. I'm no expert. If its safe and what they did in the old days, it wasn't necessary,

then I leave it to their judgement. . . .
I still find it hard to understand but I
accept it."

In the formal preoperative teaching session before tea on the day of admission this man set out to uncover any further conflict by not disclosing the knowledge he already possessed and permitting the nurse to 'teach' him again.

"I asked some questions that I knew the answers to but I was interested to see what their answers would be."

Confusion could also be induced by inconsistent information from hospital personnel. One patient later reported she had been given three different predictions on the duration of her stay in hospital - two, seven and fifteen days. Another patient was given information by nursing staff which inferred she would be having an abdominal wound but later that day the registrar informed her that this would not be the case.

"But everyone's been telling me today 'You're being cut' then this other guy comes along and says 'You're not being cut'. They're going to go up through my bladder. So I don't know what it is now. . . . Oh, it doesn't really matter. It'll be in the morning anyway."

A significant part of becoming a patient is accepting the reality that he will have to rely on the expertise of others in order to achieve the purpose for which he has entered hospital. Indeed, there is an active willingness to follow rules and undergo unpleasant, uncomfortable, and/or undignified procedures in order to maximise the

chances of a successful outcome. One patient assured the researcher of his cooperation with whatever was required.

"I'll stick to the rules."

However, throughout the study it became clear that, although this apparent submission was common, it was neither passive nor complete. In the following example from an interview on the evening of admission the patient was reflecting on his sense of powerlessness and his feeling that 'they' had taken over. Paradoxically, at the same time he was able to recount an experience in which he did exert control, when given the opportunity.

"There is nothing I can do. Its in their hands so you just have to carry on with what they do and go along. . . . Its a fact. Its going to happen regardless. . . You have got to accept it. . . . They asked me if I wanted one [sleeping pill] but I don't believe in them. . . . If the body needs sleep it will have sleep. . . . I'll wait until it comes on to me and then I'll go off. No, I don't want any sleeping pills or anything like that."

Encounters with medical and nursing students may occur in the Setting In period. The patient might be even asked to give assistance to medical students and other staff as they prepare for, or even during, examinations. Patients gave the impression that they were willing to cooperate with learning activities associated with a teaching hospital, even when 'learning' was the only purpose for a procedure. However, despite their assent to such intrusions, the patients demonstrated that they were evaluating the behaviour of the learner.

"I feel a bit like a guinea pig. . . . Two lots have looked into the eye - at the eye. The before and after stages they wanted to have a look at. . . . [later] I was rather amused. They put in the Chloramphenical and said 'Don't put your fingers in your eye. If you get tears, wipe it with a tissue'. That goes in every three hours, and in the meantime you get about four or five doctors prodding and touching."

.....

" . . . Dr _ came along and wanted to examine me and I said yes. He's taking an exam tomorrow. . . . Yes, he seemed very nervous. He did a full three-quarters of an hour investigation without me telling him what the trouble was, you know. He diagnosed it all. That was a bit wearying, I suppose. And then the Pakistani doctor came and took me away for a quarter of an hour and went through the same procedure! . . . [later] The trouble is, quite frankly, the doctors come and interrupt the nurses in their work. The charge nurse [actually staff nurse] was sitting down to give me a preoperative counselling and this guy comes along and says 'Do you mind?' - so he wheels me away and she's left like a shag on a rock and has to come back and do it this evening. Its the old coordination. I don't think doctors should have unrestricted access to patients at all hours when it suits them!"

Patients are able to recognise expertise as well as its absence. The former engendered confidence, the latter unease. In the following example the patient knew the surgeon was away and was reassured after a conversation with another surgeon who told her he would be present at her surgery.

"In fact, I didn't even know he was going to do it. I thought Dr _ was involved. In the back of my mind I thought he was a bit young - a bit inexperienced, perhaps - seeing Mr _ was away and he was just his helper. . . . So I was, in some ways, quite relieved when Mr _ came along. "

The patient's relationship with experts and his maintenance of equanimity will be developed further in Chapter 7.

Becoming a patient involves selective submission associated with an ability to distinguish 'experts' from 'learners'; retention of a degree of assertiveness; an acceptance of personal responsibility to contribute to the outcome; and a willingness to cooperate from the moment of admission. During this time the patient attempts to understand what is expected of him as he prepares to undergo the ordeal of surgery.

10

Suspending Social Roles

Each person who becomes a patient has already learned to present a 'face' to the world that allows him to survive in his social world and physical setting. His real self is not exposed. During his socialisation into his community, the individual also learns the skills associated with daily survival. These include strategies for living that are consistent with the prevailing pattern of beliefs and customs within his social group. He fills a number of social roles - such as those in relation to his family, work, religion and recreation - which place their demands on him but which also confirm his place in

10

This term was coined after a dictionary search for the most appropriate phrase to reflect what patients were saying. They showed evidence of recognising the need to give up some responsibilities for the duration of the surgery and recovery period. In this context 'suspending' means 'causing to cease temporarily' (Collins, 1979).

the world.

Admission to hospital, and the effects of treatment measures such as surgery, cause the person to change, at least temporarily, his daily pattern of living and interacting with the world, whatever his cultural background. He is required to shed or modify his usual roles and responsibilities as he assumes the role of hospital patient. Hospitalisation also requires the patient to relinquish a large degree of independence as well as privacy.

In this study a marked sense of responsibility, associated with the need to be absent from social roles during the period of hospitalisation and rehabilitation, was evident during discussions with the patients at the time of admission. The following three examples reflect the prevalent sense of commitment by patients to ensure that their usual areas of responsibility are exercised by others in their absence.

"I'm what they call the floor warden there too. . . I didn't have a deputy. I lost him because he went downstairs to another floor. I had to appoint another one yesterday - just in case. . . Also, I had to show the civil defence. . . ."

.....

"I started to try and organise things and complete things so, if I did disappear in a hurry, it wouldn't cause too much disruption. . . . So you've got to make it so that whoever does the thing [work] on your behalf is as well equipped as they possibly can be."

.....

" . . . of course, when I found out I was sick my biggest alarm was how was _ [ill husband] going to on without me. But we've got a daughter and she's holding the fort."

Prior to hospitalisation there is often a time of increased activity necessitated by the need to hand over responsibility to others. It is possible that the person may be tired from this effort when he arrives in the hospital. An example of this is the following exchange between the researcher and one subject several hours after admission.

"I was sleeping before."

"Did you just feel tired and doze off?"

"Just felt tired and dozed off."

"Had you been doing extra work at work to get ready to come or something?"

"No, not so much at work but I've been doing stuff at home."

"I see, you mean like mowing the lawns . . ."

"Concreting!"

"Oh my goodness."

"Concreting the garage floor - digging it all out and I was putting a concrete floor down before I came in so the car could come in off the road while I'm away."

The Settling In experience involves the full or partial suspension of the person's usual social roles and the assumption of the patient role. This divestment is common to all patients but its details - the constellation of roles, the concerns about their maintenance during the period of hospitalisation and recovery, the ability to

withdraw from each role and the personal investment in the roles - are specific to each person.

11 Revealing Self

During the time of settling in the patient is faced with the need to shed his privacy in relation to his person and his personal affairs. Access to personal information about his life, his activities, and his body are sought by the health professionals as a part of their work on his behalf. In addition, hospital practices demand changes in behaviour which expose aspects of his living pattern which are normally reserved for home and family.

For example, nightwear is usually worn at home, at night. In hospital it is worn all the time. In this study no patient expressed concern about this. Indeed, people enter hospital expecting to wear night clothes and most come prepared with enough night wear to last during their time in hospital. This expectation is validated by the behaviour of nurses during the admission procedure who tend to show the person to a bed, pull the screens and ask the person to change into night attire before any further action is taken.

"I came up here just as they were having a cup of tea . . . and after that I changed and put on my dressing gown and pyjamas and then they came in and checked off my clothes."

11

This term came after a dictionary search to find wording which would reflect the loss of privacy. 'Revealing' is used to mean 'disclosing; divulging; exposing to view' (Collins, 1979).

In everyday living, privacy of the person also involves restricting access by others to the sight and touch of the body and body discharges. The degree of restriction is socially and culturally determined although there is considerable individual variation. However, this restriction is relaxed when a person is in the care of a nurse. This willingness to shed privacy seems to arise from an acceptance of the legitimacy of the nurse's role in relation to the care of a person's body. No negative comment or disquiet was expressed by the subjects in this study concerning the nurses' actions in this regard. Indeed, patients seemed to tolerate this unmasking with equanimity right from admission so that procedures like weighing, often done in private at home, were willingly undertaken in public and even usually concealed body discharges, such as urine, were handed over to nursing staff.

During Settling In the patient becomes the recipient of intrusive activities related to the upcoming surgery. Some are performed by the doctor - rectal examination, vaginal examination, breast examination, for example. Others are performed by the nurse.

"Nurse has just shaved me ready for the morning [pubic shave]."

.....

"I had an enema last night only because she told me it would be a good idea."

Even the consequences of such procedures are regarded with composure, and occasionally humour. One elderly gentleman

had a twinkle in his eye as he described the unpleasant aftermath of an enema as being "just like the old tune Annie Laurie - she played on!"

The initiation rites performed by the nurse bring her into close contact with the patient. Normal patterns of self care are probed with particular emphasis on identifying areas where special nursing assistance will be required. In the data were examples of patients who found it difficult to move freely around the house and had developing coping strategies for that setting; who struggled to reach all body areas while in the shower; who had difficulty dressing because of imperfect functioning and/or painful joints; and who had difficulty reaching the toilet during the night. It was evident that such 'problems' might have relevance for nursing even when the adaptive strategies used by the patient meant they were no longer perceived as problems. For example, the researcher, as nurse, observed that one patient had no dentures, assumed they had been left at home and anticipated that this could be a problem in relation to hospital meals.

"You didn't tell me about them this morning." [Researcher had already telephoned son to ask him to bring in hearing aid]

"No. I didn't tell you about them at all." (Patient chuckles)

"Do you feel better not wearing them?"

"Well, I'm not retching and tend to vomit. That's the trouble."

"You have pretty soft food - everything mashed up?"

"Oh no, I can eat it as long as I chop it through a bit. . . . I'm quite happy without them."

Each person has his own areas of privacy which he may need to reveal, partially or completely, in word or by sight, to the nurse during this hospital experience. Acceptance of this kind of exposure is associated with the acquiescence required to attain the perceived benefits from the surgery. Nurses are accepted as being one group of people to whom it is 'safe' to expose these areas of perceived vulnerability and to receive assistance as required.

During discussion with the nurse the patient may reveal much more about himself than the nurse seeks. Nurses, who minutes before were strangers, may gain a very intimate insight into the world of the patient. One gentleman cried during the initial interview when sharing his daily pattern of living without his wife and went on to speak of how he had coped.

"I thought I had got over that. . . . I have a bit of a garden and a bit of lawn to do, so by the time I do the house and make the meals and do the garden, that occupies the mornings and the bowls occupy the afternoon. The evenings are the only time I find a little bit quiet. Pull the blinds down and shut yourself off from the rest of the world."

Such information is precious to the person and its revelation reflects the immediate human-to-human closeness which characterises the contact between nurses and

patients - even though they are actually strangers.

Admission to hospital is associated with an openness between patients, particularly in the area of health status and the upcoming surgery.

"When I came home [from clinic] I thought about it and discussed it at home and everyone one I talked to - which wasn't many because I didn't like to tell the world about my medical history. Its funny when you get in here you forget all about that. You like to know what everyone else has got. . ."

.....

". . . he's having the same operation. . . he had this eye done three years ago . . . he said its totally different than last time."

There is a camaraderie born of the shared experience that seems to begin immediately. Indeed, advice is offered by people who were complete strangers a short while before but are now considered allies and even friends.

"My fellow contemporary over there thought I should have one [sleeping pill]."

Revealing self seems to be a key task for the patient as he settles into the Nursed Passage. This transition is a period of vulnerability for the patient as he exposes, to strangers, personal information about himself and his circumstances. Support for this process of unusual openness comes from fellow patients, family, friends as well as the hospital staff. However, at all times, the patient retains some control over the amount of revealing he does. While no person lays bare his total being to anyone, patients accept that nurses have the right of

access to highly personal information for the purpose of rendering nursing assistance within the Nursed Passage.

Settling In: The Work of the Nurse

The nurse, as the agent of nursing, performs the rites that mark the patient's initiation into the Nurse Passage. At this time the nurse seeks to add a nursing component to settling the patient into the hospital, the ward, and the care of other personnel who will be intermittently present with the patient. Analysis of the field data revealed the presence of these two separate but co-existing areas in which the nursing is working during the Settling In period: i) Admitting; and ii) Appraising.

12

Admitting

Admitting comprises a routinised set of specific tasks which nurses perform on behalf of others. While these provide information for the patient as he is admitted to a surgical ward, they are also a major source of information from the patient. From the nursing documentation and nurse interviews in this study, it became clear that these tasks can be divided into two groups: those providing baseline data of primary value to the medical management of the patient such as temperature, pulse, respiration, blood pressure, weight and urinalysis, and those performed

12

This term was developed from the data itself. It was used by nurses to refer to the set of tasks which they were required undertake in order to gather initial general data from the patient and to settle him into the hospital environment - ". . just admitting him."

on behalf of the institution, such as security of clothing, labelling of records and ordering of meals.

The admitting ritual may be recorded in the nursing documentation as a partial or full checklist of tasks. Those remaining uncompleted at the end of the admitting nurse's period of duty may be specially noted to remind the next shift that they are still to be done. Entries in the nursing documentation are impersonal, usually focusing on completion of the tasks rather than their outcome.

"W/L admission to ward for above surgery tomorrow. TPR and BP / Urinalysis / Weight / Clothes /."

In interviews the admitting nurse could give either an account that focused on the 'admission' and the tasks, or a more personalised account which referred to the patient by name or third person pronoun.

"I carried out the normal admission procedures for nursing staff - so I did blood pressure, pulse, temperature . . . "

.....

"Mrs came in about half past nine - ten o'clock and I took her temperature, introduced her to the ladies in the cubicle and took her temperature and pulse and blood pressure and she gave me a urinalysis and I did her weight . . . "

It was common for nurses in both their written notes and in interviews to refer to completion of the admitting procedure in its entirety.

Nurse - " . . . just admitting him, doing normal nursing procedure, normal admission procedure."

.....

Notes - "Fully admitted by nursing staff . . ."

The tasks included in the Admitting rite are listed in Table 10.

TABLE 10: ADMITTING TASKS PERFORMED BY NURSES

Type of admission [acute or waiting list]
Time of admission
Recording - Weight
 Urinalysis
 Temperature
 Pulse
 Respiration
 Blood pressure
Ordering of meals
Wristband in place
Bedcard in place
Recording and storage of clothing
Recording and storage of valuables
Entry of patient details in Admission book

Completion of the tasks within this rite are given a high priority by nurses. A nurse will strive to complete them during the nursing duty in which the patient is admitted even when she considers herself to be 'very busy'.

"I admitted him and that's really all I've had to do with him because there's been no time to do anything else."

Nursing judgement is exercised in the way each nurse organises the individual tasks into an integrated rite for each patient's initiation. Skill is required for the proficient performance of each task and the attainment of valid readings. Judgement is also apparent in the interpretation of results. In the following example, the nursing response to the finding that a patient's blood pressure was abnormally high at the time of admission was

to institute four hourly monitoring.

"Commenced on 4 hrly BP recordings. BP
160/100 130/100 on admission."

Nursing judgement can also be inferred from the non-recording of findings. Analysis of the data revealed that no abnormal findings discovered during the patient's admission were omitted from the nursing documentation. Thus, nurses were evaluating the results and recording only the noteworthy ones.

While the Admitting rite is a nursing procedure associated with entry into the Nursed Passage, it is a rite which primarily supports the work of other hospital staff who will be involved with the patient during his hospitalisation. Thus, the nurse's admitting work can be clearly seen to affect the patient's total hospital experience.

13 Appraising

Within the field data it was possible to identify a second rite in the work performed by the nurse during the initiation of a patient into the Nursed Passage. This rite is generated by nurses for nursing purposes. It has the primary goal of establishing an initial nursing information base on the patient which will be significant

13

This term was developed after a dictionary search for a suitable description of nursing work undertaken during the patient's initiation into hospital. 'Appraising' is defined as 'assessing' the distinguishing characteristics, properties or attributes of the patient (Collins, 1979).

in the subsequent nursing of the patient through the experience of surgery.

Evidence of appraising activities can be found in the initial entries in the nursing documentation which records each patient's Nursed Passage. However, in this study the quantity and quality of the nursing appraisal and its written record were variable, even when a standard documentation format was available to guide the activity.

Although two variations of the nursing history format were available to the nurses in this study, only five patients from three wards, had any formalised nursing history completed. Of these, two were recorded on the form devised specifically for surgical patients and three were written on the alternative form which had been prepared for use in any area of the hospital. Charge Nurses in two wards of the five wards in the study had decided not to use any formal history form and, instead, asked their staff to make a short comment on the patient's social situation in the 'Special Cares' section of the nursing care plan. Analysis of the data revealed that eight patients had had no planned collection of a nursing data base while another eight had minimal social information recorded on the care plan. Of the five nursing histories which were completed, three were filled in by registered nurses and two by student nurses. Members from both groups omitted to complete them.

The history form in general use was primarily a checklist with some open-ended questions. These drew the nurse's

attention to selected aspects of the person's normal pattern of daily living as well as the patient's manner during the interview. It was closely related to the format for the nursing care plan. Questions were grouped under the headings listed in Table 11.

TABLE 11: AREAS FOR INVESTIGATION IN NURSING HISTORY

Patient's perception and expectations related
to illness and hospitalisation
Mobility
Hygiene
Rest and Sleep
Elimination
Communication
Nutrition
Social Needs
Nurse's observation during interview
Communicative patterns [during interview]

These headings reflect the perception of nursing's focus of concern held by the originators of the form. The detailed form is presented in Appendix 5.

One nurse spoke of her reason for discarding the nursing history form while actually interviewing one of the patient's in the study.

"As I was doing the nursing history I found that it wasn't appropriate to what I wanted to hear because it said so many things like 'How many times do you wash your hair?' and 'Do you sleep well?' and things like that. Um - I explained to him that it was - um - the nursing history was to help me nurse him. So I just sort of discarded that and thought No, it wasn't appropriate, and I said to him 'Well, do you know of anything that would help me nurse you better?' to which I got a lovely response"

Another nurse justified the non-use of the form in her

ward by also questioning the usefulness of the information sought.

"We don't use them in this ward. If we ever do they are just tucked away and never used. What's the use of asking someone how often they shampoo their hair, or how many pillows they sleep with when there's only two on each bed, or whether they like their windows open or shut when we can't open the windows. I can see the reason for doing the social history because that's important but to find out what their normal life is like at home is of limited use if the information is not available or we can't do anything about it while the person is in hospital."

A charge nurse shared her concern that it was difficult to persuade her staff to consistently complete a nursing history.

"Yes, I expect them to do it [history and care plan] but they don't do it. . . . They're not encouraged to use the nursing histories throughout the hospital. They find the forms difficult to use. In reality there's a lot of questions on that form that we ask and we get answers and there's nothing we can do about the answers anyway - questions about ventilation and what their likes and dislikes are. Well I suppose we can do something about meals and one or two pillows and that sort of thing. I ask them to explain to the patient why we can't do some things but that would appear to be too much trouble for some people and they don't use the form."

These comments indicate some of the areas of perceived difficulty in the use of nursing history forms to guide the nurse in gathering a nursing data base during the appraising rite. In particular, nurses seemed to experience difficulty in linking the information obtained in the nursing history to nursing decision-making and

action. Thus, the format failed to generate the kind of information that nurses valued and could use as the foundation for nursing action during the passage.

Appraisal encompasses more than asking questions. Nurses are also establishing a data base on each patient while undertaking each activity during the patient's initiation. All information obtained from any source undergoes a process of interpretation within the nurse. In their responses to the question: "How has Mr_ been since he came in and what kind of nursing has he required?" nurses gave an insight into what they considered important. Two examples of replies to this question from the field interviews suggest that nurses give priority to appraising areas that relate to the patient's status at the time of entering hospital and his readiness for the upcoming surgery, rather than his normal pattern of daily living.

"Well, she came in about 10 o'clock this morning. She was accompanied by her husband and a friend of hers - a younger female friend. She didn't appear too nervous - really - but as we were talking, once her relatives had gone home and I was admitting her, we had a good talk and, um, I think she was slightly nervous although she seems more worried about social problems - her moving and, um, associated problems, her urinary frequency and things like that - more than she seems worried about having cancer or having a breast removed. She's worried about post-operative pain. We assured her about that and the pain relief injections that we can give her. . . ."

.....

"I found _ very relaxed - ah - very cheerful. She has a very positive outlook about her condition. She didn't seem at all worried about the operation. She was willing to ask questions. . . . But - um

- I found her a very nice girl . . . and her mother seemed very supportive."

Nurses would also seek information on the patient's previous experience of hospitalisation in order to identify the nature and amount of knowledge available to him as he enters into this experience of being nursed.

"Well, he's obviously a man who's been in hospital before and is used to the situation. He didn't appear to feel out of place. He sort of knew what he was coming to . . ."

.....

"Well, he told me its the first time he's been in hospital for an operation so he's been a bit anxious."

Data such as the last four excerpts from interviews with nurses became the source for the conceptualisation of the work of both patient and nurse within the Nursed Passage. Although not guided to do so by the documentation format, nurses were gathering information that showed an interpretation of the patient's situation, albeit an unorganised one, which seemed to override the nursing history. For example, the nurses quoted above are speaking of information which can be related to some of the conceptualised areas of patient work such as: Becoming a Patient, Suspending Social roles, Managing Self, Surviving the Ordeal and Interpreting the Experience.

However, examination of the nursing notes of the patients referred to above reveals that nurses did not translate this acquired information into a written record. Nor is

it present in the notes of the other patients in the study. Indeed, very little of the nursing appraisal was transcribed into the nursing record although these excerpts from interviews reveal its presence. Occasionally it could be deduced from the nursing care plan.

The nursing care plan in use in the five wards in this study was consistent with the problem-oriented approach to diagnosis and care planning currently favoured in nursing. A copy of the nursing care plans in use at the time of the study can be found in Appendix 6. There are two major sections to the form. After appraising the patient using the established criteria the nurse is requested to deliberate on the results and identify any 'Nursing Problems' - present or anticipated. In the space alongside each problem she enters the 'Nursing Aims' which are considered appropriate to achieve its resolution. The remainder of the two page care plan requires the writing of nursing orders in relation to specific topics: mental state, nutrition, observations, hygiene, mobility, elimination and special cares. Two additional topics - rest and sleep, and records - are included on the medical nursing care plan, which was used for two subjects.

Thus, the care plan format also served as a guide for the appraising activities of the nurse. It was assumed that nurses would gather information on the status of the client in relation to each topic. The incoming cues are then filtered in the mind of the nurse and are recorded only if they can be expressed as a 'problem' which is

considered to require a planned nursing response.

A representative example of the nursing care plans completed on the patients in this study following the appraising activities of the nurse is presented on Table 12.

TABLE 12: SAMPLE NURSING CARE PLAN COMPLETED
FOLLOWING INITIAL APPRAISAL

Situation - Person admitted with possible recurrence
of cancer

Nursing Problems	- Nil
Mental Status	- Alert and Oriented
Nutrition	- Normal diet NPM [nothing by mouth from] 2400
Observations	- Daily TP [temperature and pulse]
Hygiene	- Shower
Mobility	- Up as able
Elimination	- Daily bowel check
Special Cares	- Preop checklist

If no 'problems' are noted, as in this case, the care plan consists of a prescription for activities common to all patients - daily bowel check, daily recordings of temperature and pulse - and routine preoperative activities - checklist, nothing by mouth.

Only seven of the twenty-one patients had nursing problems identified on the nursing care plan following the initial appraisal. However, problems were identified in the nursing notes of eleven patients, and eleven of the

appraising nurses spoke of patient problems during interviews. Lists of the problems identified in each of these three forms of data are presented on Table 13.

Although the study was not designed to permit any evaluation of the ability of nurses to recognise, describe and name nursing problems, inconsistencies are evident in the lists compiled from the data. The table reveals variations between the lists in both the problems and the patients. Only one problem - "loss of memory" - was identified in the nursing notes, nursing care plan and the interview of the same patient. Six problems were identified in the nursing notes and interviews relating to six patients; one problem was noted in the notes and care plan but not the interview; while one was noted in the care plan and interview but not the nursing notes. The remainder were identified in only one form of data.

The data obtained in this study revealed that the nurses were experiencing difficulty in establishing a nursing data base on patients at the point of entry into the state of being nursed. There is evidence that nurses did not have access to an appraisal protocol, consistent with a theoretical interpretation of the patient's total experience, which would consistently yield meaningful nursing-relevant information. Despite this, however, the behaviour of the nurses in this study, as reflected in the nursing documentation and interviews, supports the presence of a significant appraisal work for the nurse during the initiation of each patient into the Nursed

TABLE 13: NURSING PROBLEMS IDENTIFIED DURING
INITIAL APPRAISAL

In Nursing Care Plans - 7 patients

Reduced vision (3 patients)
Anxiety (2 patients)
Fear - preoperative
Anxiety and lack of knowledge
Postoperative complications (2 patients)
Pain - postoperative
Dialysis patient
Back pain due to recent kidney infections
Frequency and 'disurea'
Loss of memory
Says he forgets easily
Blackouts on occasions
Difficulty sleeping at times
Pain

In Nursing Notes - 11 patients

High blood pressure (2 patients)
Loss of Memory
Loose cough
Not sleeping/ poor sleep pattern (2 patients)
Pain/cramp in leg
Anxiety (2 patients)
Anxiety - pain
Anxiety - surgery
Anxiety - re leg
Apprehension
Smoking
Walks with a stick

In Nurse Interviews - 11 patients

Apprehension (2 patients)
Concern over cancer
Communication problem
Anxiety (2 patients)
Not sleeping/poor sleep pattern (3 patients)
Anxiety - home situation
Anxiety - diuretics
Anxiety - pain
Conflict/confusion over procedure
Lack of trust in nurses concerning dialysis
Loss of memory
Occasional blackouts
Lack of family support
No dentures
Shortness of breath
Worry about ability of the surgeon

Passage. An appraisal format is required that is consistent with the data-generated conceptualisation of patient and nurse work within the Nursed Passage. This would add meaning to the work which nurses are presently doing during the Settling In phase. Their appraisal would be patterned in a way that would focus it on the nursing dimensions of the patient's total experience, and would establish an information base which would be relevant to the nursing contribution to the patient's ongoing experience through the passage.

Summary

In this chapter Settling In, an interrelated set of nurse and patient tasks which mark the entry into the Nursed Passage, has been described. Nurses perform a formal initiation procedure, comprising the two distinct rites of Admitting and Appraising, which signify the formal transition of a patient from a state of 'not being nursed' to one of 'being nursed'. The data revealed that nurses are appraising the patient but the format in use at the time of the study was not achieving the desired result of establishing a useful information base for subsequent nursing intervention. Meanwhile, it was discovered that the patient has his own pattern of work to do during this initiation experience as he makes the transition from home and his usual pattern of daily living to the role of a patient who is about to undergo surgery.

In Chapter 7 the discussion moves on to a theoretical

discussion on the work of the patient as he negotiates the Nursed Passage. This is the patient's major work which begins on admission and progresses right through until discharge, coexisting and interacting with the phases of Settling In and Going Home.

CHAPTER 7

NEGOTIATING THE NURSED PASSAGE: THE WORK OF THE PATIENT

This chapter seeks to describe the conceptualised pattern of work in which the patient is involved during the negotiation phase of the Nursed Passage. As with other parts of this framework the gerundial form of the terminology has been used in order to convey the dynamic, ongoing process in which the patient is involved.

Introduction

From the time he enters hospital and begins his initiation into the Nursed Passage the patient is at work facing some of the many internal and external challenges which will continually confront him throughout the passage. It is this dramatic moment-by-moment negotiation process which characterises the patient's passage, and which provides the focus and purpose for nursing action.

From the interviews with patients as they lived through the experience of hospitalisation and the surgery itself, four areas of patient work could be identified. First, there was activity related to organising himself to cope

with the experience. Secondly, attention was paid to the relationship with the various helping people. Thirdly, each patient seemed to be focusing on getting through the potentially threatening experience and aftermath of the surgery and the anaesthetic. Finally, as had been seen in earlier phases of the experience, the patient was constantly receiving and analysing information and synthesising these and his interpretation into an integrated account of his experience.

While the awareness that these four areas of patient activity existed occurred quite early in the data collection and analysis, they were not confirmed as the most useful taxonomy of nursing-relevant patient behaviour until many alternatives had been attempted and discarded. The compilation of an integrative model of patient behaviour was a lengthy process despite the consistency in the ideas contained in the many diary notes, analytical notations written in the data, and the theoretical memos.

Attention was given to developing the distinction established between patients on the basis of the nature and significance of the problem which surfaced during the Beginning. The data was probed to ascertain if this was the most significant organising pattern for patient behaviour during the surgical experience. However, this did not prove to be a valid basis for distinction using the present data although the nature of the problem was recognised as a factor in shaping patient behaviour within the four constructs which comprise the final form of the

model. It is possible that further research of the Nursed Passage will lead to a two-dimensional patterning of patient work which links the identified work of negotiation and the continuing impact of the health problem itself.

Negotiating the Nursed Passage:
The Work of the Patient

Within the Nursed Passage the patient is working on his total situation. The general nature of this work is identified as relevant to nursing because the nurse has the mandate, knowledge and skills to share this experience with the patient, giving specialised assistance to help him in this work. Thus, nursing has a pivotal role in a patient's hospitalisation and, in this study, surgery.

Four concepts were developed to identify the different areas in which patients seem to be working as they negotiate their way through the Nursed Passage: i) Managing Self; ii) Affiliating with Experts; iii) Surviving the Ordeal; and iv) Interpreting the Experience. A summary of these complex constructs together with their subconcepts is presented on Table 14.

In the following discussion, the description of each concept may give the impression that it is a discrete entity. However, the reality is that each influences and is influenced by each of the others. Thus, the patient's behaviour is a complex and integrated network of purposeful activity.

TABLE 14: NEGOTIATING THE NURSED PASSAGE:
THE WORK OF THE PATIENT

<u>Managing Self</u>	Centring on Self Harnessing Resources Maintaining Equanimity
<u>Affiliating with Experts</u>	Acquiescing to Expertise Fitting In Retaining Autonomy
<u>Surviving the Ordeal</u>	Enduring Hardship Tolerating Uncertainty Possessing Hope
<u>Interpreting the Experience</u>	Developing Expertise Monitoring Events

It may also seem that the patient states suggested in each construct are attainable, and indeed have been attained, by the individual efforts of each patient. This is not the case. Successful accomplishment of the task, alone or with the specialised assistance of the nurse, is not guaranteed. Perhaps it rarely occurs. Rather, the data suggested that patients are continually working in each of these areas throughout the passage. Nursing works with the patient to maximise his chances of attaining the optimally achievable performance of these behaviours within the context of his situation.

To date, the Nursed Passage has not been developed to the stage where propositional statements linking specific areas of patient and nurse work can be made which hypothesise patient outcomes. Further research would be required to accomplish this. Within the present data, both patient and nurse are seen to be working to progress

the patient through the passage although no definitive criteria for success, in either patient or nursing terms, have been defined.

14 Managing Self

In the Beginning the patient's preparation for admission to hospital for elective surgery was discussed. As the anticipation becomes reality, each person occupying the patient role pays considerable attention to himself and the way he will cope with the challenge he is facing. He brings with him the self management practices he has learned through his life. While these are the primary determinants of his ability to cope with the events he is confronting, they are modified by the meaning he attaches to the problem as well as the visualisation he has of what would be appropriate behaviour for a patient. As he lives through the experience he is also influenced by the actions and reactions of others, particularly the staff, with whom he interacts as patient.

Another aspect of managing self which became apparent in the data was the patient's acceptance of personal responsibility to contribute to the outcome of the surgery.

14

This term was generated after a dictionary search for a phrase that would best encompass the patient's work in managing his resources and holding himself together during the many events associated with the surgical experience. 'Managing' is used in its meaning of 'to be in charge of' (Collins, 1979).

"My priorities are to make sure I do my bit to make sure this works out because Mr _ [surgeon] has done his bit and the nurse can put drops in it. I think the main thing is my own action - not being stupid over the thing, not bending down or jerking or getting out of bed and roaming around the ward."

One patient described her responsibilities as:

"Have the right attitude, be optimistic and do all I can for myself."

She went on to state:

"I'll try as hard as I possibly can at everything and, even if I can't do it, the nurses should know I've done my best. But, I'll need quite a bit of help from them."

Three significant dimensions in the patient's management of himself emerged as subconcepts within this major construct: Centring on Self; Harnessing Resources; and Maintaining Equanimity. These serve to specify the range of patient activities which can be seen to facilitate the patient's attainment of self-management as it applies to the experience of being nursed while undergoing surgery.

¹⁵ Centring on Self

The whole environment, including the behaviour of the people within the hospital setting, encourages the patient

15

This term was developed after a dictionary search for wording that would convey the patient's activity related to restricting his boundaries in order to concentrate himself on getting through the experience of surgery. 'Centring' is defined as 'focusing' (Collins, 1979).

to focus on himself. His problem, his body and information about aspects of his life which are considered to be related to his health status are exposed for examination by experts.

"If you didn't have anything wrong with you before you certainly would have by the time they had done their checks!"

He is constantly asked how he is feeling.

"There's lots of people been coming in and asking me if I was alright."

He, or his problem, is the centre of attention as medical and nursing staff enter his presence.

"They [doctors] didn't do much. They just showed the young students the foot where the melanoma was. Seems to be the drawcard for everyone to have a look. I am having a collection box here! A dollar a look!"

In addition, he is forced to attend to himself as the impact of the problem and its therapy are felt.

"I sat on a plank, you know, across the bath, and splashed all over, and that was very nice. Then I came back and I felt very, very tired and I felt more sore than usual. My wounds were desperately sore - sorer than any other time. My back was tired and, of course, I have this disc trouble. And I couldn't find a comfortable place for my back and I just felt more and more miserable."

This centring on self can be considered as a conservation strategy as well as a consequence of his situation. It focusses the patient's energies on the resolution of the challenge he is facing and the attainment of an optimal

outcome.

"When you're not well, you know, you've got to look after yourself."

In one interview the patient confirmed his awareness of this self-centredness but he also went on to express concern about such behaviour.

"I'm getting conceited because all I'm thinking about is myself."

However, the validity of this behaviour is confirmed by the social sanction that is given to it as illustrated by the behaviour of hospital staff and the encouragement given by family, friends and staff for the patient to suspend his usual social roles and responsibilities for the duration of the experience.

16

Harnessing Resources

In order to optimally manage his situation the patient draws on the strategies he has developed for coping with the challenges he has experienced in his daily living. The patient identifies what he believes he needs to do to endure the present experience and to maximise his chances of success.

16

This term was generated after a dictionary search for the most appropriate term to portray the patient's application of energy, including personal patterns of coping, which he believes will help him to withstand the effects of hospitalisation and surgery. 'Harnessing' is used in its sense of 'controlling so as to employ the energy of'; 'resource' means 'a supply or source of aid or support, something resorted to in time of need' (Collins, 1979).

"Everything's just floating along. Its just waiting for that healing stage which you can't hurry. You've got to have patience and tolerance and perseverance and all the other things."

Many references were made by patients to a link between the amount of rest and sleep they were able to get and their ability to handle a stressful situation.

"I adapt pretty quickly. As long as you can have a few hours decent sleep you are alright."

.....

"If you have a good night's sleep you don't feel your pains and things do you?"

Some patients manage the effects of the surgery itself by appearing to value, even welcome, it as a way of confronting the threatening presence of cancer. If surgery is possible then there is hope! One patient shared how she coped in this way and distinguished between this and how she might have regarded surgery in the absence of malignancy.

"I mean I didn't really mind going through the operation if the result was going to be okay. That was the part that was worrying me. Mind you, if it had been a gall bladder operation I'd have been worried about it from the word go - about the operation itself. But in this case it seemed to be a secondary thing, having to put up with it."

The patient may harness strategies which are unrealistic in the longterm but are considered the best way of coping in the immediate circumstances. For example, several patients spoke of using avoidance when confronted with the opportunity to see the wound at the time of the first

dressing change. However, others feel able to look at the healing wound.

"Its all exposed now. . . . And, anyway, I was just thanking him [surgeon] and I was saying I was quite surprised at the end result. 'Ooh,' he said, 'The end result hasn't arrived yet.' I don't know what he meant by that. . . . This [mastectomy suture line] looks nothing but the part under there [at side] didn't look nice when I saw myself in the bathroom - to me who's not used to wounds."

.....

"She [nurse] insisted in getting a mirror to show me what a wonderful job it was but I wasn't really interested. I might sound slightly squeamish. I still haven't seen it but I'm not in a hurry to."

Resources have been harnessed effectively when they are in balance with, or superior to, the challenge facing the person. There seems little doubt that reflection beforehand permits each person to prepare himself as far as possible for what he believes lies ahead.

"Not worrying - just the fact that I'll be having to adjust my eyes and may or may not be able to drive and am still having to get this dialysis going. I think that's a fairly good handful for me to handle. It won't get me down but its enough."

A variety of nursing actions may be required to supplement the patient's personal resources. Indeed, often the patient cannot manage alone. Many aspects of nursing's work assist the patient to endure the passage by providing an external form of supplementary energy. Examples of this are easily found including such practical actions as the skilled management of the selective

administration of pain relief, making the patient comfortable, giving information that is appropriate in timing, language and amount, being present to give confidence.

Even seemingly mundane assistance is valued as the patient negotiates the moments of the passage. For example, one patient's position in the bed was making it hard, indeed almost impossible, to manage eating a meal. The nurse researcher supplemented the patient's resources by adjusting her position, altering the pillows and also securing the meal tray.

"Oh that's given me support. Ooh, that's lovely. Now I can cope with two hands. I was really cock-eyed."

17

Maintaining Equanimity

During the Beginning, discussed in Chapter 5, the person has worked at achieving a state of equanimity or composure within himself in relation to the circumstances of his upcoming surgery. Entry into hospital changes the situation from anticipation to reality and the work continues. Now the patient is actually in the hospital and the time for the surgery is at hand. The patient increasingly feels its impact within himself and in the actions of the hospital staff.

17

This term was generated after a dictionary search for a phrase that would best describe the efforts made by patients to maintain a state of composure, at least on the outside. 'Equanimity' is used to mean 'calmness of mind or temper; composure; quietude' (Collins, 1979).

One patient, whose surgery had complications, revealed after discharge that he had become very uncertain about his agreement to the surgery soon after admission because the surgeon revealed new information during his examination.

"It came as a bit of a surprise to me when I saw him in hospital before the operation, the very day before, when he explained about this vision [post-operative problem to adjust vision in two eyes] and that night I didn't sleep too well. I thought about it quite a bit and thought 'Am I doing the right thing?' . . . I am not critical of it at all."

Comments such as this reveal the tenuousness of the assent and the hidden confusion and/or uncertainty which may be going on in a patient who, on the surface, appears composed and acquiescent. New or conflicting information may challenge the patient's equanimity throughout the duration of his Nursed Passage.

The environment itself induces a degree of apprehension within the patient as he enters the hospital.

"I do have a bit of apprehension coming in this morning. The initial thing you strike is car parking . . . and it was raining . . . Then when we came through the front entry, its a rather forbidding place. I would imagine some people could get quite upset by it - if they were the worried or nervous types. . . . But once the cubby hole was opened - very friendly - no problems."

In spite of challenges to their equanimity, the patients in this study gave the impression that they were continually striving to maintain their self-control from

the time of admission as the time for the actual surgery drew nearer.

"I am anxious about tomorrow but I am not. I won't lose any sleep over it. I'll be glad to get it done."

.....

"I'm alright now. Now I know its going to happen."

.....

"So we'll do our best and we'll just cross our fingers and hope."

—
It is difficult to transmit the quality of composure that was evident by using the actual words spoken during the interviews. The context of the conversation, the manner of speaking, and the dignity demonstrated by these patients as they recounted their experience conveyed a sense of quietude and order. Perhaps the argument for the presence of this apparently desirable patient state is enhanced by further reference to the one patient, mentioned in Chapter 5, who had not attained it by the time she was admitted.

". . . when I came here this morning I just freaked out. . . I just felt so uptight. Uptight is probably the understatement of the century. Total anxiety! . . . I was pretty anxious. The nurse that I met was really nice and put me at ease and I was able to talk. I had to talk to somebody. . . . Both the charge nurse and the student nurse. They were just great - really nice people and I felt immediately better and they told me to ask the surgeon when he came round, to ask questions because I knew so little. But when he comes round with a cast of ten around the bed you don't actually get around to saying anything. You sort of coy out on him. But I feel a lot more relaxed now than I did when I walked through that door this morning."

Her state of disquiet became evident to the appraising nurse, a student, who shared her concern with the charge nurse. The latter recounted the situation during a discussion with the researcher.

"There's nothing wrong with her. She was going to Mr _ and, when he got sick, she had to switch to Mr _. She had a bad time with the old registrar in clinic. I had a chat with her and told her to ask Mr _ when he came round but when he got to the bed he said 'I understand you want to ask me something.' She was a bit put off by this and couldn't get her questions out. I'll have to go back and speak with her but she's alright."

Through her nursing actions the charge nurse was able to provide the additional resources essential to the patient's completion of the task of attaining and maintaining equanimity. By the following day, while waiting to go to theatre, the patient's words and manner confirmed her achievement of relative serenity.

"When I saw you yesterday I probably was a bit uptight. Of course I will be pleased when its all over."

Humour was often present in the interviews conducted soon after admission. The focus of the joking was often something outside the control of the person. Indeed, such humour, often black, may be one way of maintaining self-control in a potentially fear-provoking situation. In the following examples humour is used in references to the length of the surgeon's operating day, the preparation of the operating list, the skill of nurses and the anaesthetic. These are all issues within the domain of

the experts on whom the patient is now dependent.

"Imagine operating all day! I certainly wouldn't like to be at the end of the day if he was. 'Oh who's this one? Arm? Leg?'"

.....

"I know I'm getting slotted in somewhere. I think I must be the preliminary warm-up!" [Name not on operation list]

.....

"Nice nurse. She was very gentle. I thought I might strike a rough one!" (Laughs)

.....

"I don't mind once I'm out to it what happens! (Laughs) I'm glad I didn't live a few years ago when you had to bite a rag or something!"

Throughout the Nursed Passage the patient is constantly challenged by new experiences including pain, sleeplessness, discomfort, waiting, enforced immobility, and uncertainty. As he lives each moment of the passage he strives to maintain a state of composure within himself.

"I think I've got the kind of nature that, when a thing happens, I accept it. You know, when you can't fight against it, go with it."

.....

"When it [pain] comes on I think about it then it goes off and its alright again. I stay quiet."

During his time in hospital a patient may receive news which could have a profound effect on his future. In the following example the patient describes his reaction to being confronted with the news that the surgery had failed and it was possible, even probable, that his leg would

need to be amputated.

"When they started talking about taking the leg off and things, I didn't fly into a panic or anything like that, but it takes a bit of absorbing, you know."

Later he spoke of the way in which he maintained his composure during the remainder of the day, including comment on the impact of his reaction on other events.

"That's been my day really, trying to put this at the back of my mind and, of course, getting uptight with the nurse. I didn't say anything to her. I would never do that. It was probably me being upset and I didn't say anything to her. I just went along with it."

This example suggests that the patient may consider his application of strategies for maintaining equanimity is successful if it achieves a composed exterior despite a degree of turmoil inside. Thus, the patient strives to conceal feelings which he considers to be inappropriate in the circumstances.

"I was very nervous [before surgery] but I tried to hide it. . . . It was nervewracking to think about it."

Such behaviour presents a real challenge to the nurse as she seeks to ease the patient through the passage. Identifying areas of 'turmoil' without damaging the maintenance of the desired state of composure requires considerable nursing skill.

Sometimes efforts to maintain equanimity are reinforced by paying attention to the ways in which the patient presents

himself to the world. For women, continuing activities such as the use of makeup and care of the hair may increase the feeling of composure and self-control.

"I was just going to comb my hair and put my lipstick on and try to look brighter."

Achieving equanimity in the presence of considerable discomfort may be assisted by the fact that the state has been predicted and adequately explained beforehand by an expert person. In the following example the expert was the physician who had referred the patient for surgery.

"I feel so weak. I've got no energy whatsoever. told me I would feel like this. I would feel absolutely dreadful for a couple of days and my calcium would go all to pot and down but they would gradually start building it up and I would gradually start feeling better. And I do really feel dreadful. But that's what I expected."

However, no patient can totally prepare himself beforehand for an experience he has not previously encountered. Within the Nursed Passage the patient is able to benefit from nursing's presence through the agency of individual nurses who seek to ease the patient through the unexpected as well as the anticipated events.

Patients vary in the number and type of unexpected challenges to their equanimity which they encounter during their time in hospital. These often arise from some of the accoutrements of their treatment, such as an intravenous infusion becoming detached during the night or multiple attempts to insert a needle to restart an

infusion - a common feature in the data. In addition, in the life-and-death setting of the hospital where many patients are facing personal crises, tragic events do occur and these have an impact on those who share the environment. The following comments from two patients reflect the way in which each was seeking to maintain his composure as they both reacted to the sudden death of a patient in the same room.

"It didn't bother me. Its one of those things. Its got to happen. You won't go before your time. When your time is up you'll go no matter what you do. I'm fatalistic in that respect."

.....

"You probably found out we had a bit of a problem this morning. I went out in the other room and had breakfast in the other room. Didn't find out till later that he had gone. Stuns you a bit!"

As previously stated, equanimity is not always attainable by the efforts of the patient alone. Indeed, from time to time a patient may falter in this work and feel overwhelmed by his situation. Nurses are often granted the privilege of hearing a patient admit this, or of identifying cues that indicate this while she is present with the patient. Comments such as the following statement made during an interview are cues that suggest the patient will welcome nursing assistance to help restore a state of quietude.

"I am really a bit confused just now. I don't know whether I am coming or going."

Affiliating with Experts

A person enters hospital in order to receive the specialised assistance necessary to resolve a health problem. This help is given through the services of a variety of health professions - nursing, medicine, physiotherapy, occupational therapy, radiography and many more. Additional help comes from other groups who contribute to the daily maintenance of the hospital and its services - cleaning, kitchen, clerical, porter and others. Many representatives of these groups enter into face-to-face contact with the patient. Some meet the patient on only one occasion; others enter into relationships which last throughout the person's stay.

From the patient's perspective, there is the job of identifying each face by group, by title and, perhaps, by name. Then there is the task of clarifying the specific nature of the service each is offering to him - each group, each visit, each person. The patient quickly learns that there are individual differences in the approaches and the expertise of the people he encounters. Wisdom grew within the patients in this study as their personal experience of each group and each individual

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This term was generated after a considerable period of reflection and dictionary search to identify a term which would preserve the paradoxical dependence/independence apparent in the behaviour of the patient in relation to 'specialists'. 'Affiliating' is used in its meaning of 'coming into close association with' (Collins, 1979). There is an acknowledged element of subordination inherent in this term which arises from the patient's recognition of his need for the expertise of the specialist person.

helping person increased.

There is work for the patient to do as he enters into associations of varying closeness and importance with each person and each group. He recognises that there will be times when, once he has submitted, he is totally under the control of other people as happens, for example, when he is unconscious during surgery. There seems no doubt that patients try to cooperate as much as possible with the experts in order to obtain the optimal resolution of the problem. However, for most of the time, the patient seems to retain some autonomy over himself and to exercise some selectivity in the degree to which he accedes to the 'orders', 'advice' or 'rules' which he encounters.

Three subconcepts within this major construct have been identified: Acquiescing to Expertise; Fitting In; and Retaining Autonomy. Each reflects a different dimension of the independence/dependence dichotomy which characterises the patient's affiliation with the various groups of specialist hospital staff whose services are needed during the surgical experience.

19

Acquiescing to Expertise

This aspect of the work of the patient has previously been referred to during the discussion on both the Beginning

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This term was generated to depict the the patient's predominant mode of 'agreement without protest' to the ministrations of specialists whose work is assumed to be beneficial even if it is unpleasant (Collins, 1979).

Settling In. Now it emerges as a significant and separate concept. As in the previous phases of the experience, the patient is prepared to follow instructions from the experts - particularly medical and nursing personnel - because these are considered to arise from their specialised knowledge.

"I've been allowed to take my pad off today so that's the big event."

.....

"Look what I've got to do now all the time [breathing exercises]."

.....

"Apparently I've got to go and have a shower first."

.....

"If I want to go to the toilet I have to go and see them [nurses] again."

There is a degree of submission present in the acquiescence of patients. However, it seems to be willingly given when there is confidence and trust in the person and the reason for the request.

"I want to get out and have a bath or shower but I can't until the doctor says."

.....

"He wanted me to have bedrest, not to be getting up or trying to walk or anything like that."

Even when the prescribed treatment is not pleasant, or the patient would have made a different decision if given the opportunity, the patient attempts to adhere to the regimen prescribed by the expert person. There is a presumption that benefit will follow this course of action.

"I've been drinking. I've nearly drowned in water. I've just about drunk the sea dry, I think. And then they brought me those pills and there's quite a lot of them. I said I'd be rattling very soon. They're two every hour."

.....

"I think I could actually have gone home today, I felt, but he said tomorrow and I won't argue with him."

Acquiescing may be associated with a sense of powerlessness in the presence of the expert person, particularly the surgeon. His power is significant because of the work he does and is further increased by the reliance placed on his short and often irregular visits for major decisions concerning care, outcome of surgery and discharge. Authority and trust are ascribed to him and there is a degree of passivity apparent in the behaviour of many patients in his presence.

"Yesterday he [surgeon] came. He seemed to be quite satisfied. Holding my hand. You don't get much satisfaction. I suppose they will talk to you before you leave or you can go and see them, can't you. . . You do [have the opportunity to ask questions] but what could I ask him? Only what I keep thinking about - that I hope I won't have any more trouble. I suppose he gets that all the time and gets sick of being asked."

.....

"Not long ago Mr _ came round and I was getting up on my feet. I was going for a walk along the passage. He said 'You could just about have that [nasogastric tube] out.' He said 'What have you been getting out of that today, Nurse?' And she told him and he said 'I'll tell you what, as long as you don't drink anything but ice you can have it out.' I said 'It's a deal.' He said 'Right, take it out.'"

Deference is not so apparent in the relationships with nurses in which contact is more frequent as assistance is given in the moment by moment activities of the patient's hospitalisation.

"Nurse gave me a pain relief before she got me up for a wash and that. She sat me up there. She found a sheepskin for me. So she put that on. . . . I had a bit of pain at the bottom of my tummy. I thought it might be because my bowels haven't moved since I came in. She gave me a suppository and I sat there for two hours. . . . She said to have a tablet tonight because I am used to going every morning. . . . I sat out while they made the bed. . . . Nurse said my bottom wasn't red or anything and she gave me a little bit of a rub there."

This different relationship is significant for nursing. It gives the nurse the opportunity to work more closely than any other group on a person-to-person basis with the patient as he reacts to the consequences of his reliance on the expertise of others. For example, the deference ascribed to the senior medical staff, together with their pattern of intermittent visiting, often associated with critical decision-making, may generate feelings of uncertainty, even fear. Supportive activities, such as clarification by filling in the gaps or transcribing medical terminology into everyday English after a doctor's visit, may be required from the nurse to ease the patient's way through the passage. The nurse can also help by ascertaining the patient's areas of concern prior to medical visits and encouraging the patient to express these, or even conveying these to the medical staff herself.

Fitting In

Fitting In is a concept developed to reflect the adaptation, or sense of belonging, the patient attempts to achieve in relation to the people, the system and the hospital environment. It indicates the fact that the patient senses a need to 'fit in' because he feels an obligation to the staff. They are there to help him and the other patients in the ward.

"_ [Staff Nurse] asked me if I'd like a bath. This was before morning tea. I said 'Does it make any difference when I have my bath?' I mean, I wanted to fit in with her. She said 'No, I can give it to you now or before lunch, whichever you prefer."

Seeing the nursing staff as allies in a joint endeavour allows the patient to feel involved in the experience. Thus, fitting in can also include a partnership with the nurse to ensure treatments, procedures etc. are carried out.

"Doctors came around and wondered why the stocking hadn't been put on yesterday. So _ [staff nurse] rushed around and put it on. I had forgotten about it myself or I would have reminded them. Poor _ [staff nurse]."

This sense of joint responsibility extends to the patient becoming familiar with what will indicate progress and

This term was actually generated from the words of patients - "I wanted to fit in with her". The phrase was retained and assigned the meaning of 'belonging or conforming after a period of adjustment' (Collins 1979). It reflects the patient's willingness to change his normal pattern of behaviour while in hospital.

maintaining a sensitivity to its occurrence. As in the following example, normal daily activities assume importance, and even generate excitement, when they are perceived to be indicators of progress.

"I had that beautiful bowel movement today. I am proud of that. Mr _ laid stress on that. He said as far as he is concerned its a sign that everything is working after the operation and this is what they look for to find out."

The mutual geniality which is commonly found in the interaction between patients and nurses reflects the cooperation which the patient seeks to maintain.

"Well, I make it as pleasant as I can for them and they make it as pleasant as they can for me."

Even practices which are perceived to border on the absurd are accepted with good humour and even occasionally, as in the following example from a patient interview, with a touch of sarcasm.

". . . and next thing it was the 6 o'clock ritual of the hospital. You've got to wake them at 6 o'clock or the world comes to an end! And then they go back and relax until 9!"

The concept of Fitting In acknowledges the patient's willingness to change his normal expectations within the hospital environment. It includes the realisation that the conditions which one has control over at home - including noise, visitors, light, daily schedule of personal activities - are not controllable in the hospital ward. This is particularly apparent in relation to

activities such as sleep, food and hygiene. Patients in this study seemed to extremely tolerant in relation to such issues.

"I had a good night's sleep. . . There was some toing and froing. It must have been about 1 or 2 o'clock in the morning - perhaps earlier than that. I think there was an admission or there was somebody being difficult in the next ward."

.....

"We had rather a nice lunch - lambs tongues in mushroom gravy. - It was tasty. I was a bit frightened to risk it but I tried it and it was lovely. Not that crazy on mushrooms but it was alright. Nice baked custard too."

21

Retaining Autonomy

Paradoxically, in the presence of a desire to accept the advice of experts and to adapt to the environment, the patients in this study consistently demonstrated their retention of a degree of personal freedom. They revealed this autonomy in a variety of ways. Sometimes it was apparent in areas outside the immediate health problem and its therapeutic regime; sometimes it related to general aspects of the patient's experience as a patient; but, on some occasions it was linked to the therapy itself. This independence could be either overt or concealed from others. Also, it could remain as independence of thought or extend to autonomous action.

21

This term was developed after a dictionary search for appropriate wording to account for the independence which patients often demonstrated. 'Autonomy' is defined as the 'freedom to determine one's actions' (Collins, 1979).

Independent behaviour on the part of patients was rarely confrontational, or angry, or acrimonious. Only one instance of direct confrontation was recorded in the data where the patient directed challenged the behaviour of a staff member, in this case the surgeon. According to the patient's perception of the incident, the surgeon only wanted to inspect the wound because the plaster was not adhering to the skin in one place. This patient had been loosening the plaster herself as she had heard from 'somebody' that she would have half of the clips removed from the wound later that day. When he came around the surgeon reprimanded her for this action.

"I can't believe it. The stupid old - I didn't say that! Most unusual man! I'm told he is conservative in his views. I was upset because the healing process is now stalled somewaht. . . . The plaster was half off so he thought 'Oh well, I'll have a look,' but I wouldn't let him. Its been a disaster all round, really!"

Patients in this study gave no indications of a perceived power conflict with medical or nursing staff. Instead, there was a matter-of-factness in the patients' behaviour which seemed more indicative of a sense of shared control rather than a feeling of total subordination.

In the interviews there are many examples of patients speaking of being offered an opportunity to make a decision by the nurse and their choosing to do so.

"I had a sleeping pill - only one. A little one. I said 'I'll take one.' 'Take two,' she said. I said 'No, one will do.'"

.....

"So she came and I said 'Oh I might need one [sedative].' So she gave me one."

.....

"They asked me if I wanted a sleeping pill but I don't believe in them."

.....

"This morning they would have given me lemon drink if I had wanted but I said I preferred the water. Tomorrow I might go on to something else."

However, autonomous behaviour may be deliberately concealed as illustrated by the behaviour of one patient who had been prescribed a small dose of Valium three times a day soon after admission.

"I think maybe when I came in they might have thought I was a bit - I don't know if 'nervy' is the right word or not - 'het up', perhaps, about what was happening. But I don't think I was actually."

She commented on the inconsistent administration of the drug.

"Once or twice I've said I don't want it and they've taken it away from me. Once or twice they haven't come at all. They were chopping and changing quite a lot. It must be written down somewhere and some obey it and some don't - or some know my feelings and some don't. But, anyway, I don't mind taking it at night because I don't sleep at night."

And then went on to state:

"I've got two actually, stuck in there [locker] that I haven't taken. I thought if they gave me nothing to take home I might take one at night [laughs] at home for a night or two. I shouldn't be telling you this, should I!"

There were occasions when a patient, even when aware of

what he 'should' be doing, chose not to do as requested.

"I was supposed to wait for a nurse to come around and help me but I just thought 'Oh I can brave the course. I can do it.'"

Another patient found it difficult to accept the different regimen of care followed by the present ward team in comparison to his previous experience of the same surgery when the ritual of care had been rigorous and strict. He retained his ability to judge and reach an independent decision despite his overt cooperation.

"I still don't think inwardly that the relaxed system is the right system. . . I don't sort of agree at this stage. . . It takes a bit of accepting. While I don't accept it, I'm not critical of it."

However, he went on to indicate that his overt compliance was limited because of his faith in the previous regimen. Indeed, even his present behaviour concealed autonomous decision making.

"People have different systems, different techniques, fair enough, but my lying quiet, quieter than I have to under this particular system, isn't hurting the system. And, if they said I could get up and jump around and do a dance and make a lot of movement, well, there I would be fighting it. I don't think I would accept it readily."

Some patients seemed to be aware that they could retain a measure of autonomy through the deliberate concealment of information that could initiate a response from staff which was not wanted.

"I'd like to drink a lot more but I can't. I've drunk more today than I should have. Not that I'd let on!"

.....

"I don't want to tell them here [that has constipation] because I don't want them to start giving me pills and things to make it work. I don't want that."

However, many patients are also exercising autonomy when they make the decision to seek assistance from the nursing staff.

"And I haven't had my bowels moved. I'm going to ask them for a pill. I'll perhaps have one tomorrow morning at breakfast time."

As has already been noted, when a person undergoes surgery he follows a dynamic path in relation to his independence and self-care. At the actual time of surgery he is in a significant state of dependency. As the period of recovery lengthens there is a gradual withdrawing of nursing presence and a resumption of self-care. In this period of transition there is potential for uncertainty on the part of the patient as the nurse no longer appears to perform, or even offer assistance with, tasks such as those associated with daily hygiene care. Now the initiative is handed back the patient's as he is expected to resume more and more independence.

"I'll just go along and have a bath in the bathroom. This bedbath is not necessary any more, I don't think. I'll get in there and get organised."

.....

"I had a good wash up and down. They didn't say anything so I just washed up and down myself. I went by myself."

In this study it seemed that the patients never totally submitted to the 'experts' beyond their conscious decision to accept the surgical procedure. However, they were selective in the people with whom they shared this information. Their proven willingness to retain a degree of autonomy in thought and action seemed to be of value as they tended, and were required, to respond with alacrity to cues that increased self-care was appropriate.

"Well, its been very pleasant because I've been allowed up and to do what I flipping well like. I was able to start the day off in the the normal fashion by heading for the bathroom in my own time, and going through all the motions in my own time. Its starting to get a bit of independence back, I think. You feel useless and helpless."

22

Surviving the Ordeal

Undergoing an experience like surgery is an ordeal, although its degree varies considerably between patients. This variation is determined as much by the individual resources available to the person as it is by the significance and the degree of severity of the operation. There is evidence that patients actively work their way through the experience harnessing a variety of internal and external resources to withstand the effects of the

22

This term was developed after a dictionary search to discover the most appropriate term to describe the pattern of patient behaviour which seemed to have the goal of helping him to get through the experience of surgery. In this context 'surviving' is defined as 'continuing in existence after adversity'; 'ordeal' is defined as a 'severe or trying experience' (Collins, 1979).

ordeal. In this concept, the emphasis is on the different dimensions associated with the work of survival. Three different subconcepts were identified within the data: Enduring Hardship; Tolerating Uncertainty; and Possessing Hope.

23

Enduring Hardship

Hardship is associated with a variety of feelings and reactions which are linked in some way to the problem, the surgery, and/or being in hospital. Enduring such symptoms seems to be accepted by patients as a part of the experience. Assistance is on hand from both nursing and medical activity. However, this study revealed that patients are prepared to 'put up with it' with the expectation that it is a temporary phenomenon.

Each patient's story of endurance is different. Some of the variation is evident in the following excerpts from patients' reflections on their status during an interview.

"Now and again I get a sort of muscular spasm or something. It really goes through!"

.....

"Just before lunch I felt a bit funny. I was sitting out in the dayroom and felt almost faint, you know. Still feel a bit wonky."

.....

23

This term was developed after a dictionary search for a phrase to convey the patient's need to manage the negative consequences of surgical intervention. 'Enduring' is defined as 'undergoing without yielding'; 'hardship' means 'something that causes suffering or privation' (Collins, 1979).

"I've been feeling alright actually. Only thing is I noticed every time I closed my eyes I see all sorts of figures. I hallucinate a lot for some reason. I don't know what that is. Open my eyes to see something out there and there is nothing there."

.....

"Sweating here and my legs as cold as anything today."

.....

"My back's pretty achey."

.....

"I've got a terrible headache."

.....

"My mouth is so dry. Very sore throat. I'm feeling very sorry for myself."

.....

"Generally washed out. No energy. No desire to do anything."

.....

"I haven't been so good today. . . . My neck has been hurting very much and I have been trying to pass water. Haven't been able to."

Some of the discomfort was linked to the actions of others involved in the care of the patient.

"Dreadful. I've got too much fluid on board. . . I've never felt so dreadful for a long time." [Too much intravenous fluid]

.....

"Nurse came and took the sutures out this morning. I was holding on to the bed but it wasn't too bad. Just a couple of pulls."

One of the findings in this study was how patients seemed to have prepared themselves to experience pain during the 24-48 hours after surgery. Most, but not all, seemed to associate their feeling with discomfort rather than intolerable 'pain'.

"If I sort of move it [eye] around it can ache a bit. Its got a suggestion of a little bit of stinging . . . certainly nothing uncomfortable that I can't tolerate. . . You'd think it would be a lot worse."

.....

"I've been fairly good today. I've had no pain, no trouble, so I've got nothing to complain about. . . I thoroughly enjoyed the day."

.....

"I don't think its necessary to take a pill. I can grin and bear quite a lot. . I know I don't have to but I don't want to be taking drugs. I don't actually agree with it if I can do without it. . . I'm not in agony with it."

.....

"No, not much pain. Will it get worse?"

.....

"Very bad [pain] when I cough or move. Is still a bit sore [after injection]."

However, it is possible for any patient to reach the end of his ability to endure, even when supported by the actions of the nursing staff. This was not a common occurrence in this study. In the following example the patient became so distressed by the pain and discomfort caused by the suture holding the haemovac tube that he demanded its removal before he would go to sleep. The nursing staff met his demand after a telephone consultation with the house surgeon.

"It hurts like hell. Its pulling in the corners. I think I'll go to sleep when its out. Its really sore. It really is sore!"

Tolerating Uncertainty

Each experience of surgery and a general anaesthetic contains an element of uncertainty before the event, no matter how many previous operations or admissions to hospital there might have been. The patient needs to live with this uncertainty until it is resolved, although it can be minimised by the mutual work of patient and nurse at all stages of the experience.

Even if the patient is given preoperative information on what is going to happen, he cannot be knowledgeable about every minute or circumstance of the experience beforehand.

"I don't know what its going to be like so its an unknown factor. Of course, I'll be pleased when its all over.'

.....

"I didn't realise what it was going to be."

Sometimes uncertainty before an event is increased by the receipt of conflicting information from members of the staff. In such circumstances, unless the nature of the conflict is known and resolved, the patient experiences confusion as well as lack of certainty.

"Dr - [surgeon] said I could get out of bed and then the male nurse said I couldn't. So!"

This term was developed after a dictionary search. 'Tolerating' means 'putting up with; being able to bear; treating with forbearance'; 'uncertainty' is used to cover the aspects of the patient's experience which are 'not able to be accurately known or predicted' (Collins, 1979).

A significant cause of uncertainty is the realisation by the patient that decisions are sometimes made, even in his presence, without his having any direct involvement. The conversation may take place at the foot of the bed and the patient may not hear or understand what is being discussed.

"I saw them [doctors] at a distance [end of bed] and they said nothing. They hardly said a thing. . . . No, I'm not actually sure what is going on the simple reason—that this [catheter] was—supposed to come out on Friday. That's what the doctor said - one of them. And then I think it may be because there's been a clot of blood come down since."

.....

"I heard him saying something to the sister this morning but often when they are talking you don't fully comprehend what they are talking about. I presume it will be another couple of days like this."

The presence of cancer introduces a longterm uncertainty into the life of a person. Despite this, the patient seems to find strategies to endure the situation he finds himself in.

"I think we all get the fear of death when anyone tells us we've got cancer anywhere. And cancer of the breast comes as an awful shock because, you know, it usually comes with no warning. And in my case, I just have a tremendous feeling of relief that it hasn't been as bad as I thought it was going to be."

Laboratory examination of tissue removed during the surgery gives further information on the cancer and the result may be available while the patient is still in hospital. This happened with several patients in this

study and one was informed her future was very uncertain.

"He made a special trip up here and told me all about that - that it was a cancer tumour in my groin caused from that melanoma - and he said from what they knew they had got everything. But he said you cannot guarantee that it could affect somewhere else. He said that they were going to keep close checks on me. He said the only thing they wouldn't like it to get into the blood stream because it can travel and you can't pick it up as quickly."

For other patients, however, the outcome may remove uncertainty.

"I got the path report today and that is good. He [surgeon] was very matter of fact - 'Good! Fine! Clear! No problems. Appointment in January. See you.'"

25

Possessing Hope

Patients undergoing surgery seem able to visualise a future in which there will be an improvement in their condition. This hope, when supported by encouragement from nursing and medical staff as well as the family, sustains the person through his present circumstances. The future which is anticipated may be minutes or hours away, or it could be days, weeks or longer.

"Oh, its a bit sore but its getting, you know, every hour now I think its getting better now."

.....

25

This term was generated from the data combined with a dictionary search. 'Hope' was used by patients - "I hope its all over" - and 'possessing' means 'owning' (Collins, 1979). The concurrent work of Hinds (1984) in inducing a concept of 'hope' is acknowledged.

"My one thought is to get through today. That's why I think I'll be better tomorrow if I can just get through today."

.....

"I feel a little washed out. Its going to take a day or two to get rid of the dope they put into you to put you out."

.....

"I figure it will take a week before I come right. I might go home by Saturday or Sunday."

.....

"This time next week I'll be back to normal."

Hope is tempered by reality and seems to be consistent with the patient's circumstances. Loneliness, grieving, aging with disability or chronic illness, family concerns, job stress - all were present in the patients in this study as well as the concerns related to the presenting health problem. Despite these, or perhaps because of these, the belief in a favourable future seemed to be a source of support as the patient endured the present.

Patients who face a personal crisis as a result of the nature of a problem which has necessitated the surgery have a specific hope that the threat has, indeed, been removed.

"I hope it is all over. I don't want any more trouble. Hope its all gone."

Those patients who are waiting for pathology reports may reveal that consideration of dying is present in their thinking. Even this may be associated with an element of hoping in terms of the future if the news is bad.

"Cancer is a nasty thing. I asked [surgeon] about the checking of cancer and he said he hadn't had the pathological report on the tests made as yet. I will have the joy or otherwise of knowing later on whether I have it or not. One thing, I'm not going through this again. Not worth it! Anyway, I've had a fair lash over the years. What worries me is the suddenness of it. I want to get a few days notice so that I can make arrangements."

Hope is a dynamic feeling which is also present in the less dramatic but still significant moments of the patient's experience.

"I have taken a sleeping pill. Hope for the best."

As the patient regains more and more independence and the effects of the surgery and anaesthetic diminish, the patient begins to hope that the time is nearing for going home. This anticipation is usually delayed until the patient feels 'ready' in himself.

"I understand and accept the need to be here but its getting near the end now - at least I hope so."

.....

"I'm waiting for doctor's rounds so he says 'Pull the stitches out and you can go home.' At least, they're the words I'm hoping to hear."

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Interpreting the Experience

As the reality of the patient's experience of hospital and

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This term is a continuation of the concept identified in the Beginning. See Footnote 7, p.138 for origin of the phrase.

surgery unfolds he receives a constant input of information from without and within. His story, which commenced with the surfacing of the problem, is changing and developing.

Individuality is evident in the way stories are recounted. In addition, incompleteness within the story tends to be tolerated. The following account of a conversation between the researcher and one patient illustrates how patients reinterpret information into lay terminology. This man has retained what he perceives to be the information of immediate concern to himself. A meaningful story has been compiled despite obvious gaps in his understanding of the actual surgical procedure. It seems this ignorance is tolerated because the information is known to the person who 'needs' to know - the surgeon - the expert.

"Do you know what is going to happen in your operation?"

"Vaguely. As far as I know they are going to open it here and they cut part of it out, which part I don't know. I know Mr _ did say that they would have to cut away part of the stomach which will make it that much smaller. 'For a period of time you just have to have small meals and more often,' he said. Eventually the stomach will extend itself, possibly not to its full extent, but will reach a stage where I will be able to eat a larger meal. I don't know how long that will take though. I imagine it will take several months."

Interpreting the Experience is a continuing task of the patient as he negotiates the Nursed Passage. The work of analysing incoming information and adding it to the story

as known to date, and then synthesising all elements into an integrated whole proceeds regardless of the efficacy of the incoming information. Information may be wrong, conflicting, or incomplete; the interpretation may be flawed; or the reactions of the patient may be unforeseen. As the nurse is the most consistently present person she is a significant participant in the information giving. She also has access to the patient's reactions to his interpretation of events as they occur.

During analysis of the data it became clear that several new elements were appearing in the patient interviews in relation to this construct. As more and more information about himself in relation to the problem and its amelioration becomes available for use, two subconcepts can be identified: Developing Expertise; and Monitoring Events.

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Developing Expertise

From a very early stage in the field work the notes contained reference to the presence of what was described as 'patient wisdom'. Each new event which involves the patient is added to his growing repertoire of knowledge about himself in relation to the situation in which he finds himself. As the information is analysed and

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This term was developed as a result of a dictionary search to find a term which would describe the patient's growing wisdom about himself and his experience. The reference by Stevens (1979) to the patient's 'expertise' gave the researcher a predisposition to recognise this in the data.

integrated into the patient's total subjective experience, there is an increasing ability to interpret events, and take independent action, on the basis of the wisdom gained through experience.

"I had a really sore stomach so I had a couple of Paracetamol and then about half an hour later I felt really quite sick, as if I was going to be sick. . . . Never had aspirins or disprins in the house or anything like that so that's why they probably bowled me over. So I think I'll just have one if she brings some back. Two is too much."

.....

"I feel funny again now. Its [urinary catheter] clotted again. I can tell. It hurts like fury."

.....

"Its not too bad now. I keep moving around a bit. If I don't sit down on a hard seat too often it'll be alright."

.....

"Yesterday it [dressing] was put there but I don't think it was put on the best way. They sort of just wrapped it around. But this time I put it around properly myself. . . So, as soon as I did it, it was better straight away."

.....

"I'm feeling good now. . . No clots, not since I've been keeping it [catheter] pressed every now and then and its running fairly well now. Its running good."

Despite the increasing wisdom about his own situation a patient may feel this is unrecognised by the staff and submit to an intervention which he does not believe will be successful. One patient had repeated problems with urinary flow through his catheter.

"It played up again! Oh, it was terrible! Like nothing on earth! . . . So they gave me a couple of pills. I said 'Pills won't

do me any good!' So I took them. . . .
And that's what it was - the blasted bag!
. . . But, anyway, they put a new bag on.
Its been as good as gold since then. . . .
I knew the pills wouldn't do any good. I
was positive."

The patient may feel confident enough in his understanding of his situation to assist the staff when he feels they forgotten something.

"I think there's been one thing overlooked. I'm supposed to be on a fluid balance - measuring input and output. She just took one away. I hope she measures it because she told me to go to the toilet and give an MSU [mid-stream urine sample] and didn't give me a bottle so she obviously had no intention of measuring it, but she should be. I'll tell her."

This increasing expertise about himself in relation to the surgery gives the patient confidence about future self care. It can result in a feeling that the time for going home is approaching, even in the presence of a continuing limitation, because he feels he has the ability to manage himself.

"Everything is good and going along, but I am ready to go home now. I won't be silly. I know when I am ready to do a bit more each day with my leg."

The patient gains wisdom in relation to specific issues such as the impact of medication on himself.

"The linctus is not bad. It did the job.
But I liked the lozenge."

.....

"Last night wasn't too bad. I like the Valium better than anything else they give you."

At the time of admission the patient already possesses considerable expertise about himself. He has developed a wisdom arising from experience about what works for him and what doesn't.

"I like eggs but they tend to constipate me. That is another thing I have to watch. I had milo by mistake for afternoon tea and I was half asleep when I said milo, but I think it constipates me. . . . I'll get my husband to bring up some tangelos. They're the best thing for it."

.....

"Sometimes I say to - [husband] at night 'My back's sore. I feel its a tense soreness.' I've just got to unwind my back and I like nothing better than a read. So I say 'I'm going to just have a good old read. I must read for an hour before I go to bed or my back will be dreadful.' And it's only letting the tension go and relaxing - and it does."

Although patients vary in their ability to express their wisdom, there is considerable evidence of its existence. Such expertise, when acknowledged and encouraged by nursing staff, changes the shape of the relationship between nurse and patient to one of mutual and complementary expertise.

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Monitoring Events

Monitoring, as identified in this situation, has a strong evaluative component. Experience has given the patient a

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This term was developed after a dictionary search to find a phrase which would describe the evaluating behaviour demonstrated by patients. 'Monitoring' is used in its meaning of 'observing and recording the activity or performance of self and others'; 'events' refer to 'anything that happens' (Collins, 1979).

growing expertise associated with increasing confidence to reveal his judgements. Indeed, no part of the total context in which the patient finds himself, is immune from comment. The examples of patient evaluation identified in the data were usually subjective and personal.

In the following three excerpts the patients have reflected on their initiation experience and evaluated it in comparison to their previous hospital experiences.

" . . . the nurses, they were very nice too. I am impressed by the friendly atmosphere that is clearly apparent in this ward which wasn't there in Ward - and, in fact, it was a very noisy ward. . . the click clack of all the thousands of heels that clattered up and down the corridor. . The occasions when the phone has rung here it has only been a muffled sound - whether it is the bell or it is all the carpet . . I am impressed by the decor as well. Its a nice modern place."

.....

"You see, a lot of them [staff] don't like the old people - and that I do know! . . . I can pick it in the way they talk. . . . I haven't seen it at all today."

.....

"Oh well, the whole procedure went quite well I thought. They're quite attentive and, as I say, I think the nurses have been mucked around by the doctors. I suppose its the old story in hospitals but I think it shouldn't necessarily be like that. I'm giving you this as a comment - a serious comment. I think there could be a routine that doctors observe as well as others and it would make everybody's job easier."

The behaviour of staff members is evaluated even in personally stressful situations. In the following examples the patients reflected on the manner of the surgeon who had given them the pathology report after

surgery.

"And he was direct with me in a nice way.
He was very good."

.....

"Very matter of fact - "Good! Fine! Clear!
No problems. Appointment in January. See
you.'"

The patient's evaluation was not always positive as in the
following comments from two patients on one doctor.

"I had a visit from our lady friend - our
lady doctor in here - who tried to explain
in detail how Mr _ got on in this
operation which was no good whatsoever. .
What she was trying to put across - and
she used too many words - was that the
operation wasn't successful."

.....

"This lady doctor, she was hopeless at
putting it in [catheter]. Hopeless!
Pricked me inside. I don't think she had
much idea about putting it in."

In some comments on the behaviour of individual members of
staff patients revealed the criteria they were using in
their evaluation.

"Some [nurses] are better than others.
There are one or two who are not quite as
good as the others. . . . I'd say
attitude. Some of them have got it and
some of them haven't. But when it comes
to the point they're all doing a good job.
I think on the whole the standard I would
class as 'above average'. . Tonight's
combination isn't as good as other
combinations you get. . . . When things
don't appear to be running quite as
smoothly you can sense it. You can pick
it up."

.....

"The whole procedure went quite well, I
thought. They're quite attentive."

.....

"As we've gone along I've been very impressed with him [surgeon]. He comes in first thing in the morning and you know when to expect him."

Patients were also consistently monitoring their own performance and progress.

"I think I've made quite a bit of headway today."

.....

"I'm a big disaster today."

.....

"And the moment I started eating today and got my tummy settled, I seemed to feel better in myself."

.....

"I went down the passage - down there and back. It didn't knock me out."

.....

"A better day than I thought I was going to. The same as yesterday wasn't so bad."

The words of nurses are welcomed and evaluated for their significance. Confidence is increased when the patient's interpretation is consistent with that of the nursing staff.

"I'm not too bad at all and the kids [nurses] around here reckon I'm doing famous."

.....

"Actually, I think Sister seems to be quite pleased with me because she said 'I think you've been marvellous.' So, she must think everything's gone okay."

Summary

In this chapter a nursing-relevant theoretical interpretation of the work of the patient as he negotiates

his Nursed Passage during the experience of surgery has been presented. The major areas within which the patient is working throughout the passage were identified. Each of the four major constructs and the subconcepts were generated from the data.

Chapter 8 continues the presentation on the negotiation of the Nursed Passage with the focus changing to the work of the nurse.

CHAPTER 8

NEGOTIATING THE NURSED PASSAGE: THE WORK OF THE NURSE

In this chapter the discussion sets out to describe the multiple aspects of the work of nursing, through the agency of nurses, that contribute to the goal of assisting the patient to negotiate his way through the Nursed Passage.

Introduction

Within the Nursed Passage both patient and nurse play their part. Each makes a specific contribution to the patient's negotiation of his passage - patient as passagee, nurse as agent of nursing. While there is considerable qualitative variation between nurses in their expression of nursing in the presence of the patient, there is also an identifiable commonness which has been conceptualised as the 'work of the nurse'.

As the process of analysing the field data progressed a large number of substantive codes relating to nursing were generated. Concurrently with this coding, many theoretical memos were noted and attempts were made to

pattern and reduce the codes. It became clear that both the nurse and the patient were actively working to progress the latter through the Nursed Passage. In an endeavour to emphasise the mutuality of this relationship an attempt was made to develop a conceptualisation in which a nursing action was directly matched with each area of patient work. For example, such a scheme would link one specific nursing behaviour with the patient's work of possessing hope. However, this approach was found to be forcing the data in a way which did not reflect the complex reality of the nurse's work. Instead, a complementary pattern of nursing work emerged which is unidirectional in that it focuses on the patient and his ongoing situation. Within it, each category of work identified with nursing is available, singularly or collectively, to assist the patient in any, and every, aspect of his area of his work during the passage.

Negotiating the Nursed Passage: The Work of the Nurse

The work of the nurse is dynamically variable and situation-specific as nursing responds to the immediacy of the patient situation as he negotiates his Nursed Passage. Nursing strategies are available to ease the path for the patient from his entry - Settling In - to his exit - Going Home. Thus, negotiating co-exists, interrelates with, and facilitates the nurse's work during these transition phases.

Nursing's negotiation work within a patient's passage can

be encompassed within five theoretical constructs:
 i) Attending; ii) Enabling; iii) Interpreting;
 iv) Responding; and v) Anticipating [see Table 15]. Both
 Attending and Enabling contain a number of sub-concepts.
 Elements of a number of these constructs can be identified
 within an individual nursing episode, and within each
 nursing act. Thus, nursing actions are multidimensional
 and complex. However, to facilitate explanation, each
 will be presented separately.

TABLE 15: NEGOTIATING THE NURSED PASSAGE:
 THE WORK OF THE NURSE

<u>Attending</u>	Being Present Ministering Listening Comforting
<u>Enabling</u>	Coaching Conserving Extending Harmonising Encouraging
<u>Interpreting</u>	
<u>Responding</u>	
<u>Anticipating</u>	

Two hundred and seventy different nursing behaviours were
 identified in the data - patient interviews, nurse
 interviews, nursing notes and field notes. Analysis of
 these, using the processes of the grounded theory
 approach, led to this conceptualisation of the work of the
 nurse. Although it seeks to explain what was happening in
 the field, this interpretation was not known to the
 participants and, therefore, was not guiding their

actions. Rather, it seeks to give an integrated theoretical shape to the actual work of the nurse as it was observed in the field.

Nursing behaviours reflecting each concept were clearly evident in the data. Some were effective in terms of furthering the patient in his passage, while others were not. Both negative and positive examples will be presented in the discussion which follows. Qualitative differences in the work of each nurse in relation to the concepts and their application within each patient's individual passage were apparent. However, the emphasis in this work is on presenting the pattern of nursing's work, recognising that determination of definitive performance criteria for the 'ideal' nursing performance within the Nursed Passage will require further research.

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Attending

As the nurse attends the patient - for seconds, minutes or hours - there is a significant sense in which she is accompanying him through each phase of the experience. Nursing knowledge and skills are exercised within every nurse-patient encounter through the agency of the nurse herself. In the following example the matrix of situation-specific thinking and acting required from the

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This term was developed after a dictionary search for a multidimensional concept to encompass the nurse's key work of being with the patient during the passage. It conveys the meanings of 'giving care; paying attention; serving; accompanying; devoting one's time; providing for the needs of' (Collins, 1979).

registered nurse is evident as she is in purposeful contact with the patient.

"She had her dressing taken down and her suture line's a bit red and gaping in a couple of places so we had to dry dress it rather than put some op-site spray over it. She was a wee bit reluctant about actually looking at it. She talked about it and shut her eyes while I was taking the plaster off and then I said 'If you want to have a look its still got a bit of gauze over it.' And so she had a look then and then shut her eyes again and when I did take the gauze off she actually did have a look. And she's worried now that she's going to have to go out and have a bosom on one side and not on the other. So we rang the lady from the Mastectomy Association who's going to come and see her tomorrow or the next day. . . . So I think that today's the first day she's actually really thought about it because, obviously, she realises that its coming closer to her going home and she's beginning to worry about her appearance and so on."

One nursing action - changing a dressing - has induced patterns of patient behaviour which have been identified and led to other nursing actions. The example illustrates that the quality of nursing is dependent on the ability of each nurse to maintain a vigilant presence, ready to apply nursing knowledge and skills to the patient's immediate situation.

Reflection on this exerpt and others led to the generation of four sub-concepts, each of which serves to highlight a significant aspect of the nurse's attending work: Being present; Ministering; Listening; and Comforting. Within all four there are strong affective, as well as cognitive, elements which reflect the reality that nursing is a

specialised expression of altruistic helping offered to another person to ease his way through a particular life event.

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Being Present

This concept reflects the fact that nursing is translated into action by the individual nurse in the presence of the patient or nursed person. By being present the nurse is able to 'nurse' the patient in the immediacy of his situation. She adjusts her nursing to the moment-by-moment circumstances of the patient in a way that an unqualified person cannot do.

Table 16 contains examples from the data in which the presence of a registered nurse is significant to the outcome.

TABLE 16: SAMPLE OF ACTIVITIES WITH AN IDENTIFIABLE ELEMENT OF 'BEING PRESENT'

Appraising the current status of the person
Making frequent visits to the patient
Responding to call bell
Giving support during painful procedure
Sitting and talking with person in distress
Giving assurance of nursing presence as needed
Modifying actions in response to patient reactions
Giving encouragement
Assisting patient out of bed for first time

30

This term arose from a theoretical memo made during substantive coding associated with a dictionary search for a phrase to describe the nurse's work of spending time with the patient - being there and being with - as he negotiates his passage. It came from one of the meanings of attend - 'be present at' (Collins, 1979). The concurrent work of Gardner (1985) and the earlier work of Paterson and Zderad (1976) are acknowledged and served to validate the decision to emphasise this element of nursing work.

To illustrate the value of the nurse's presence, two negative examples and one positive example from the data are presented.

After surgery on the eye, patients were told not to bend over or make any sudden movement. However, a nursing presence was required to guide the patient through the permitted range of movements when he encountered the opportunity for bending or sudden movement for the first time after surgery. This seemed to be the time when the patient was washed, sat up, changed, and had personal belongings such as dentures and watches made available. On this occasion, by being present the nurse is able to coach the patient and manipulate the environment so that harmful movements are not required. One patient experienced severe pain and considerable bleeding on the surface of his eye after bending over from the bed to look into the cupboard of his bedside locker searching for his dentures. The nurse was not present at the time and recounted the episode to the researcher.

"I reminded him about not overdoing it and no sudden movements or raising pressure after it happened. I think one of the reasons that he did that was because I got his wife to assist him with the post-operative wash seeing she was there. I told him not to over-exert himself and I think he forgot - like he needed my reinforcement when I was giving him the wash. . . . After that incident he was very quiet, lying quietly, and he definitely wouldn't exert himself."

This nurse recognised with hindsight that, although teaching had taken place before the event, her presence

was required to nurse the patient through this critical time. By contrast, in the following example from the same day in the same ward the nurse's presence allowed her to give attention to the safe completion of challenging moments in his experience and to observe his ability to cope.

— "Well, he's required routine postoperative cares really. Um, what I've done is make him comfortable, given him a postoperative wash and mouthwash and started him on sips of fluids. He seemed to be coping with those quite well until it came to teatime and we thought he could possibly have a little bit of - um - sandwiches and some soup. Just the motion of sitting him up though made him feel quite nauseated so we sat him down a little and he was complaining of slight pain in his eye so I got him an injection of Maxalon and Pethidine. He's been much happier since then. . . . In the meantime I made sure, you know, that he was less anxious by doing things for him like making sure a bottle was on hand and getting his valuables out of the locked cupboard. So he's been fairly routine cares really."

The second negative example is recounted because it was the one which confirmed the need for inclusion of the concept. It was the absence of the nurse which highlighted the impact of her presence in the many other patient situations described in the data which had previously been taken for granted. An elderly patient who required a stick for ambulation went down to the bathroom on the third day after surgery complete with dressing and drainage. She described the episode to the researcher later that day.

"I had a shower all on my own. Showered myself. I had to cart this thing [suction drainage]. I did ask the nurse round there. I forgot to ask it when I went but asked one of the nurses round there and she said "You just leave it on the floor." It dragged on the floor while I showered. I am not quite up on it. I was afraid of slipping when I stepped out. I had only one towel that I had here but they [other patients] told me here I should have thrown that one on the floor and got myself clean ones. They are there. You can help yourself but I never thought to. I'm not used to helping myself. I tried to manage with one towel and I was slipping around a bit. I didn't want to slip on the floor."

The marginal note by this account stated - 'Need for nursing presence'. From this note the concept was generated and its significance quickly became apparent as a key - indeed the key - aspect of the work of the nurse because of nursing's concern with the patient's lived experience through his passage.

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Ministering

Ministering, as used in this context, is attending to the patient by using nursing care strategies. It was developed as the second sub-concept because it reflects the fact that nursing is thoughtful, sensitive action that demonstrates skill and relevance within the patient's immediate situation.

Table 17 lists a sample of nursing actions from the data

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This term was generated after a dictionary search for a wording which would convey the nursing work of actually giving care to meet the needs of a patient. It came from one dictionary definition of attending - 'to give care; minister' (Collins, 1979).

in which there is a strong element of 'ministering'.

TABLE 17: SAMPLE OF ACTIVITIES WITH AN IDENTIFIABLE
ELEMENT OF 'MINISTERING'

Giving pressure area care
Application of calamine to skin rash
Giving mouthwash
Giving hot drink for sleeplessness
Giving postoperative wash
Giving bed pan
Washing patient and changing bed after incontinence
Combing and washing patient's hair
Cleaning dentures
Using fan to reduce body temperature
'Milking' catheter for blood clots —
Assisting patient with shower/bath/bedbath
Putting cream on inflamed intravenous site
Removing sutures - anal packing - drain - IV needle
Changing intravenous fluids
Dressing wound
Giving medications orally or by injection
Recording temperature, pulse, respiration
Recording blood pressure
Completing preoperative checklist

Examination of this list reveals that it encompasses a range of different nursing acts which are initiated and performed by the registered nurse in order to progress the patient through his Nursed Passage and, as a consequence, towards an optimal outcome from the surgery.

The concept of ministering can be applied to the planned performance of skills as well as the incidental activities that are performed in response to the dynamically changing needs of the patient. For example, the nurse's presence while a patient is having a shower allows her to adapt her ministrations to his needs by thoughtfully altering her behaviour throughout the procedure - standing back, giving assistance, giving advice, giving encouragement, or substituting for the patient.

Ministering may involve the nurse in the performance of a pain-inducing activity which is considered to have a beneficial purpose. For example, one patient recounted his experience of having packing removed from his rectal wound.

"I was given the injection about 11.30 so it would have been about 12.15 before I went to the bathroom and had my saline bath. . . . Tried to remove it first but that was a bit painful so I hopped in the bath and stayed there for about five minutes and then she came and removed the wadding, or whatever. I think that would be a once in a lifetime experience! . . . I was actually feeling queasy just before. I was in the bath and I'd been left for a few minutes. I felt I was about to faint. I was just on the verge when I was sort of finding things sort of twirling around. I was about to black out so I was moving myself over to one side so I wouldn't fall back into the water. Two nurses came in and got me to lie back and take deep breaths. Then they removed the wadding, then I felt the full experience."

Ministering was apparent in the planning for the experience, the administration of analgesia beforehand in anticipation that the removal of the packing would be painful, the decision to let the patient soak in the bath to moisten the dressing, the promptness in returning with assistance, and the spontaneous management of the patient's fainting. In all these areas the nurse was making situation-specific nursing judgements leading to actions which were ministering to this patient's immediate needs. The removal of the packing from such a wound is often one of the more stressful events a patient has to experience while undergoing surgery. Ministering activities, skilfully and appropriately performed, assist in

beneficially progressing the patient through such experiences.

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Listening

Because the nurse is involved with the patient throughout the duration of an experience in hospital, part of her work is to listen as he reacts to his situation as it unfolds. It is equally important for the nurse to attend to the patient by taking heed of the answers given in response to the probes for nursing-relevant information.

Table 18 lists a sample of nurse activities recorded in the data in which the element of 'listening' is apparent.

TABLE 18: SAMPLE OF ACTIONS WITH AN IDENTIFIABLE ELEMENT OF 'LISTENING'

Listening to patient concerns
Listening to family member concerns
Encouraging patient to speak of anxiety/fear
Sitting down at patient's bed side to listen
Returning to speak with patient as promised
Establishing eye contact
Moving to side of bed to speak with patient
Being sensitive to patient cues
Stopping activity while listening
Listening when patient's wishes differ from nurse's

Evidence of listening was common in the data. However, as with all concepts in the nursing pattern, it was sometimes identifiable by its omission rather than by its presence. Any data on nursing in action could be expected to

32

This term is used in its dictionary sense of 'taking heed of; paying attention' (Collins, 1979). It stresses the importance of the nurse's work of giving the patient an opportunity to express himself, hearing and seeking to attach meaning to what he is saying.

as this study did, many examples of imperfect exchanges between nurse and patient. For example, one patient with an indwelling urinary catheter shared his feeling of distress during one interview. He had been certain that the cause of his pain was a mechanical obstruction to the flow of urine and his experience was made worse by his inability to get his message across to the nurses. There is evidence of the patient's increasing wisdom about the impact of the surgery on himself and his body. He believes he knows about what will work and what will not.

"It played up again! Terrific pain like nothing on earth. And my wife came in and I told her and she said 'Why didn't you tell them?' And I said 'I told them before.' . . . So she went and saw the Sister. So they gave me a couple of pills. I said 'This won't do me any good!' So I took them. And they came in later and they said 'Oh well, we're going to flush your tube out.' And they gave me a new bag. And that's what it was - the blasted bag!"

The second example is that of a patient who spoke of his urinary frequency during an interview. When the researcher shared this information with the nurse, the latter was distressed that she had not been the recipient of this information during her own contact with the patient. It seems the nurse has work to do to convince some patients she is ready and able to listen, and has the time to do so.

"He never sort of complains much or says very much. You have to sort of really enquire after him and even then he doesn't tell you everything, as I've just found out."

Evidence of listening is apparent in the following comments selected from the nursing notes of four patients. Each one reveals that the nurse has gained a valuable insight into the patient's situation by listening and this is assisting in nursing decision-making.

"Pt anxious about surgery and what degree of pain to expect."

.....

"Wound area was very painful when moved and she admits to being very scared of moving."

.....

"Feels that the yellow sleeping pills (Valium) make him too sleepy during day time and that the need for them has passed."

.....

"Did not want a wash today. Face and hands only."

33

Comforting

Comforting has been included as a separate concept within Attending to emphasise the capacity nursing has to soothe pain, ease discomfort, bring solace and induce well-being in patients as they negotiate their Nursed Passage.

Table 19 lists a sample of activities within the data which contain an element of 'comforting'.

This concept is well illustrated in relation to the spontaneous responses the nurse is called on to make

33

This term is used to describe the nurse's work of 'inducing state of well-being; relieving pain and grief; supporting; soothing; strengthening through bringing ease' (Collins, 1979).

whenever she enters into contact with a patient. The nurse brings to each encounter interpersonal and instrumental skills, as well as a body of nursing knowledge, which are capable of soothing, easing, allaying and giving comfort within the patient's immediate circumstances.

TABLE 19: SAMPLE OF ACTIVITIES WITH AN IDENTIFIABLE ELEMENT OF 'COMFORTING'

Placing locker within reach
Adjusting pillows
Giving assurance of progress
Responding to patient requests for information
Giving pain relief
Allaying anxiety about painful events
Holding hand and supporting patient through painful procedures
Arranging for wheelchair when patient concerned about ability of relative to walk to ward
Listening to patient concerns
Assuring patient of nursing presence
Performing procedures with skill

This comforting work of the nurse is consistent with nursing's traditional role. It is also a continually challenging work. On entering into the patient's presence the nurse may be confronted with a range of situations which require immediate comforting as well as interpretation and action. Table 20 lists a cross-section of patient situations which required comforting work from the nurse. While the nurse had available the full range of nursing modalities which comprise this theory, the comforting role has primacy while other responses are planned and implemented.

TABLE 20: PATIENT SITUATIONS REQUIRING 'COMFORTING'

Weeping	Vomiting
Sleeplessness	Nightmare
Agitation	Nausea
Pain - severe	Anniversary of wife's death
Pain - slight	Inflamed intravenous site
Feeling cold	Sore throat
Hiccoughs	Discomfort
Rash	Blocked catheter
Dizziness	Abdominal distension
Fainting	Post-operative shock
Bladder spasm	Stress incontinence
Diarrhoea - in bed	Death of widowed mother's dog
Breathlessness —	Diarrhoea - on floor
Backpain	Concern for frail husband —
Anger	Confusion through misinformation
Headache	Fear of pathology report
Dry mouth and throat	Leaking of blood from drainage
Profuse sweating	Passing of blood clots in urine

One patient became very agitated on his second day after major abdominal surgery. Pain, noise, light, people moving around, strange bed, regular recordings - all had contributed to his state. The nurse used a number of comforting interventions to cope with the situation - discussed it with surgeon and administered medication, washed the patient and made him comfortable, changed his bed to a quieter room, darkened the room, drew the screens around the bed, delayed nursing interventions, and gave the patient encouragement to rest. All were very important to the patient.

"The nurse, she's a lovely person . . .
the worst is over. I feel much recovered
in comparison to how I felt. . ."

In another similar situation the nurse gave the patient an analgesic, placed a sheepskin in place to ease an aching

back, drew the screens and encouraged rest. This nursing work also drew an appreciative response.

Comforting is induced by the competence of the nurse as she reacts to a patient situation. It is also apparent in planned nursing activities which could be a fearful experience for the patient. In the surgical wards in this study, nursing attention to the wound, the drainage or the intravenous infusion clearly required a comforting component.

"_ took it [drain] out so gently this morning. I didn't like the thought it it. You'd think it would hurt more but the biggest hurt was the stitch at the beginning."

Unfortunately, behaviours which are instituted to bring comfort may not achieve that end. For example, one patient had been given the news that his surgery had failed and further problems lay ahead. The nursing staff were genuinely concerned about this outcome and sought to comfort the patient by expressions of sympathy.

"All the nurses trotted around one by one when they got the message and sympathised with me which didn't help much either . . . They've all been helpful . . . Their sympathy was quite genuine, I could see that."

The nurse responsible for nursing him during that duty was aware that all had not gone well. There was a sense of unease apparent in her reflections. She shared her reactions to his anxiety, his desire for privacy, and the difficulty she was having in knowing how to comfort him.

"I found it quite a challenge because he won't let you be the nurse, sort of thing. He likes to set the level of the relationship and lets you know when you're intruding."

Although this nurse was able to share her awareness that her comforting work had not been successful, this was a rare occurrence. Similarly, nurses seemed to have a limited awareness of the importance of this work when its outcome was beneficial. During this study the researcher sensed that the comforting work of the nurse was devalued by nurses and yet, for the patient, was very important indeed.

Nurses often subsumed this significant, nursing-initiated work in phrases like "reassuring the patient ", and "giving lots of TLC [tender, loving care]." As used by one nurse, the term 'TLC' conveyed the need for nurses to specifically include tenderness, gentleness, and warmth when with a patient who was distressed on the day following major surgery.

34

Enabling

Enabling emerged as a major concept which encompasses the empowering dimensions of nursing's work. By means of activities with a significant component of this element the nurse assists the patient to attain the power, means, opportunity or authority to act within his present

34

This term was developed following a dictionary search for a word to describe the empowering work of the nurse by means of which she makes it possible for the patient to make beneficial progress throughout the passage.

circumstances. Five sub-concepts have been developed to describe the different aspects of Enabling which were identified in the data: Coaching; Conserving; Extending; Harmonising; and Encouraging.

35

Coaching

At first the term 'teaching' was applied to this concept. However, there seemed to be a particular element in the teaching role of the nurse which made the use of 'coaching' more appropriate. Coaching can be identified in activities undertaken by the nurse which assist the patient to expand his knowledge base and improve his skills performance in relation to his particular situation. However, coaching does not stop with tuition. It includes a strong element of ongoing support and guidance from the coaching person throughout the experience as happens with the coach of a sports team during a game. Thus, coaching is a moment-by-moment activity as well as a formalised programme of teaching in preparation for an event.

Within the experience of elective surgery the coaching dimension of nursing is easily identifiable. Table 21 lists a sample of nurse activities drawn from the data which contain an element of 'coaching'.

35

This term was derived from its use by Strauss to mean the giving of 'guidance as the patient moves along step by step . . . not merely because he needs to learn skills but also because some very surprising things are happening that need explanation' (Strauss, 1970, p.110). The concurrent use of the term by Benner (1984) is acknowledged.

TABLE 21: SAMPLE OF ACTIVITIES WITH AN IDENTIFIABLE
COMPONENT OF 'COACHING'

Persuading patient to accept analgesia appropriately
Strategies for relaxation and movement
Preoperative teaching
Guidance on ordering diet
Self administration of eye drops
Discussing breast prosthesis
Arm exercises after mastectomy
Passing urine after removal of catheter
Stopping smoking before surgery
Care of wound while in shower
Adaptation to altered body image
Positioning arm to maintain flow of IV infusion
Increasing mobility after surgery

During interviews nurses often made reference to their coaching work.

"He's anxious, tense, restless and hasn't been resting enough really in the last few days. And I explained to him today the more he rests the quicker it will absorb and the sooner he'll get home. . . . He's inclined not to listen very well."

.....

"We could actually start teaching him to do it himself if he wants to. . . . We'll teach him tomorrow." [put own drops in]

.....

"I've told him what to expect tomorrow. . I told him about the importance not to do too much on the first day. You know - no sudden movement with his head or not to be too active, and that we would be helping him with a sponge in bed."

.....

"Normally we do give people soup and sandwiches but because he is on a special diet I just gave him the tray with the normal sized meal and I said 'Don't be in too much of a hurry to eat it. Just eat a little bit.'"

.....

"First of all I made sure she knew what nursing procedures - like when she was given her premed and what it would do to

her and where she would be going. Made sure she knew when she could have a shower and just made sure she realised just what sort of things were going to happen . . ."

In each of these examples, the nurse was fully involved with the patient in the experience as it happened. The coaching was situation-specific and incidental as well as planned. By being present with the patient and involved in his care the nurse is able to judge the nature of coaching that is required to ensure that each person has the knowledge and skill that is appropriate in his present circumstances.

36

Conserving

Conserving is used in this study to describe the component in nursing which has the purpose of assisting the patient to maximally maintain his available resources so that he is able to meet the challenges he is encountering during his surgical experience. In order to assist the patient to conserve his energy the nurse may, for example, encourage the person to rest, do something on his behalf, give assistance, or delay energy sapping activities when resources are low.

Table 22 lists a sample of activities which have an element of 'conserving'.

36

This term was developed from a dictionary search and is used to describe the nurse's work of 'protecting, preserving, and carefully managing' the patient's resources (Collins, 1979). The use of this term by Levine (1967) to mean 'keeping together' is acknowledged and contributed to the researcher's sensitivity to discovering this work in the data.

TABLE 22: SAMPLE OF ACTIVITIES WITH AN IDENTIFIABLE
ELEMENT OF 'CONSERVING'

Moving patient with minimal induction of pain
Administering analgesia before painful activity
Inducing rest in presence of fatigue
Giving bed bath instead of shower
Assisting with bath/shower
Assisting patient to sit up
Assisting patient to turn over in bed
Grouping patient care activities
Teaching patient strategies for conserving energy
Encouraging patient to indicate when rest is required
during energy-using activity e.g. walking

On one occasion a patient had a bad day during his post-operative recovery. Instead of a reduction in the quantity of nasogastric aspirate, which was known by the patient to be a good indicator of progress, the amount had increased. The medical order for nothing by mouth had been reimposed. As a result he felt very tired and rather low. Previously he had been having a shower with assistance. On this day the nurse increased her assistance to the patient and supported his staying in bed for hygiene care to conserve his temporarily limited resources.

"He's been quite tired today compared with yesterday. I mean he didn't want a shower so I gave him an assist sponge."

In another example a patient who had renal failure and required haemodialysis had received an excessive intake of intravenous fluid which had affected him. The nursing notes give an indication that his nursing care prior to undergoing haemodialysis was primarily aimed at conserving the patient's strength in order for him to cope with the

effects of the additional fluid.

"Very tired and rather breathless early in duty and left to rest as much as possible."

37

Extending

Extending occurs when the nurse intervenes with strategies that enable the patient to enlarge the amount and scope of his activity. Once again, it is situation-specific in that the nurse makes a judgement that the patient has the resources to manage increased activity. This judgement is translated into nursing actions which increase the patient's range of self-care activities relative to his present circumstances. Flexibility and creativity on the part of the nurse are essential qualities as she is 'there' for the patient, dynamically reacting to achieve a maximum fit between his status and his self-care.

Table 23 lists a sample of activities from the data which contain an element of 'extending'.

TABLE 23: SAMPLE OF ACTIVITIES WITH AN IDENTIFIABLE ELEMENT OF 'EXTENDING'

Withdrawing nursing presence
Reducing assistance to patient
Changing from bed bath to bath or shower
Putting hand bar on bed to facilitate movement
Teaching patient to instill own drops
Administration of pain relief before activity
Transfer of patient into open ward

37

This term was determined after a dictionary search and is used in its sense of 'adding to; enlarging' the scope of the patient's functioning relative to his circumstances (Collins, 1979).

In the recovery of one patient there came a time when the nurse judged that he was ready to increase his activity level. In particular, she decided that the patient could manage a shower although he was loath to take this step forward.

"And then I've given him a shower which he actually, I think, quite enjoyed. He was a bit reluctant about going."

This extension of his actions was accomplished with the result that the patient felt able to shower himself without assistance the following day.

"Didn't want a hand with his wash or anything."

It is common for nurses to gradually withdraw their assistance so that it becomes necessary for the patient to increase his self-care. Although a nurse may be present with the patient over a number of days during the procedures associated with daily hygiene, her role is different each day. This is apparent in the following sequence of nursing notes on successive days during the post-operative experience of one patient.

"Full sponge given."

"Bathed this morning - enjoyed by patient."

"Up to toilet and bath. Managing well with minimal assistance."

"Assisted with shallow bath as necessary."

"Supervised with bath. Patient slightly unbalanced [unsteady] at times."

"Accompanied to bath but only a little assistance needed with washing back. Managing on own quite well."

On the following day the nurse withdrew so that patient bathed independently and dressed herself ready for discharge.

38

Harmonising

The fourth aspect of Enabling is the nurse's work in the maintenance or accomplishment of synchrony in the patient's environment and within himself in relation to his present situation. This requires the nurse to be present with the patient, observing, listening and interpreting, in order to identify any inconsistency. Thereafter, the nurse is able to select nursing strategies that will facilitate the restoration of harmony. In some cases the nurse may have to act on behalf of the patient, but more often she will work with the patient, giving specialised assistance as he strives to attain harmony through the moments of his lived experience.

Table 24 lists samples from the data of nursing activities which have an element of 'harmonising'.

38

This term was developed after a dictionary search for a word to describe the purpose of the activities undertaken by the nurse to achieve 'accord; consistency; balance; congruity' within the patient and between himself and his environment (Collins, 1979). The concurrent use of the term 'harmony' in relation to the status of the patient by Parse, Coyne and Smith (1985) and Watson (1985) is acknowledged.

TABLE 24: SAMPLE OF ACTIVITIES WITH AN IDENTIFIABLE
ELEMENT OF 'HARMONISING'

Adjusting pillows
Placing locker within reach
Adjusting bed height
Selecting and arranging pillows and bed linen
according to surgery and patient condition
Ensuring privacy for rest
Obtaining soft pillow
Placing bell within reach
Providing sheepskin for backpain
Using fan for high temperature
Providing additional bedclothes
Placing urinal/bed pan within reach of patient
Settling patient for night
Positioning patient for meal service
Fitting hand bar to bed
Positioning arm with IV to maintain flow

Several examples from the data are presented to illustrate the variations in patient situations which may require nursing intervention to restore harmony. Firstly, disharmony may be present within the patient as a result of conflicting information, as was the case with one patient who had been given two different explanations about the procedure, as distinct from the purpose, of her upcoming surgery. On the day of surgery the nurse assigned to her care for the day became aware of some inconsistency leading to confusion on the part of the patient.

"There were two ways they could have done it and I asked Dr _ this morning exactly what was happening and he said what he was going to be doing and explained the other way it could have been done but that wouldn't be necessary for her. Whereas, last night they probably thought it was going to be done the other way in which she would have had the suture line if it had been done. . . . So she was quite pleased to understand that."

Several patients spoke of being given as many as three quite different indications of how long they could expect to be in hospital.

Harmonising also relates to selective application of nursing actions to assist the patient to attain consistency between himself and his physical or social environment. If, for example, the patient is restricted in what he can or is permitted to do, the nurse will seek to manipulate the environment so that it is in harmony with his status. In practical terms, the nurse assesses the patient's situation, visualises what he may need to achieve maximum control, and takes steps to make sure it is available to him.

"I made sure a bottle [urinal] was on hand."

.....

"And he was quite pleased that he was given a hand bar to pull himself up on. That made his mobilisation much easier."

.....

"She's still using pans by her bed at night but that's because she can't make it to the toilet in time."

In the final example the nurse discovered that a patient was not drinking enough fluid. On investigation she discovered that the patient did not like the fluid supplied and was able to change it to one that he liked. This led to his adherence to the therapeutic regime.

"And he's allowed 30 mls of water - which he doesn't like - the water - so we've added a bit of lime to that, and an ice cube - and I think that's pleased him."

Encouraging

Within its repertoire nursing has a variety of actions which can be used to inspire the patient with confidence or courage. Encouraging is particularly required in situations where the patient is a little uncertain, or afraid, or unwilling to extend himself. It is a component of many nursing actions and is related to, but not the same as, coaching.

Table 25 lists a sample of nurse activities from the data which contain an element of 'encouraging'.

TABLE 25: SAMPLE OF ACTIVITIES WITH AN IDENTIFIABLE ELEMENT OF 'ENCOURAGING'

Assisting patient to view wound and consider the
resulting alteration to body image
Encouraging patient to increase fluid intake
Encouraging patient to breathe deeply
Encouraging patient to speak of anxiety/fear
Allowing patient to make decisions
Encouraging movement in bed after surgery
Encouraging patient to walk on first ambulation
Inducing hope
Encouraging patient to rest
Giving patient confidence to trust staff

A patient may be afraid of inducing pain or discomfort if he moves. In spite of explanations about the importance of movement, he may remain still. The nurse may consider that her best form of encouragement is to be present during the specific activity which is causing concern,

39

This term arose from the data itself - 'He needs encouragement.' It is used to denote the nurse's work of 'inspiring the patient with courage and confidence to take action; stimulating by approval and help' (Collins, 1979).

perhaps holding the patient's hand or otherwise giving guidance and support. In this way she gives the patient the confidence and the confirmation that his activity is appropriate to his circumstances.

On occasions the nurse's encouraging may be fairly assertive.

"He also needs to be pushed a bit, I think, because he has a tendency to lie just in one position and not do a single thing for himself."

.....

". . . because she's been in a medical ward and she'd had a coronary and she'd had a lot done for her - nursing-wise - she was very demanding at the beginning of the morning. When she came into hospital she felt we did everything for her. We got the comb out and combed her hair and everything - which I don't mind doing if she needs it but she could do it. So I quietly got over to her that if she could manage it was better for her to do it. So she did do it in the end. So she's quite independent now."

Nurses often used the word 'encourage' when describing their nursing care. The following examples reflect the fact that the presence of the registered nurse provides her with situation-specific opportunities to provide encouragement to the patient.

"Um - he needs encouragement with fluids. Hasn't been drinking very well lately. His urinary output has been low. . . . He's eating really well. Its just his fluids. You know, you have to keep on going in and offering it to him. Like, before he used to drink without you asking but now you need to encourage him. . . . then all of a sudden he's cut down on his drinking. He had a bit today but that's still with encouragement."

.....

"She's been quite bright and she seems - she just needed a bit of encouragement to be out of bed and doing exercises. She seemed to be sticking to her bed quite a lot. And she's a lot better. She only had a couple of drinks - she needs a lot of encouragement with that. Otherwise she's good."

.....

"And he's just feeling a little bit grotty and he needs some positive reinforcement that he's getting better. . . . I've encouraged him with his deep breathing exercises and coughing because of his chest."

40

Interpreting

Throughout each episode in which the nurse and patient meet during the negotiation of a patient's Nursed Passage, the nurse is continuously involved in interpretive activities - in relation to the patient, his status, his circumstances, his requirement for nursing, and his responses to intervention by all members of the health team. Interpreting has many constituent elements including observing, monitoring, analysing, translating, contextualising, synthesising and decision-making. There is an element of interpretation in each nursing action as the nurse adjusts to the patient's presenting situation. The outcome of each interpretive activity is influenced by the nurse's perception of nursing and what it can offer in a given patient situation.

40

This term arose from a dictionary search to find a word which could convey the nurse's work of 'translating; explaining the meaning; construing the significance' of aspects of the patient's situation (Collins, 1979).

Table 26 lists specific examples of nurse behaviours with an element of 'interpreting'.

TABLE 26: SAMPLE OF ACTIVITIES WITH AN IDENTIFIABLE ELEMENT OF 'INTERPRETING'

Making decision to consult medical staff
Conserving patient energy
Extension of patient activity level
Modifying nursing care plan
Writing nursing notes
Clarifying medical and other information
Problem identification
Selecting appropriate nursing response
Description of patient and status
Change in orders for nursing care

Examples from the nurse interviews will be used to illustrate different aspects of the interpreting work of the nurse. In the first group each nurse has reached a conclusion about the status of the patient after observation and interaction.

"I think she's had quite a hard time - a lot to cope with - and I think its a lot to bear at the moment. . . . she sort of needs a lot of TLC or something, I think."

.....

"He is a bit apprehensive but he's not very vocal about how he's feeling. He likes to pretend that he's a big and brave man not to complain about pain even though its obvious by his face that he does have some."

.....

"He'll just take it in his stride because he's used to so many things, probably."

.....

"His whole attitude was one of wanting to give up because his shoulders were sagged and his head was cupped in his hands and he sat on the edge of the bed in a sort of total attitude of hopelessness."

Interpreting is closely interwoven with other nursing work so that the nurse's analysis is consistently linked with action. This is illustrated by the following two reflections by nurses on the care of patients during the previous duty.

"Well, he's been - physically his condition is really stable. All his observations are stable. He's putting out lots of urine and he looks good. His colour's good. But he's extremely uptight! Very tense. Even though he appears to be quite well covered with his pain relief, when you go to move him or do anything he immediately starts to breathe very quickly and tenses up totally. So he needs a lot of reassurance. He also needs to be pushed a lot, I think, because he has a tendency to lie just in one position and not do a single thing for himself, you know. I think that's basically his problem at the moment."

.....

"Mr _ was in quite a bit of pain about 4 o'clock this afternoon both in his penis and, it seemed like, his bladder. I couldn't work out whether or not he was getting bladder spasms but it seemed like he was. So I irrigated his catheter and got quite a few clots back and some very dark haematuria. It didn't seem to help him but his catheter was draining well all along, you know. It hadn't stopped draining. And he had Codis and he seems to have settled down now. . . . When he sits up is when he gets the pain. I don't really know why that is."

The monitoring aspect of Interpreting is most apparent in the nursing notes when specific patterns of reporting on the status of each are in evidence. This is particularly so immediately after a patient's return from undergoing surgery as illustrated by the following notes from one patient at the end of the morning shift.

"Returned from OT 1130hrs. Obs now 4hrly and stable. Drowsy but rousable. Has not taken any oral fluids as yet and HNPU. Drugs - Omnopon 20mg IM 1500hrs for anal discomfort. Wound - No ooze. Is packed with 2 green swabs. ? further orders for same."

By the end of the afternoon duty, the progress of the patient was also reflected in the notes.

"Good post-operative afternoon. Obs 4hrly and stable. Tolerating oral fluids and eating small amounts of food. No wound ooze. UTT x1."

The amount of monitored information which is recorded in the nursing documentation is variable depending on the type of surgery and the presence of therapeutic measures such as suction or intravenous infusion, as well as the individual nurse's decision on what she will enter. In the following example the night nurse coming on duty has considerable information on the status of the patient during the afternoon.

"Intake - IV Barts 12hrly infusing due at 0430hrs. Tolerating fluids and had 150mls soup for tea. Output - HNPU. Nil ooze from wound. H'vac drained 30mls. No vomiting, nausea or BM. Recordings - Now 2hrly. P 72-80. BP 170/70 - 190/90 T 36.4 House surgeon aware of BP. Recordings are stable. Could be QQH overnight. General - O2 discontinued at 1800hrs. Omnopon 15mgs and Stemital 12.5mg IM given at 1730hrs, with good effect. Omnopon 15mg IM given to settle at 2200hrs. Post-op wash given. Moves well when encouraged. Needs reminding to do post-op exercises. Heel protectors in place. Visited by husband twice."

The nursing notes also contained nursing interpretations of abnormal events. Four examples are given to illustrate

this. Considerable variation in the format is apparent. Specific reference to the status of the patient during and/or after the event is rarely noted. Neither is it common for nurses to record significant nursing work in the context of the presenting patient situation e.g. situation - nursing action - impact of action.

"Confused and disoriented overnight. Asking for husband and stating why he wasn't there? how he got there? why didn't he stay? Slept for most of night."

.....

"Patient said he had a nightmare and removed his IV cannula. IV replaced by 1st on."

.....

"BP dropped to 72/40 at 1630hrs. Seen by Dr -. IV fluids increased. I unit of whole blood over three hours."

.....

"BP dropped to 84/60. House Surgeon notified and pt given 1 unit whole blood. Recs 1/2hourly while blood in progress - f/satis at present. . . . Appears comfortable."

Another source of information on the outcome of Interpreting is the nursing care plan - in particular, the section where nursing problems are entered. In this study it was consistently apparent that nurses were not entering nursing problems in the care plan despite the evidence of their existence in the nursing notes and/or interviews. Only three of the twenty-one patients actually had problems identified after the initial plan was prepared on admission. The seven stated problems were:

Patient 1 - "Pt appears to have little concept of time"
"Potential problem - retention following removal of IDC"

"Deafness"

"Potential problem - ability to manage once discharged"

Patient 2 - "Pain"
"Productive cough"

Patient 3 - "Pain and discomfort"

It is significant to note that the four problems identified in Patient 1 were entered at the time of rewriting the care plan ten days after surgery. Thus, it became apparent that nurses were experiencing difficulty to using problem-identification as the basis for planning individualised nursing care, despite the obvious presence of interpretive behaviours.

41 Responding

Many nursing actions are initiated as a consequence of a nursing interpretation of a patient situation which she encounters. They may be spontaneous and occur only once, or they may be planned and continued over a period of time. This responding work is not predetermined although it is consistent with nursing's scope and function. Rather, it is variable according to nature of the presenting situation and the choices which the nurse perceives are available in the circumstances.

Table 27 contains a list of nurse activities encountered in the field in which there is a recognisable element of

41

This term was selected after a dictionary search for the most appropriate word to describe the nurse's work of 'reacting' to aspects to the patient's immediate situation (Collins, 1979). It has the added component of being 'favourable' or beneficial to the patient.

selective 'responding'.

TABLE 27: SAMPLE OF ACTIVITIES WITH AN IDENTIFIABLE
ELEMENT OF 'RESPONDING'

Bed pan at bed side for patient with diarrhoea
Adjusting pillows for comfort
Providing sheepskin to relieve back pain
Providing privacy for rest during day
Monitoring of blood pressure level when high
Informing medical staff of abnormal observations
requiring medical response
Emergency measures in response to post-operative
shock episode
Administration of pain relief
Sitting with distressed patient
Performing procedure in place of Enrolled Nurse at
patient request
Modifying care plan following patient appraisal
Administration of aspirin and honey for sore throat
Modification of discharge plan in response to
patient concern
Administration of laxative for constipation
Irrigation of catheter to clear blood clots
Consultation with medical staff to change night
sedation
Confirming evidence of progress on part of patient

Responding is present in the nursing action of referral of
a problem for partial or complete resolution by another
health professional, usually a member of the medical team.

"And other than that he's been up to the
toilet a lot with diarrhoea which he's
found a bit disturbing but we got some
codeine phosphate charted for him and
that's had a good effect."

On several recorded occasions a nurse found herself
choosing to respond to the patient's situation in a way
which was contrary to his wishes. At such times, the
nurse sought to persuade the patient to accept a nurse-
initiated course of action which she judged to be a valid
response even though he did not agree.

"He refused pain relief but he appears quite sore - just from the way he was moving. His movement was quite limited so I gave him pain relief - forced it on him - and he seems a lot better since then."

In this example the nurse's interpretation gave priority to the patient's 'pain' as she perceived it to be. She has noted a lack of synchrony between the patient's words and her perception of his behaviour. Her desire for the patient to be comfortable led her to respond in a way which she considered to be in his best interests. A lower priority has been given to maintaining the patient's ability to control his world. This pattern of responding by persuasion was not uncommon in the data.

"She refused pain relief but I made her take a couple of Panadol. I felt she'd actually been a long time without anything and it would be sore."

Occasionally, responding is formalised and recorded in the nursing notes as suggestions/orders for colleagues to follow. The following represent a sample of nursing responses recorded in the documentation.

"Watch heels - protectors on but they need a rub 4 hrly please."

.....

"Hospital Linctus for troublesome cough."

.....

"Pad in situ due to stress incontinence."

.....

"Complained of excessive drowsiness this morning. Night sedation recharted."

.....

"Complaining of sore throat. Given Aspirin and Honey for that."

.....

"Had 700mls this duty. Water jug taken away." [Patient on fluid restriction]

42

Anticipating

Anticipating has a predictive quality whereby the nurse visualises the future, both immediate and longer term, as it affects the recovery of the patient from his surgical experience, and uses this as the basis for selecting nursing actions which will beneficially progress the patient. The visualisation is based on the nurse's increasing understanding of the patient as a person, an assessment of his present circumstances, a comparison between the path of progress attained by this patient and others the nurse has had contact with, and some understanding of the potential shape of the future for this person. It is linked closely to the nurse's perception of what nursing can offer the person to optimise his present and future status.

Table 28 lists a sample of nurse activities in which there is an identifiable element of 'anticipating'.

Anticipating can be seen as a component in nursing actions which have the purpose of looking ahead. During the preoperative phase, when the patient is new and fulfilment of the purpose for his admission lies in the near future,

42

This term was selected after a dictionary search for the most appropriate word to describe the nurse's work of 'foreseeing and acting in advance of' (Collins, 1979). Actions may be initiated with the intention of 'forestalling' the unwanted and/or 'causing [a desired goal] to happen sooner'.

TABLE 28: SAMPLE OF ACTIVITIES WITH AN IDENTIFIABLE
ELEMENT OF 'ANTICIPATING'

Discussing and demonstrating breast prosthesis
Administration of pain relief before painful
procedure
Staying with patient in bathroom after injection
of pain relief
Arranging for visit by voluntary group member
Leaving bed pan or urinal at bedside within reach
Delaying discharge until family support available
Discussing future with patient
Preoperative talk
Withdrawing nursing presence and encouraging
independence
Guiding patient expectations about upcoming events
Placing articles within reach of patient
Writing orders for nursing care

the nurse anticipates the patient's participation in and reaction to the upcoming experience. This activity generates the basis for decision-making, including assumptions, about the nature of the attending and enabling work the nurse will initiate.

"I asked if he was worried about anything just to ask us but he hasn't asked anything. I just explained to him what I thought he'd want to know. He hasn't really been asking any questions."

Throughout this study it was apparent that nurses were closely involved in the patient's experience of rest and sleep. In anticipation of the night that lies ahead nurses ascribed importance to the management of night sedation and the initiation of sleep inducing activities.

"She had Oxazepam to settle. The girls asked her yesterday about her sleeping and she said that she often woke up early in the morning and so they got her charted something to sleep in hospital and she is - she did sleep well last night."

However, a few days after surgery this patient found herself not sleeping very well. The charge nurse responded to this situation by discussing the situation with the patient. This led to a nursing decision to approach the medical staff for a recharting of night sedation so that the patient would receive what she was used to when at home. Thus, there is a constant movement between anticipating and responding.

"We had a chat about that [not sleeping] and she said that normally at home she has Valium 2mg which she found suitable. So I've had the House Surgeon up and she's recharted her Valium. . . . So we've recharted her Valium in the hope that, since that's what she's used to, that will suit."

Anticipatory nursing actions often refer to the immediate future. As nursing is concerned with the moment-by-moment lived experience of the person during the Nursed Passage, the nurse is able to take action in the present in anticipation of a positive impact during an upcoming event. This was apparent in observed nursing activities such as the administration of analgesia before taking the patient through a painful procedure.

"I gave him some Morphine 10mg intramuscularly and then half an hour later bathed him, removed his packing and he's now resting on his bed."

This same patient was waiting with apprehension for his first bowel motion after surgery. As the time approached the nurse counselled him about the upcoming experience. She selected nursing activities which reflected her

anticipation that the patient would manage the situation better if he knew what to expect, the experience would be painful, it would induce unpleasant sensations, and help would be available.

"And then later on he rang the bell and I ran in and he said his bowels were going to move and I said 'Well you can just go to the toilet and move your bowels and we'll see. If you feel its too painful ring for me, if you need anything.' And I said 'You're going to feel hot and funny because you do when you have your first bowel motion.' So he went and his bowels moved and he said he felt a bit hot but it wasn't that painful and he was just going to have a bath. So he's quite happy."

During an exchange later in the day the patient confirmed the nurse's anticipatory work had been accurate.

"Knocked me for six when I had the first one this afternoon. Had to lie down. Seemed to settle then."

"Staff Nurse told me she told you that you would be hot and cold."

"Yes. She wasn't far wrong either!"

The following exerpt demonstrates that nurses act in multiple time orientations as they work with the patient. In this case, the nurse attends to the immediacy of the patient's situation and anticipates his future status.

"Actually he's been quite good today. He's had no pain relief at all. He's had an assist sponge and he's been up for a walk by himself. . . He seems pretty cheerful, you know, and chatty. . . . He's on oral fluids now and they're 30mls an hour which he's tolerating okay. He's burping less than he was a couple of days ago. . . . He's pretty lucky actually because his suture line looks absolutely beautiful - no muckiness or anything. its

lovely. I think once he's rid of his IV and his nasogastric he'll just be up and away really."

Anticipating may be undertaken by the nurse to forestall the onset of a negative situation and/or to facilitate the accomplishment of a positive state. Inherent in anticipating is a nursing oriented visualisation of the immediate or longer term future of the patient.

Summary

Throughout this chapter, the discussion has focused on a conceptualisation of the work undertaken by the nurse to facilitate the patient's progress through the Nursed Passage. Exerpts from the data have been used to illustrate the dynamic quality of this work. There is evidence to suggest that the nurse works within the immediacy of the patient's situation to maximise the beneficial impact - present and future - that can come from the strategic application of nursing knowledge and skill to optimise the patient's own work.

Chapter 9 will conclude the presentation of the work of patient and nurse within the Nursed Passage with an exposition on the final stage - Going Home.

CHAPTER 9

GOING HOME

This chapter describes the nature of the work undertaken by patient and nurse in order to assist the patient to make the transition from hospital to home.

Introduction

Throughout the Nursed Passage the patient and nurse are at work negotiating the path of the patient through the passage. Thus, the work of both nurse and patient, as discussed in Chapters 7 and 8, continues until the patient is discharged from hospital. However, there comes a time when the focus moves from the present - being nursed - to the future - without nursing. At this time the activities of nurse and patient are expanded by the inclusion of work which specifically prepares the patient for the transition experience of leaving the passage and going home.

In this study the decision to discharge a patient was made by the medical staff. However, this decision could be, and in some instances was, influenced by the actions of both the patient and the nurse. Such actions were primarily initiated by concern for the patient's personal

circumstances, that is, the non-medical aspects which the patient had revealed to the nursing staff. Despite this opportunity for collaborative decision-making, both nurses and patients tended to acquiesce to the decision of the surgeon which is usually not confirmed until the actual day of discharge, although a tentative date may have been established earlier in the patient's hospitalisation. There was no evidence of formal discharge planning.

Consequently, the terms 'probable' and 'possible' were commonly used by nurses and patients when they spoke of the time for the patient's discharge. This uncertainty is illustrated by the nursing notes and interviews on one patient in the three days prior to discharge.

3 days before discharge -

Notes: "For possible discharge at weekend."

Nurse: "He'll probably go home at the weekend. . ."

Patient: ". . . he indicated I could expect to go home probably before the weekend, so I interpreted that as Thursday, but probably Friday."

2 days before discharge -

Notes: "For possible discharge on Friday."

Nurse: "He's probably going home on Friday morning."

Patient: "So I'm not coming home on Friday definitely but it looks pretty likely I will be home Friday."

Day before discharge -

Notes: "Looking forward to possible discharge on Friday."

Nurse: "He's still hopefully going home in the morning."

Patient: ". . . about 4 or 5 o'clock he'll probably wander around and have a look at Mr _ and come over to me and I'm expecting him to say 'Well, yes, you might as well clear off in the morning.' He'll probably have another look in the morning. "

Although there was a degree of uncertainty, the indications were clear and both nurse and patient had, at least, a tentative goal to which their efforts could be aimed. Indeed, work before the final confirmation would seem to be essential as patients tended to leave as soon as possible after the decision was made. Haste may be a characteristic component of the transition out of the Nursed Passage unless nurse and patient attend to their work prior to the medical decision.

The data revealed indications that the patient works to ready himself to leave hospital and to resume his life at home, and the nurse uses her specialised knowledge and skills to facilitate this transition. In the remainder of this chapter the specific contributions of patient and nurse to the conclusion of the passage will be described and illustrated by excerpts from the field data.

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Going Home: The Work of the Patient

During the Nursed Passage, in addition to the continuing work of negotiating the moments of the passage, the patient begins to sense the healing taking place within himself and assumes increasing self care. He begins to

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This term was derived from the data. Patients consistently spoke of 'going home'.

prepare himself for going home.

From the final interviews with patients after their return home, it became apparent that 'going home' did not mark the patient's return to the pattern of living which was his before the onset of the problem which necessitated the surgery. Rather, it was only a step, albeit a significant one, on the patient's road to recovery from his ordeal. Following discharge the patients found there was still a lot of work to do and problems related to the surgery could still arise. There was evidence that the shape of this experience could be influenced by the preparatory work of both patient and nurse immediately before discharge.

Four concepts which reflect different dimensions of the patient's work in preparation for going home were generated from the data: i) Maximising Readiness; ii) Making Arrangements; iii) Discovering Requisites; and iv) Resuming Control. Although they co-exist and interrelate with each other and also with the concurrent activities of negotiation, each will be discussed separately with supportive extracts from the field data.

44

Maximising Readiness

As discharge became a possibility, the patient's growing

44

This term was developed after a dictionary search for a phrase to describe the patient's preparation of self for going home. 'Maximising' means 'make as much as possible'; 'readiness' means 'preparation for action' (Collins, 1979).

expertise in relation to his status was revealed as he would assess the likelihood of the surgeon saying he could go home. The patient had usually learned some of the factors which would influence the surgeon's decision to let him go home.

"Well, if its clear tomorrow, I wouldn't be surprised if he says I can go home Monday - if its as clear as it is now."

He often had the confirmation within himself that he was ready to go. This seemed to come from his own sense of himself as well as the cues given by others, especially medical and nursing staff.

"Every day I used to look forward to being able to do a bit more but suddenly I can do it all and there's nothing to look forward to other than going home."

.....

"I wasn't surprised when he said I could go home."

.....

"I think they intend to take the plaster off and have a look and say 'That's alright. Go home.'"

When the patient's sense of readiness seemed to be confirmed by the external cues, even though the final decision was usually not made until the actual day of departure, then the patient was able to maximise his own preparedness to go home. At such times he would seek to increase his independence by resuming maximum self-care. However, there were occasions the patient was actually in receipt of confusing messages which were inconsistent with his own feelings about his status and which posed a threat

to his ability to ready himself for going home. In the following two examples one patient felt ready to go home but received no confirming message from the medical staff, while the other patient had received several different stories from medical staff, none of which were consistent with how she perceived herself to be progressing.

"I don't know what's the story. He just said 'See you tomorrow,' and walked away. I'm just on holiday now, it seems like."

.....

"Dr _ [Registrar] said I would be in about a week. About an hour later _ [medical student] said 'Yours is only a small one. You'll be out in a couple of days.' That's why I've been wondering all this time. A couple of days! That's why I asked Mr _ [surgeon] because I didn't have a clue. . . . After two days I couldn't even move my leg. I realise now that I will be longer. A couple of days have passed long ago!"

The first patient did go home the next day while the second actually went home on the 14th day after surgery.

Despite an awareness that they were ready to go home, patients anticipated that there would be some residual effects from the surgery which they would become aware of as they made the transition from hospital to home.

"Well, I feel remarkably well lying in bed. I guess I won't have so much energy when I'm moving around."

Experience proved to the patients that life does not return to 'normal' for quite a while. During the home visit patients retrospectively reflected on the impact of the surgery.

"It affected me for a while too. I was surprised, you know. It took the stuffing out of me completely, it did - for a while."

.....

"Just shattered a bit . . . I'm not feeling the best. . . I'm starting to come right."

One patient expressed anger as she reflected on her lack of preparation for going home. She felt that specialised assistance should have been available to help her.

"I knew nothing about what I could expect afterwards. I mean not just in hospital but when I left hospital and went home. I didn't know I would be so tired. I was a bit, resentful isn't the right word, a bit annoyed that I wasn't prepared for going home. I was just dismissed that morning. [surgeon] came round and said 'Well, you've got your running shoes on. The job's right. Out you go!'"

For those patients whose problem had surfaced with a crisis pattern, there was a continuing need to incorporate a degree of uncertainty about the more longterm future as they prepared themselves to go home. These patients reflected on this during the home interview and revealed that their newly discovered vulnerability had made them less secure.

". . . you sort of realise that things are - they can't guarantee it won't happen again. Something could happen where it [cancer] comes up somewhere else. . . . It doesn't really frighten me. I suppose, having my faith and that, I accept these things more than somebody that hasn't got any. Not that I want to die or anything. I hope I can keep on living for a good while."

.....

"It makes you feel you don't know what's around the corner. I mean things you took for granted are no longer. I don't feel so secure now. . . Well, I just think 'What might happen next?' - all the things that can happen."

This second patient also spoke of the impact of the experience on her husband who had himself been ill in recent months.

"I think he realises I'm not to be taken for granted . . . and I think its given him the chance to do something for me and I think he likes to do things for me now."

While the presence of a life-threatening problem requires some patients to re-examine their view of life, there may also be a need for some patients to ready themselves for an immediate future containing uncertainty relating to the outcome of the surgery itself. If no resolution occurs before discharge, each patient has to give due attention to this in his planning to go home. A period of waiting may be necessary before the surgeon can confirm a positive outcome has been achieved.

"He said there's some doubt about the nerve at the back. He can't quite see that. He's not sure whether or not that's been damaged in the past quite unrelated to the cataract. . . . so that's still an unknown but we'll have to wait and see."

.....

"Mr _ was also mentioning that there's a bit of soft cornea there that he may have to tighten up the stitches."

.....

"Apparently I am going to have it [frequent diarrhoea] for a couple of months before things settle down."

.....

"The only bit I'm worried about is that I've got quite a bit of fluid [under wound]. . . . He said the district nurses would watch it and they would get in touch with him but he said I might have to have a needle - whatever he means - drawn off I suppose."

Thus, in their work of readying themselves to go home, the patients in this study were faced with incorporating the impact of the experience into their view of themselves and their world, as well as their pattern of daily living. Both immediate and longer term issues required work from the patient with support from the nurse.

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Making Arrangements

All patients spoke of the need to make arrangements for their discharge. This means that discharge is a phenomenon requiring specific planning activities on the part of the patient himself as well as the involvement of others, particularly family members. Arrangements had to remain tentative until the patient received confirmation that he could, indeed, go home.

"So I'll wait until tomorrow and then it's a question of when he thinks I can go home. And then there's a multitude of arrangements to make at home because my wife's got things on which she'll change if necessary to suit the convenience of my discharge. . . . I'll get everything worked out when I've seen him."

.....

45

This term was derived from the data. One patient spoke of his need to "make a multitude of arrangements" before he could go home while other patients conveyed this same idea in other words.

"Its only a matter of a phone call. . . ."

.....

"My husband got a surprise when I rang and told him. I have been saying to him to get some shopping in case I came home for the weekend. . . . I will get a friend to take me home or I will get a taxi."

Even obtaining clothes to wear home requires a degree of organisation.

"I've got some clothes here. I'm not going home in pyjamas." —

.....

"My wife brought in my clothes last night."

If given the opportunity to name their own time for discharge, patients tended to choose a time which suited the activities of other family members. When the confirmation of discharge was delayed until the afternoon this seemed to cause more problems for family members than those made in the early morning.

"I could have gone out today but it would have been a bit of a gallop and she had other things on as well so I said I wasn't crashing to go out. . . . So I'm definitely going out tomorrow."

One patient who was expecting to go home became a little upset when the surgeon passed through the ward around midday and, within the patient's hearing, said he would be back later in the afternoon to see his patients.

"If its go home then its a frantic call to the wife to come and get me. I'm a bit annoyed. If he'd come in here first of all - the three of us - and the way he goes through it wouldn't have taken him five

minutes to do the three. Its possible that the three of us are going home. You know, we could have got things organised. Now its going to be a bit more awkward 'cause she may go shopping after work and things like that. Whereas, if I'd got her at school she could have come straight in. We've just got to sit here and wait it out."

Although the day of discharge was a medical decision, there was evidence that nurses could negotiate with medical staff and with patients on the arrangements for the patient's departure. Nurses revealed both flexibility and inflexibility in their willingness to fit in with the personal circumstances of the patients in this study. For example, one patient who lived 50 kilometres from the hospital, and whose wife worked near the hospital, planned to go home with her at about 5pm when she finished work. He was reportedly told by nursing staff that this was not acceptable and his wife was required to take leave from her work to pick him up and take him home. By contrast, two patients, one in the same ward as the previous patient, had their discharge delayed when nursing staff recommended to the surgeon that this should occur. In the first instance the patient unwillingly accepted the decision that he should remain in hospital for an additional day; in the second, the patient initially sought the delay, albeit indirectly, by her expression of concern that no help was on hand.

The first patient, an elderly man who resided in a town some 70 kilometres from the hospital, was planning to travel alone by bus then train and then bus to his home.

By the fifth day after surgery he felt ready to go home. However, the charge nurse did not agree and asserted her judgement.

"I said 'Can I go today?' 'I suppose so,' he said. The Sister said 'I have got him down for tomorrow. If you have got someone to take you home you can go today.' I haven't got anybody, so. A day won't make a lot of difference."

The second patient was an elderly lady whose husband required assistance with his own serious chronic illness, and who lived 60 kilometres from the hospital. On being told she could go home she became anxious that no help was available that day, although an elderly sister-in-law in another city was available to fly down in a few days. Unfortunately, despite early indications that additional arrangements would be required, discharge planning was not initiated by nursing staff until the medical discharge was confirmed.

"My own doctor is away on holiday I gather, and I had the two other doctors he's usually with. And he just said 'Go home today and we'll make an appointment for you to come back.' I think he said Thursday or later in the week. But then I said I wasn't really going home today to anybody that could really do anything for me. He said 'Well, stay till Thursday here,' but then the Sister said, since I've been talking to her, she said 'Go home Wednesday,' and she'd have help arranged."

This study has clearly revealed that patients do make plans about when to go home, how to get home and how to manage when they get there.

Discovering Requisites

As the patient prepares himself to go home he leaves the ordered environment of the hospital in which he has been exposed to the specialised services of a variety of helping personnel. In his own home he will be responsible for as much of his own care as he can manage. While help may be available, he is usually the primary self-care agent. Therefore, there is a need for him to find out the after-care recommended by hospital personnel - nurses, doctors, physiotherapists, dietitians, and others. However, there is a significant element of chance in this discovery process because the patient often does not know what information is required, from whom it should be sought, and when it is complete.

Several patients denied receiving any guidance on after-care when they were interviewed after their discharge.

"No instructions whatsoever - not from anyone."

But most patients agreed that they had received some specific written or verbal guidance on what they should do for their self-care at home.

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This term was developed after a dictionary search for a phrase to encompass the patient's need to know what he had to do for himself at home in order to continue his recovery. 'Discovering' is used in its sense of 'determining; finding out; learning; ascertaining'; 'requisites' are those 'essentials; necessities' which the patient must undertake to optimise his continued recovery (Collins, 1979).

"Just got this stocking and I've got to wash it out each night. She said I would possibly have to wear it for twelve months or so."

.....

"I had a doze off in the afternoon. I obeyed the instructions - 'Rest up for an hour or two in the afternoon.' That's just what I did."

.....

"The physiotherapist came today and I've got to continue my exercises. She told me I was quite good today so I'm going home with reasonably good arm movements."

.....

"I have to have a bath after every bowel motion. I rang work and told them I'm getting out but I can't go back to work till next week. He said 'Yes, its a bit hard. I can't let you off to go home and have a bath.'"

.....

"I've got my diet sheet. Its good. Nothing restrictive about it. There's a lot you can eat. All I can see is the quantities will be the important thing. . Little and often."

Most of the self-care requisites which had been given to patients were primarily aimed at continuing the healing process. However, many of the patients in the study experienced unexpected problems after going home and were less aware that they had been prepared to cope with these. Therefore, when these did occur they often found themselves having to develop their own management strategies.

The kinds of problems which patients spontaneously shared with the researcher in the final interview at home are listed on Table 29.

TABLE 29: POST-DISCHARGE PROBLEMS REPORTED
IN STAGE 3 INTERVIEWS

Severe headache
Needing to sleep during the day
Inability to sleep
Inability to get comfortable in bed
Giddiness - dizziness - heart 'patter'
Feeling weepy
Feeling 'sick'
Fatigue after activity
Inability to manage a full day's work
Feeling tired 'all the time'
Chest pain
Feeling 'depressed'
Feeling 'nervy'
Pain
Discomfort
Delayed healing of wound
Severe bleeding
Diarrhoea
Loss of sensation in area of wound
Collection of fluid under suture line
Itching
Oedema and ascites
Infected intravenous injection site
Getting dressed after mastectomy
Swollen hand after mastectomy

Most patients seemed to have been given advice on how to manage any pain which they might experience after going home.

"I had to take quite a few Panadol for pain."

Some were offered sedation to use at home.

"They gave me Halcion tablets - twenty-one of them - when I came out of hospital."

However, most of the problems which did arise were not amenable to pharmacological relief. Guidance on issues such as what kinds of problems might arise, when and who to call for help, and what strategies to use to manage

temporary problems was not consistently received by patients.

One kind of knowledge which can be considered as a requisite before discharge is the recognition and self-management of reactions to actually going home. One patient, who had appeared to be apprehensive during much of his hospital experience, described a pattern of behaviour which caused him concern several hours after he returned home.

"I was feel bad. I eat something and it sort of repeat in me and I start to sort of wind and come up to the throat. I feel funny. So we call him. . . . It be coming home the doctor said. That what he said. After that I pick up."

In this situation the patient seemed to be experiencing a reaction to leaving the hospital and going home. At least three other patients also revealed a temporary reaction to the transition from hospital to home during the final interview. Two of these patients associated the presence of visitors with the reaction.

"There was a constant stream of people that afternoon and I thought 'I can't cope, can't cope!'"

.....

"During the afternoon we had visitors and I got quite a depressed feeling. I don't know why. Everything seemed to be on top of me yet I was feeling quite well. But I sort of felt that I wished I was back in the security of the hospital ward. . . . Perhaps it was because I wasn't feeling very bright. I was getting quite a lot of aches and pains down underneath the ribs there."

The other patient ascribed her reaction directly to the impact of going home.

"I think you feel as though you are in a different world. That world is going on outside and you're in this one and it takes a little while to adjust when you come out again . . . You miss it all at first when you first come home."

During the home interview one patient who had undergone surgery on his prostate gland was quite distressed. He was passing a lot of blood in his urine and this was associated with severe pain. He was greatly concerned. Once again, he did not have access to the knowledge to know whether or not this was 'serious' and what he should do about it. He knew it was most unpleasant and unwelcome.

"I don't know what to do. Its red. Its red blood. You do urine and you have almost stopped and its very hard to get more. Then you stop and all of a sudden blood comes pouring out. That's what it is. Its blood, straight blood. No doubt about that."

Yet another patient described the onset of a serious problem and demonstrated that she had ascertained what to do in case of emergency [haemorrhage] but not before it reached that stage. Initially she felt 'rotten' and this progressed to a major haemorrhage some ten days later. It signalled a general deterioration in her health status caused by progression of the chronic liver disease which had necessitated the surgery. Her husband reacted to the haemorrhage by calling the ambulance but she had previously instituted her own coping strategies when she became aware of the more generalised indications that all

was not well.

"In fact I think I went home too early. I couldn't cope with anything. I had to get my sister over to stay with me. My husband said he could cope but he was useless. It was so sore. The leg ached and ached. I didn't even want to get up. I made myself go to the toilet and I made myself walk. If I could have just laid there without moving I think I would have. I felt rotten. . . . Just feeling off colour - just feeling as if there's something wrong and you can't pinpoint it. . . . But I wasn't thinking of another bleed to that extent. So, of course, it was rush in and just transfusions until it subsided again."

In preparation for the resumption of maximal autonomy when he goes home, the patient has a work to do to ascertain the requisites for self-care which are specifically prescribed for his optimal recovery. Requisites take two forms. Firstly, there may be a need to continue activities commenced in hospital such as exercises, diet, medication, and treatments and adapt these to progress continues. Secondly, there is a need for the person to be given guidance on appropriate actions to take in the event that potential problems arise. These requisites are known to the various groups of specialist hospital personnel who have been involved in his care. Some of the problems which did arise were transitory; others signalled problems requiring specialist intervention; a few became real emergencies necessitating an ambulance callout. Patients demonstrated a willingness to learn management strategies when they were made aware of them by the staff member concerned with that aspect of their care, and/or through the agency of the nurse. In particular, they valued an

opportunity to sit down with a trusted staff member - a nurse - near to the time for discharge to review the experience and discuss the time that lies ahead as they go home.

"Sister's on tomorrow and she will be able to give me a few ideas as she is very good. She usually makes sure she has a chat, doesn't she?"

.....

"I think there is a need for a bit of time so you can talk things over."

—

"This great white coat thing . . . you don't get the same responses from nurses. You can ask them more. You feel they are more on your level. . . You really do need to find someone you can trust to give you the answers if everybody isn't."

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Resuming Control

As the patient prepares to go home he is also getting ready to assume more control over himself in his usual activities of daily living. In addition to taking responsibility for the self-care requisites prescribed by hospital personnel, he is now required, once again, to make decisions about what he should and should not, will and will not, do. Before going home patients are already thinking ahead and anticipating an incremental increase in activity as they gradually return to a more usual pattern of daily living.

47

This term was developed after a dictionary search to discover the most appropriate term to describe the patient's activities related to resuming responsibility for self. 'Resuming' is used in its sense of 'taking back'; 'control' means 'the power to direct or determine' (Collins, 1979).

"When I get home I'll just have to take it gently."

.....

"I am not going to be a stupid fool and rush around and mow the lawns and that sort of thing. I am going to take it easy for the next few weeks."

During the home interview patients shared the strategies they had used to manage their lives after leaving hospital. There was often the realisation of a need to conserve energy as this seemed to be at a premium for many patients, whatever — the nature of the surgical intervention.

"Its interesting isn't it - an operation on your eye which is over so quickly and still has its after effects."

This patient described his first few days after going home and the way in which he coped with the fatigue.

"I came home on the Tuesday night. The Wednesday I virtually slept all day and it was not till Thursday after lunch that I started to get up and wander around. . . I just slept for about a day and a half."

There was also a need for patients make decisions about the modified routines they would follow, at least initially, until they felt able to resume their usual pattern of daily living. During the final interviews patients revealed that they were making self-management decisions and evaluating outcomes.

"The hard part's still getting dressed. For the first nine days I wore the same frock. That was the only one that opened right down the front."

.....

"I think this time I went back to work a bit quicker, even on the glide time. . . I think I thought I was a lot better than I was. The same with the concreting yesterday. This morning I felt quite had it and I was up at half past six and ended up going back to bed until about one o'clock. I felt I had had it and I knew I had had it."

.....

"I got the bright idea of putting about an inch and a half of water in the bath and just sitting in it. The water didn't come up to my groin [wound] and I could wash my back and everything better and soap myself better. I told the district nurse and she said 'I won't tell if you don't!'"

.....

"I'm a bit mixed up inside . . . Towards night time I'm getting tense . . . I think I've been subconsciously a little scared of even trying to go to sleep [pain due to insufficient blood supply to leg]. . I've had to swap sides in the bed so I can hang my leg over the side."

.....

"I have taken my wedding ring off. I thought I would be prepared - like the girl guides - just in case it swelled up. I would be sorry if I hadn't taken it off, but it hasn't swelled up."

In resuming autonomy the patients were also making decisions on the extent to which they would comply with the recommendations of hospital personnel. Away from the hospital patients makes judgements on how long they will continue to comply and the degree to which they will modify the self-care instructions they have been given.

"They gave me Halcion sleeping tablets. I took them for fourteen days. I'm keeping one or two up my sleeve. I thought I might get a reaction and I thought I didn't want to get in the habit of taking them."

.....

"I've still got to be careful. Fruit - you know when I eat fruit - fruit doesn't agree with me. Apples or pears are alright. Green peas is not very good either and even cabbage not very good. To tell you the truth, sometimes I eat too much. But if I eat a little at a time I feel better. That's the way I'm supposed to eat."

.....

"Torvan and Mogadon and Aspirin - I was taking those and I thought its one of those that is giving me a headache so I've cut them off the last few nights."

The patient's resumption-of autonomy is one part of going home. This signifies the formal return of decision making authority back to the patient after the shared pattern which characterises the hospital experience. Self-management means that choices have to be made in the absence of helping people. The work of both patient and nurse during the Nursed Passage can provide patients with opportunities to prepare for this critical time.

Going Home: The Work Of the Nurse

While there was no formal discharge nursing plan in use to guide nurses in their preparation of patients for going home, in their documentation and during the interviews nurses did reveal an awareness of progression in the patient's status. Dynamic change and incremental movement towards self-care were characteristic of the passage. Consequently, nursing time and episodes of contact with the patient tended to reduce as the patient neared the time for going home.

With the final decision about the actual time of the

patient's discharge usually being in the control of the medical staff and delayed until the actual day of discharge, there was a continuing element of uncertainty among nurses about the time available in which to prepare the patient for this transition experience of going home. Despite this, the nurse had available many cues - from the status of the patient, from the behaviour of the medical staff, from her previous experience - which gave an indication of when the patient was likely to go home.

"I gather he's going on Tuesday.
Everything's planned for Tuesday."

.....

"I wouldn't be surprised if he goes
tomorrow. They don't usually keep them
long."

.....

"He's going home tomorrow."

.....

"He's probably going home at the weekend."

The negotiating work of the nurse precedes and then co-exists with the onset of specific nursing work aimed at preparing for the patient's discharge from hospital. It seems almost inevitable that this work is undertaken in the presence of a degree of uncertainty about the actual time of discharge.

Two separate but interrelated concepts were developed from the data to identify the additional nursing activities which have the goal of assisting the patient's transition out of hospital and out of the Nursed Passage: i) Appraising; and ii) Supplementing. Illustrations for each concept will be drawn from the data.

A major part of the work of the nurse is assisting the patient to regain his capacity for self-care in the activities of daily living and selectively giving assistance. She achieves this by constantly appraising the patient's status and deciding what nursing work is required during each episode within his Nursed Passage. Appraising, as it occurs at the time the patient is preparing to go home, is as significant for the patient as when it happens during Settling In. Although there was no formalised discharge nursing assessment, the data revealed indications that nurses were making judgements about the patient's status in relation to his situation as the time for going home drew nearer. Firstly, after progressively maximising his self-care ability, the nurse seeks to specify the residual limitations. Secondly, she assesses the patient's understanding of the surgery, the after-care, and the future. Thirdly, she ascertains the nature of the home environment into which the patient will be going in order to match his self-care capacity with his home setting, both the physical environment and the available family support. Finally, she evaluates the community resources which can be called on to assist the patient with temporary or longer term support after his

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This term was developed after a dictionary search for a suitable description of the evaluative nursing work undertaken as the patient moves towards the point of going home. 'Appraising' is defined as 'assessing' the distinguishing characteristics of the patient and his situation which are judged to be significant at this time (Collins, 1979). See Footnote 13, p.162.

discharge.

Most patients in this study were managing their diet, hygiene, activity level, and elimination almost, if not completely, independently by the time they went home.

"He's been up and about - independent with everything. He hasn't required anything."

.....

"The only nursing care she required was her remaining clips removed. She was completely independent and she was looking forward to going home."

.....

"He's on a soft diet now and really likes that. He was worried that he was constipated . . . so we gave him some PAP. He's just having his antibiotics and that's all the nursing you have to do for him. He's up independently - going to the dayroom and talking with the men in his cubicle. Nothing really to do with the nurses."

One lady who had not been bathing independently prior to the day of discharge was hurriedly given a test that morning. She described the experience during an interview later that day.

"They made me get my own bath. I was a bit surprised that I wasn't going to be pampered and have my bath run for me. I had to run my own bath and get in and out of my nightdress and bath myself. But I did it! She was getting me ready to go home, that was it. She said 'If you really want me, press the buzzer.'"

Another patient had a large wound in the groin which would require considerably more time to heal and would affect her mobility, her sleeping position and her ability to bathe or shower. At the time of her discharge this issue

had not been appraised with a view to assisting her to develop alternative self-care strategies as required. During the home interview she described her experience.

"The staff nurse said 'You can have showers. You should have had one before you left hospital.' And I thought to myself 'I don't think it looks very good to be having a shower or a bath myself,' And that was the day I was leaving. . . . so I asked Sister and she said 'Oh yes, you can have one.' Sister came back and she said 'You haven't had one for two weeks. I wouldn't have one for a bit longer to make sure because you don't want to get an infection in there.' . . . The first couple of nights I couldn't sleep at all. I just lay there with my eyes closed. . . . I couldn't sleep and on and off now I don't sleep. . . . It was always painful to get into bed. . . . It seemed to take ages. Dreadful sort of agony pain to get myself flat. I tried sitting up but I'm not very good at propping myself up to go to sleep."

This study showed that each patient undergoing surgery, no matter how major it has been, will not be totally restored to health and independence in all aspects of his living at the time of discharge. Indeed, many problems may yet lie ahead of the patient as he leaves the hospital and the passage. Therefore, it is apparent from this study that the nurse can play a major part in easing the patient's transition from hospital to home by appraising his self-care status prior to his departure.

Nurses are also involved in assisting the patient to come to terms with the surgery, its consequences and the nature of the future. Spending time with the patient as the time for going home approaches gives the nurse an insight into his readiness and the additional work both may need to do

before his departure.

"I explained his drops to him. He understood all the treatment he has to have at home."

.....

"I took her for a shower and she's still a bit iffy about her suture line and what she can and can't do with it. But she does cope with it quite well. She's coming to terms with it really well at the moment."

.....

"He's got a little crack there so when his bowels move it will sting or hurt a bit. We'll have to impress on him that he'll have to keep it [anal wound] clean and have quite a few baths."

On the day before one patient's discharge a nurse evaluated the effectiveness of a visit from a member of a community self-help group and discovered that important questions remained unanswered.

"I think she was a wee bit anxious about it because the lady hadn't really explained where she could get things and what the story was. So, we've got a little stock out the back and we've fixed her up with that and she seems to have that off her mind now. . . she's tried it on and she's seen how it looks when she's got something on over the top. She said 'Oh, it looks even so that's good!' So I think she's already to go home tomorrow now."

The nurse working with this patient on the following day revealed that more nursing time, particularly time for appraisal, had been given to the patient during the morning in order to ensure she was indeed as ready as possible within herself for going home.

"She was really good today. There's such a big improvement. She said when she went that she's still afraid of cancer but she felt a lot better within herself that she was looking normal and that she was getting back to her own home. . . . I think the cancer bit is really frightening and also the self image part is really important. . . . She felt good which sort of makes you feel its worthwhile doing something for somebody, doesn't it. She told me today she feels a fraud because she feels so well. . . . The other lady in the room [same surgery] was very impressed with the fact that she looked so good when she left. So, we've had a good day, really."

Nurses were also aware when things had not gone well and their appraisal indicated their work was incomplete. The uneasiness of one nurse is apparent in this excerpt from an interview just after the patient had departed.

"I'm concerned about him going home and I'm not very happy about him at all. . . . He's lost all his 'oomph'. He's a different man from when he first came in. I said to him 'What are you going to do when you get home?' He said 'I'll be right as soon as I'm back in my own garden.' . . . I don't know. He's not himself. . . . His whole attitude was one of wanting to give up because his shoulders were sagged and his head was cupped in his hands and he sat on the edge of his bed in a total attitude of hopelessness. . . . So I went and talked it out. . . . I don't know what he's going home to. . . . I don't think his needs have been cared for and whatever is causing his depression, whatever fears he's got, he's not getting support for them."

While this nurse chose not to share this concern and thus attempt to alter the medical decision to send the patient home, two examples were referred to earlier in this chapter where the nursing appraisal had led to nursing

intervention. In both cases the patient's discharge was delayed in order to allow time for the completion of preparations for going home.

The nurse evaluates the assistance and support available from family and friends. While the patients in this study revealed diversity in their social resources at the time of discharge, almost all felt they were able to cope without any outside assistance. One patient lived at home with parents; two lived in flats; three lived alone; and fifteen lived in a marriage relationship. Six of those who lived with a spouse were themselves elderly and so were their partners. Also, three of the women had fragile husbands who had previously required assistance from their wives. One of the patients who lived alone went home to family members to recover but two went home alone.

Several patients without adequate family support had already recognised their need and had made short-term arrangements within their family. This information was readily available to contribute to the nursing appraisal.

"Sister said 'When can your sister-in-law come down?' And I said 'Well, all the time she's been booked to come tomorrow.'
. . . So everything's working out well. .
She'll cope with helping [husband].
That'll keep her busy enough."

.....

"I'm going to my sister's when I get out.
I'll stay just a few days until I feel
okay to manage on my own."

.....

"Mum's come down and she'll stay till
Sunday."

.....

"I have booked my flight home [to parents]
for Monday. . . . I'm going to leave him
[husband] to it."

The nurse is able to assist the patient by checking that he does have friends and family available to give the kind of assistance she judges he will need, at least initially, when he goes home. In this study there appeared to be little direct purposeful contact between the nurse and the patient's closest helping person as a part of a discharge planning appraisal process. Instead, all the _patients seemed willing to resume control of, and capable of, managing their own situation and conveying information relating to post-discharge care to their family. However, it seems unlikely that this would be the case with all patients going home from hospital.

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Supplementing

Supplementing work by the nurse covers any form of nursing action that adds something to a deficiency of some kind which the nurse identifies in her appraisal of a patient. In this context, the purpose of any supplement is to achieve a broadly defined wholeness in the patient and his situation. That is, it may be undertaken to give knowledge, support, and/or assistance that benefits the patient as he leaves the Nursed Passage. In addition,

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This term was developed after a dictionary search to ascertain the most appropriate word to describe the nursing work of organising supportive community services for the patient on his return home. 'Supplementing' is used to mean 'adding to; making up for a deficiency' (Collins, 1979).

this work may be either performed or arranged by the nurse, or both.

As discussed, few people in this study actively sought additional supportive services after going home from hospital. Most believed they required nothing; a small minority felt that they could not cope alone. However, in each individual situation the nurse, aware of the range of community assistance available, had the choice of bringing this information to the attention of the patient and guiding his decision-making so that appropriate use could be made of the services.

A significant amount of supplementing work was left until the day of discharge and its performance was dependent on the individual judgement of the charge nurse or the nurse responsible for the patient. The effective utilisation of family support and community services requires the nurse to know what is available and how it could be used to help the patient at home.

In one case the nursing staff judged that a patient would require additional assistance at home after major surgery. When it was ascertained that he had no one at home and he would be alone, he was offered several alternatives but his constant wish to go home was finally heeded.

"He doesn't want to go anywhere but home."

The nursing appraisal had led to the decision that this patient was incapable of total self-care and his discharge was delayed until a level of help acceptable to both the

patient and the staff was arranged.

"He [surgeon] suggested that, as I am alone and so forth, I won't get any help at home - which, of course, I haven't had for years and years. He suggested I go out to a convalescent home I said 'No, I am not very keen on that. I would prefer to be home.' I'll look after myself even if it kills me. . . . The Sister approached me . . . so, as a compromise with her, I will have meals on wheels."

He also accepted visits from the community health nurse with some reluctance. His preference would have been to have the telephone number of these nurses so that he could call for help if he believed it was required.

"I can't see the point of the district nurse coming. She would be pretty busy going the rounds of the various people she is obliged to see and perhaps who aren't as fit as I am, even though I am not too fit at the moment."

Eventually, six patients received visits from nurses in the community health nursing service; two received meals on wheels; two received linen service; one had home help; and two received visits from a voluntary organisation.

"He'll go out in the morning and Meals on Wheels will start at lunchtime."

.....

"Sister's arranged a bit of home help for her, which I think she was really relieved about."

.....

"We rang the Mastectomy Association and they're coming to see her."

.....

"The district nurse is going to dress the wound."

One ward seemed to make more use of community support services than the others. The reason for this was unclear but the attitude and behaviour of the experienced charge nurse seemed to contribute to this outcome. She tried to spend time with each patient on a regular basis and particularly on the day of discharge, and she also actively encouraged her staff to explore the patient's home situation. Whenever supplementary services were initiated, their use was selective and appropriately targetted to revealed need.

There were often occasions when the patient preparing to go home would have benefited from other supplementing work from the nurse in the form of confidence-inducing knowledge. Nurses often showed they were uncertain about the specific medical plan for the removal of each patient's sutures, clips, and haemovacs, particularly whether or not they would be removed before discharge. Also, if they remained in when the patient went home, who would remove them - staff in the outpatients department, the surgeon or the district nurse? Uncertainty is evident in the following examples from the words of a nurses and several patients.

Nurse - "It [wound] gets taken down when she comes back to outpatients, I think." [The wound was actually redressed before discharge and the sutures removed by the district nurse.]

.....

Patient - "They didn't say anything about the stitches. I mentioned them to the sister and she said she'd find out." [They were removed the following day before he went home.]

.....

Patient - "I don't know whether he said the stitches can come out and you can go home or whether he takes them out or what." [Removed by nurse in outpatient department.]

However, uncertainty was not universally present as is well illustrated by the consistent references to one patient's sutures over a three day period. In this case doctor, nurse and patient all knew what was happening.

Day 1 - "_ [surgeon] and Dr _ came to see her and had a look at her suture line and told her the sutures could come out on Wednesday."

Day 2 - "She's having her stitches out tomorrow."

Day 3 - "I took her sutures out. Good union."

Nurses conduct the day-to-day management of wounds. Therefore, any uncertainty about wound care, would seem to be a barrier to the effective nursing preparation of a patient who is getting ready to go home. At least, the nurse should be aware of the parameters for decision-making and able to discuss these with the patient. Although, in this study, the problem was resolved by the point of departure, it often remained an unknown for nurse and patient until then. Then, the nurse made the arrangements, having ascertained any special preferences the surgeon may have for after-care. Private patients tended to go back to the surgeon in his rooms, while some received an appointment for the outpatient clinic and had sutures removed there. Nurses from the community health nursing service were also enlisted to continue wound management and they gave other supplementary nursing care as required.

"The district nurses are marvellous really. It was one long stitch and she said 'I'm afraid I'm going to hurt you a little bit.' So I just thought 'Okay,' and I didn't feel a thing! . . . They popped in once or twice just to see how I was."

As discharge approached, patients often failed to hear, or understand, communications from the medical staff concerning their discharge. At such times these patients needed additional assistance from the nursing staff - explanation, confirmation, listening to concerns.

"I heard the doctors say to _ 'Make an appointment for so and so and so and so,' and I didn't gather who or when but she's had her orders so I suppose I'll be told tomorrow."

.....

"This morning he had a little fumble around and he said - I don't know whether he said the stitches can come out and you can go home or whether I see him on Wednesday in Outpatients or what."

.....

"But he didn't say much. He just said 'Well, you're doing well. How are you?' And I said 'Well, I'm feeling alright, thanks.' 'Oh well, you can go home tomorrow,' he said."

Valuable support could also be given to patients by providing them with specific guidance on the appropriate helping resource to contact in the event of a problem arising after discharge.

"And if he has any problems he just rings up."

.....

". . . the district nurses will keep an eye on it [wound] and contact him [surgeon] if there are any problems."

The final entry in the nursing notes tended to summarise both the nursing and medical followup information given to the patient by the nurse. Nurses were performing a range of activities which maximised the patient's readiness for going home. Two examples from these entries serve to illustrate this part of nursing's work.

"Discharged home to wife. Followup at 2 weeks. Private appointment with Mr _ on _ . Referral to district nurse. Nursing instruction given. Cont on increased fluids during day. Cut back after 3pm. Explanation of district nurse's visit. To notify hospital of any change of condition - bleeding. Prescription given for soluble aspirin."

.....

"Seen by surgeon. Discharged home this PM in care of wife at 1830hours. Private patient - to make own followup appointment in 2 weeks time. For discharge on Gutt Chloroptic 1% BD and Gutt Maxitrol 1 drop QID. Eye care instruction sheet given to patient. No script or health services required on discharge."

It is evident from this study that the nurse is in an important position to initiate a range of supplementary assistance for patients before and after discharge when nursing judgement suggests they are needed. The purpose of such actions is to ease the person out of the Nursed Passage as safely and comfortably as possible, secure in the knowledge that his needs have been identified and targetted help has been given. This supplemental work is undertaken in negotiation with the patient and/or his family and is consistent with nursing's scope of practice as portrayed in this theoretical framework.

Summary

This conceptualisation of the work of the patient and the nurse in preparation for the patient's departure from hospital and the Nursed Passage, was generated from the field data gathered from nurses and patients during Stage 2 of the study and from interviews with the patients after they went home.

The work of both patient and nurse during the patient's negotiation of the Nursed Passage, presented in Chapters 7 and 8, is expanded by the two patterns of Going Home work described in this chapter. All are essential to optimise the patient's transition from hospital to home.

Chapter 10 adds a new dimension to the theory of the Nursed Passage by presenting three contextual determinants which impact significantly on the shape of the Nursed Passage.

CHAPTER 10

CONTEXTUAL DETERMINANTS WITHIN THE NURSED PASSAGE

In this chapter the presentation of the Nursed Passage concludes with a discussion of three complex factors within the nursing environment which were discovered to have a significant impact on the shape of the passage.

Introduction

Nurse and patient meet in the complexity of the hospital setting which is influenced by a multitude of factors. These include such diverse elements as the architectural design of the ward, the financial, physical and staffing resources available, current medical practices, the social and cultural support for surgical intervention, and the provision of support services within and without the health care system to assist the person through such an experience. Against this background the nursing service is organised. Staffing patterns, conditions of service for nurses, practice philosophies are all influenced by the social and cultural environment for nursing. In turn, these factors influence the Nursed Passage.

As the grounded theory of the Nursed Passage evolved, it became apparent that there were three specific determinants within the nursing setting which were consistently affecting both patient and nurse throughout the passage. Thus, they were having an impact on the shape of that passage. Indeed, it became evident that they are an essential element within this theoretical framework if it is to be a close reflection of the reality perceived in the data.

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Contextual Determinants within the Nursed Passage

A hospital ward comprises a group of people collected together because of their need for nursing, caused by a health problem which usually requires specialised medical intervention. Nursing care is organised twenty-four hours a day, seven days a week by a group of nurses who have specified conditions of service. In addition, the social sanction given to nursing means that patients enter hospital with some expectation of what being nursed will mean. There is a valuing of the service and a tendency to think well of its practitioners. Each of these factors has an influential impact on the relationship between nurse and patient.

50

This term was developed after an extensive dictionary search and reflection on the most appropriate wording to describe the group of emergent factors within the nursing environment which were exerting a significant influence on the shape of the passage. 'Contextual' is used to refer to 'circumstances that are relevant to an event'; 'determinants' are 'factors that affect' the context in which the Nursed Passage occurs (Collins, 1979).

As data analysis progressed the large number of codes representing factors that seemed to be influencing the passage was reduced to three: i) Episodic Continuity; ii) Anonymous Intimacy; and iii) Mutual Benevolence. These will be discussed with supportive excerpts from the research data.

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Episodic Continuity

Entry into the Nursed Passage means that the patient is in a situation where nursing is constantly available to him - twenty-four hours a day, seven days a week while he remains in hospital. However, that does not mean that he is constantly in the presence of nurses. Analysis of the data has revealed that the contact between nurse and patient throughout the passage is episodic. In effect, nursing is seen to be a series of comings and goings as nurses purposefully enter into the presence of the patient and leave many times in the course of a nursing duty. Paradoxically, the cumulative effect of the episodes of nursing, spread as they are over the twenty-four hours of the day, is that patients perceive the nursing as being continuous.

"There's a whole lot of people been coming
in and asking me if I was alright. . . ."

.....

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This term was developed following a dictionary search. 'Episodic' is used to mean comprising a series of 'incidents; events'; 'continuity' means 'occurring without interruption or as a whole' (Collins, 1979). The concept is paradoxical and reflects the shared perception of wholeness in spite of the reality of intermittency of contact between nurse and patient.

" girls in and out all the time."

.....

"The nursing care is good. Its still fragmented but - its someone different popping in all the time and doing different things. But they seem to have everything under control and they're very nice. You know, got a good manner with the patients. They're trained to be good."

As the fieldwork progressed, the short duration and intermittent nature of nursing contact became evident to the researcher. In order to further examine this phenomenon, a period of constant observation of two patients was undertaken. Neither patients nor nurses were aware of the observation at the time. Coincidentally, both patients were on their second day after similar major surgery and each was being nursed by a different nurse. They were in two open cubicles within the same room and could be observed, except when the screens were drawn around the bed, from a vacant cubicle in the room. At the time they were the only patients in the four-bedded room.

During the period of observation one patient received eleven, and the other twelve, nursing visits, mostly from the nurse assigned to their care. The total nursing time was 53 minutes for one and 63 minutes for the other. Field notes revealed an almost identical pattern of nursing contact by the two nurses concerned. Table 30 contains the field notes made on one patient. This clearly demonstrates the episodic, task-focused nature of the association between nurse and patient.

In discussion with the patient's nurse at the conclusion

TABLE 30: OBSERVED NURSING CONTACT WITH ONE PATIENT

8.10 - 8.50: Bed bath, change of night attire, mouth care, checking IV, care of nasogastric tube, out of bed for first time, walk around bed, patient sitting in chair, bed made, patient taken for short walk then assisted back to bed, positioned and nurse leaves.

9.54 - 10.01: Nurse enters, aspirates nasogastric tube and records amount, takes temperature, pulse and respiration, places call bell within reach, checks intravenous infusion, checks with patient that he is alright.

10.14 - 10.15: Student nurse enters and stands at end of bed, they greet each other with a smile, she asks how he is feeling, responds to his reply and moves to other patient.

10.53 - 10.57: Nurse enters, smiles at patient, checks IV, speaks quietly to patient, assists him to move up the bed and leaves.

11.06 - 11.08: Charge Nurse enters room, stands between patients beds and greets them one by one, smiling at each and leaves.

11.28: Nurse enters, checks IV, smiles at patient and leaves.

11.59: Nurse enters, checks IV, fills glass with water and leaves it by patient, records it on fluid balance chart, asks patient if he is alright, he says yes and she leaves for lunch break.

12.59 - 1.00: Nurse enters, checks IV, patient has eyes closed, nurse leaves.

1.12: Nurse enters with daughter who has gone to get her, tells patient she will get him an injection, he nods and she leaves.

1.17 - 1.19: Nurse returns, pulls screens, administers injection, repositions patient, records temperature, pulse and respiration, fills his glass with water, pulls back screens and leaves.

2.15 - 2.19: Nurse enters, checks with patient that he is alright, checks intravenous infusion, aspirates nasogastric tube, checks fluid balance chart, refills glass with water and leaves.

of her duty she expressed surprise that the cumulative total of nursing time was only 63 minutes. She felt she had spent considerably more time with the patient. Analysis of her comments in the interview indicated that, despite the episodic nature, and short duration, of nursing time given to the patient, the nurse perceived her contact as being continuous. This experienced nurse was only working two days a week in the ward and this was the first day she had been assigned to this patient.

"Right - first of all he seemed bright. Very eager to please, I felt. I gave him a full sponge. Um - sat him out in a chair - um - probably getting on for an hour all told. And then I took him for a walk from cubicle 4 to cubicle 2 and back again. But then, once he got back into bed he seemed to get a bit more progressively miserable - and his daughters have since confirmed it. And I think its just because he had a sleepless night and he's feeling a little bit grotty. He needs some positive reinforcement that he's getting better. And - apart from the bed bath, he's on four hourly recordings - TPR and BP - and they're not bad except at 2 the temperature's 37.9. But he had complained earlier of being cold and I had bundled him up in a cuddly - so whether that helped to bring it up. He's on four hourly nasogastric asps and I got a lot - 130 and 250mls. But he's on free fluids which he's not tolerating. He's tolerating them but he's not drinking a lot - 30 to 100mls an hour. And he's on free drainage of his nasogastric tube but that's drained nothing freely. I've had to aspirate it. His wound's dry. I've encouraged him with his deep breathing exercises and coughing because of his chest. And that's about him, I think. I can't think of anything else. He had Omnopon 20mg and Maxalon 10 at 1320 hours and he had his last dose prior to that at 0630. He had been sleeping so I didn't see any reason to give it to him sooner but he was ready for it when I gave it."

During this period of observation, the episodic contact was almost exclusively with the same nurse, that is, the nurse actually assigned to nurse each man. The presence of two empty beds in the cubicle meant that fewer nursing visits were made to the room in the course of the duty but this can not be assumed to have significantly affected the total nursing time for each patient. Neither nurse gave any time to the other patient while she was in the room.

If this pattern of nursing time and episodes, even including the longer period usually required for morning hygiene care, was repeated over the three nursing shifts in a twenty-four hour period, each patient would have had contact with a minimum of three separate nurses for up to 30 visits amounting to no more than three hours of actual nursing time. The cumulative total of nursing contact observed in this instance occurred at a time when both patients required regular nursing attention to the intravenous infusion, nasogastric drainage, pain relief, hygiene and mobility, oral fluids, and recordings of blood pressure, temperature, pulse and respiration.

Nursing episodes consistently became less frequent and of shorter duration as the patients progressively assumed more self-care. This is apparent in the following comments by nurses.

"Um - what have I done for her today? She's been fairly independent all day again. She's had a sponge - just needed her backwash done. . . .Up and about. She's fine. She's had no pain relief or anything really."

.....

"He's just having his antibiotics and that's all the nursing you have to do for him."

.....

"He's been independent of all cares. He looked after himself. He showered himself and got up and cleaned his teeth and - yes - he's independent. . . . He hasn't needed any nursing at all. He's just had his diarrhoea and coughing but he's coped with that."

.....

"Well, she's independent with everything. We only made her bed . . ."

Episodic nurse-patient contact is understandable when the work demands on the nurse are considered. Regardless of the organisational pattern operating in the nursing team, each nurse seems to be constantly on the move - circulating between her patients, the service areas of the ward, and the nursing office. During the duty she anticipates being continually available to her patients at all time by means of the patient's call system as well as her periodic visits. Thus, paradoxically, she has a perception of continuity in her nursing of each person.

The following three examples illustrate the way in which nurses consistently wove together their episodic contacts with the patient - incorporating both planned and spontaneous incidents - into a story that reflected their perception of a continuing nursing presence during the duty.

"He got up for a while before tea and he sat in his chair. And I went in after tea, about quarter past six I think. He'd just got up on his bed and he seemed to be a little bit distressed and upset. He just sort of shed a few tears. I think

things were just sort of getting on top of him a bit so I just sort of talked to him for a while. He was a bit sore and uncomfortable and fed up. I helped him put some xylocaine jelly around his catheter site and he cheered up. He was okay after that. I think he's just wound up. I just feel that he's very pleasant and cheerful but sometimes I think it might just be a bit of a brave front. But Dr _ came in this evening and told him he could have his catheter out tomorrow so he's quite rapt about that."

.....

"He slept soundly. Never saw him awake all night. Well, he had Valium 10mg orally to settle. So he did very well. Got him up reluctantly for a shower this morning but he's fine. He's first on the list so he's already to go. He's just had his premed and he's ready to go down at 8 o'clock."

.....

"Mr _ started the day off very badly. When I arrived he was sitting on a pan with diarrhoea and he had been there for some time I suspect. And his drip was leaking back and his pyjamas were soaking, his bed was soaking - so, absolute misery! So I took the drip out and gave him a choice of a shower or a bath and he decided on the shower and half way through the shower he decided that it might have been a mistake. It was a bit late by then so we completed the shower. Back to bed and he had his dressing done. He had pain relief and he had quite a long snooze after that. He was a bit agitated for some of the time but not too badly. But he's on Valium 5mg TDS and that's really helping now. He's still nil by mouth. He's got an IV with 8 hourly vitamins. Generally his output was low this morning because of his reduced input. I don't think there's anything to worry about. . . it wasn't until 2 o'clock when he'd had a sleep that he said 'Thank you for how you cleaned up the mess this morning', and then he said 'Like a veteran!'"

This first contextual determinant on the Nursed Passage has been conceptualised as a paradox because of the way in which the contact between nurse and patient is actually a

series of purposeful episodes, usually of short duration, while both have the impression of a continuous nursing presence. Against this background, the nurse and patient work their way through the passage.

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Anonymous Intimacy

Another paradox becomes evident when attention moves to the nature of the relationship between nurse and patient. From a very early stage in the fieldwork the researcher became aware of the difficulty patients were having in distinguishing between nurses and attaching a name to a particular nurse. The concept of 'anonymity' began to appear regularly in the coding. Even when recounting particular incidents, the patient rarely identified the nurse by name.

During the nurse interviews, when the nurse was guided to speak about a named patient, only four nurses began to describe another patient until the researcher intervened and corrected the nurse. So, nurses were able to name the patient consistently at the end of the duty. However, it was apparent in later discussions that the majority of patient names were not retained by nurses for long after the nurse-patient contact had concluded. Questions such

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This term was developed after a dictionary search to discover the most suitable words to explain the paradox revealed in the data. The word 'anonymous' was initially used in margin notes and was retained for the concept. 'Anonymous' is used in its sense of 'lacking individual characteristics'; 'intimacy' indicates 'closeness incorporating warmth and understanding' (Collins, 1979).

as 'Now which one was he?' or 'Was he the - [operation]?' indicated that personalising details were not retained after the patient left hospital and his place was taken by another, and another. Despite this mutual anonymity, the activities within the nurse-patient relationship are of an intimate and personal nature.

In a surgical ward there is a constant turnover as patients come and go. Nurses are confronted with changes among the patient group almost every day they are at work. In addition to the constant changes in the patient group, the nursing group itself is also constantly changing. The nursing team functions on a rotation of three eight-hour shifts with two days off each week for full-time staff. Part-time staff, who may work reduced hours and/or as few as two days each week are usually included in the nursing team.

Whatever the system of nursing care, the maximum number of eight hour periods in which a patient can associate with one full-time nurse is five out of twenty-one each week. Even if a nurse is assigned to the same patient every day she is on duty, her total nursing time with him may be no more than one hour per duty at the most and this may occur only on the morning duty, and only when he is requiring the 'most' nursing.

Table 31 represents a quantitative summation of the number of changes in nursing personnel experienced by each patient in the study. This clearly illustrates the difficulty of a system based on the division of nursing

personnel into 8-hour shifts and a 40-hour week to provide continuity of patient contact with one nurse.

TABLE 31: FREQUENCY OF NURSING PERSONNEL CHANGES
PER PATIENT DURING HOSPITAL STAY

<u>Patient</u>	<u>Total Duties</u>	<u>Total Nurses</u>	<u>Duties per Nurse</u> Range	Average	<u>Maximum per nse</u>
1	64	21	1 - 9*	3.0	14%
2	49	23	1 - 5	2.1	10%
3	46	21	1 - 8*	2.2	17%
4	36	21	1 - 6	1.7	17%
5	34	16	1 - 5*	2.1	15%
6	33	9	1 - 6	3.7	18%
7	28	16	1 - 5*	1.8	18%
8	28	8	1 - 7*	3.5	25%
9	25	18	1 - 3*	1.4	12%
10	24	10	1 - 6	2.4	25%
11	22	14	1 - 3*	1.6	14%
12	20	10	1 - 5*	2.0	24%
13	19	10	1 - 4*	1.9	21%
14	19	8	1 - 5*	2.4	26%
15	18	8	1 - 5*	2.3	28%
16	16	8	1 - 5	2.0	31%
17	13	7	1 - 3*	1.4	23%
18	10	5	1 - 3*	2.0	30%
19	10	6	1 - 3	1.7	30%
20	10	5	1 - 3*	2.0	30%
21	10	8	1 - 2	1.3	20%

KEY:

Column 1: Patients in order of time in hospital expressed as number of 8-hour nursing duties

Column 2: Actual no. of 8-hour nursing duties during stay

Column 3: No. of different nurses assigned to patient

Column 4: Range of no. of assigned duties per nurse

*: The maximum includes more than half night duties when only one or two nurses are responsible for the whole ward

Column 5: Average no. of duties per nurse

Column 6: Maximum contact with one nurse during stay

The assigned nurse may not be the only one regularly in contact with the patient in each duty. For example, in three of the wards, students were assigned patients under the supervision of a registered nurse. When a nurse tutor

was also present, the patient had regular contact with three nurses during that particular duty. In all wards, some degree of centralisation of specific tasks was in operation so that patients tended to have services such as drug administration undertaken by nurses other than the one assigned to each one. Finally, there were incidental episodes between the patient and other nurses in the course of a duty. Therefore, it was possible for a patient to receive nursing from a number of nurses during an eight-hour duty.

[Which nurse is looking after you?] "A variety of them."

.....

"There still seems to be a lot of people coming and going - a lot of different people. . . . An uncounted number of nurses!"

Analysis of patient interviews revealed that the recall of an individual nurse by name was exceptional. Not one patient consistently named all nurses who were involved in his care. Even the fact that the interviews took place at the end of a nursing duty did not mean that the patient could name who cared for him during the duty. According to Column 2 on Table 31, the twenty-one patients in this study had an opportunity to name a cumulative total of two hundred and fifty two nurses assigned for at least one duty. Of these, only sixteen nurses were ever specifically named by patients while discussing their care with the researcher.

Five nurses were consistently referred to by name by a

total of six patients. Each of the three male nurses in the study, distributed among three wards, was always referred to by first name. Four patients received nursing from one of these male nurses. As the female colleagues of these male nurses were not named by the same patients, the assumption can be made that there are few male nurses and, therefore, they 'stand out' from their female colleagues. This leads to retention of their names. A particular female third year student was also regularly named by two patients. In consultation with the charge nurse, she chose one of the subjects for her own case study, so was assigned to nurse her, and a second research subject in the next bed, for five consecutive duties - an unusual event. One staff nurse who worked with the third year student in caring for these same two patients, and continued to nurse them after the student changed to night duty, was also named by both women. While quality of performance was not associated particularly with the male nurses, it was definitely linked with the student and, to a lesser extent, the staff nurse.

The retrospective comments on this student nurse by these two patients made her stand out as no other nurse did.

"That little one _, she was only a little thing but she seemed as though - like, when she was taking tubes out and things, she seemed gentle but firm. She knew exactly what and you had confidence in her. You knew she was going to do her best not to hurt you, whereas some of them just take things out and don't sort of help you."

.....

"It was that _ _ , she's a gem of a nurse.
We all liked _ . . . "

Ten other nurses and one charge nurse were named on either one or two occasions during a patient interview but the use of their names was not consistent. Seven were referred to only by their first names. In the remaining three, which included the charge nurse, only the surname was used.

Instead of being referred to by name, specific nurses were occasionally identified by the use of such distinguishing terms as: 'the Dutch one', 'the dark one', 'the one in blue', 'not this one, the other one', 'the one that calls you Lovey', and 'the girl with ginger hair'. It was common for nurses to be referred to using the more impersonal forms - 'Nurse' or 'the nurse' or 'she'.

"Nurse helped me. It was very nice. Some young nurse helped me shower."

.....

"I am making water all the time. She has taken one pan away. I thought perhaps I had a catheter in me and I asked Nurse. She said no, it was draining."

.....

"Nurse has just shaved me ready for the morning."

.....

"Nurse helped me out and I sat in the chair while she changed the bed."

.....

"The nurse came in and told us what the operation entailed."

However, the most common term used when discussing nursing care was the impersonal plural - 'they' - even when

referring to the actions of a single nurse.

"Then they came and got me into my theatre things."

.....

"They gave me a pain injection so that made me feel a bit dozey."

.....

"After they put the dressing on it was very uncomfortable so once they [wife and children] left I asked one of the nurses if they could get to take it [eye pad] off. . I asked if they would and they did."

.....

"They took that [IV] out . . . and they pumped the bladder out."

It seemed that patients were identifying with nursing and nurses rather than individual nurses, in most instances.

"The company's very nice and these frequent changes of female company are a great life. They come and they go and I don't really recognise them next time round because I haven't really seen them very well first time round."

.....

"Later on, when I went for a walk down the corridor I saw Dr . I said hello to him and told him and the nurse that I had taken these things out but the trouble was, I was talking to the wrong nurse. She didn't know what I was talking about. When I look at a person I don't look at the card or whatever they have got on. They are either white uniforms or green or whatever and it doesn't worry me who is there as long as the person who is meant to be looking after us is there."

.....

"I couldn't tell you their names. . . . they were all very good. . . No, I couldn't say any special ones at all. They were all exactly the same to me."

Despite the overwhelming prevalence of a lack of

individualisation of nurses by patients, and the brevity of the relationship with each nurse, the content of the contact between them was immediately intimate for the patient - such as being washed, having an enema, using a bedpan, verbalising concerns, and many more. In each nursing episode the patient sheds his privacy and exposes himself to the ministrations of a stranger. The submission, unacceptable in other situations, is possible because such activities are considered to be within the domain of nursing practice. However, it was obvious throughout the fieldwork that the work of the nurse is constantly under scrutiny and the patient's initial openness to all nurses could be reviewed in the light of events as they unfold.

"One day one old lady that was in there, she wanted one of the nurses and I said 'Don't get out of bed. Ring your bell.' When the nurse came she said 'The lady over there told me to ring my bell.' She turned round and gave me such a look. I thought 'Next time I mind my own business.'"

.....

"I couldn't stand it any longer and I called the night nurse. She is a bit of an old grump. She does speak but she hardly looks at you. You don't know whether you should call her or not."

.....

"Well, there were some people you would ask if you needed something and there were other people who you wouldn't. . . . You didn't really want to be a bother to anybody and some people made it feel, seem, that it was a bit of a bother."

Although there was a lack of individualisation of nurses, patients were able to distinguish between groups of

nurses. On several occasions, one charge nurse was referred to by name, but the uniform colour or positional category was most consistently used - 'Sister', 'the one in blue', 'the one in charge'. At the time of the fieldwork there were students from the hospital who were commonly identified as 'the one in white' or 'the _ year nurse'. Students from the local technical institute were usually labelled as 'the polytechs'.

Patients were able to distinguish between students and registered nurses and seemed willing to be nursed by students. One patient, on his first post-operative day after surgery for repair of an inguinal hernia had managed to go down to the bathroom to wash and groom himself for the day. Some time later he found that he was to be cared for by a first year 'polytech'. He refrained from informing the student that he had already cared for himself and submitted to a full bed bath and assistance to get out of bed!

"Well, they have to learn. They don't do you any harm."

Later he allowed each of the group of students to take his blood pressure.

"Well, this morning they were all having a go. They were trying so hard and absolutely hopeless, some of them. . . and you see the keenness in them, you know. Have a look at them in five years' time!"

Another patient who had been in the hospital on a number of occasions and who had the opportunity during her

present hospitalisation to observe the recovery of a number of patients as well as herself, shared her perception of the difference between students and qualified staff. She spoke of her observation that beginning nursing students have not developed skill in inducing confidence in patients. In the following excerpt from an interview she recounts her own and another patient's responses to receiving nursing from a first year student who was unsupervised during the performance of a procedure at a critical time for the patient after surgery.

"Some of them are the first year ones. I don't think you are quite as confident, especially if they are going to get you out of bed when it is your first time out of bed. You feel as if they might hurt you. They don't really know how to hold you as well as one that's in her third year or a staff nurse. They know exactly how to hold you, whereas they are not sure of themselves or of you either. I was trying to do things to help myself. I was saying 'No, I'll do this and that.' Like the other lady - she was a nervous wreck at even the thought of anything. But she was terribly upset when the first year one took her down for her first bath after her operation. She was in such a state when she came back. She said she was so afraid she got down on her knees but she wouldn't get down in the bath. I think it was just because it was a first year nurse."

In addition to their confidence-inducing competence in the performance of skills, the staff nurse group was attributed with the possession of 'more' nursing knowledge.

"I think they have a bit more know-all, don't they?"

At least in the surgical setting, there seem to be few opportunities for person-to-person closeness of the kind associated with a friendship or an on-going helping relationship. The 24-hour nature of nursing and the staffing patterns which have been devised to maintain that service mean that continuity exists between the patient and 'nursing', rather than a single nurse. However, even when confronted by a series of nurses who, as people, are strangers, the patient is willing to 'reveal' much of himself as he receives a variety of intimate services which nursing has the social sanction to provide.

This second paradox, in conjunction with the first, means that the nurse's episodes of contact - for seconds or minutes - with people who are essentially strangers provide the context within which the nurse performs the work of nursing.

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Mutual Benevolence

A third and final concept emerged from the data to form a trilogy of contextual determinants, each impacting on the other. It became apparent that the relationship between nurses and the patients progressing through Nursed Passages is one of mutual good will. Throughout the field experience both nurses and patients appeared to be

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This term was developed after a dictionary search for a suitable wording to reflect the good will discovered in the data. 'Mutual' conveys the meaning of 'common to or shared by both'; 'benevolence' means actions and feelings of 'good will, kindness or friendliness' (Collins, 1979).

genuinely concerned for the welfare of the other. For the nurse, this concern can be considered as an integral part of her professional role. Thus, her benevolence is manifested as a generalised inclination to help associated with an ability to translate that disposition into a specialised form of beneficial action.

During interviews the nurses made frequent optimistic statements about patients. Such comments tended to suggest that 'all is well', or soon will be.

"He's really good. . . .I've been really impressed with him today."

.....

"I think once he's rid of his IV and his nasogastric he'll just be up and away really. But he's been doing really good today."

.....

"He's doing very well. He's really good. I mean, he had a hernia repair as well, and a laparotomy, so he's done really well, really."

.....

"He's good. He's fine, yeah. His eye could still improve a bit but I think he's quite happy with what's happening to him at the moment."

.....

"Well, for a start when we came on he was a bit tearful and full of pain - a bit wet around the eyes and not very happy about his regression. . . .and progressively over the PM duty he's cheered up and he's back to his normal, happy self."

It seemed that nurses were also trying hard to coordinate their personal and professional perspectives and to avoid expressing negative feelings about their patients. The few personal comments recorded during interviews with

nurses tend to be gently positive.

"He's a nice old gent."

.....

"Poor man, I feel sorry for him."

.....

". . . . he's a very pleasant guy,
actually. Be quite nice to nurse."

.....

"Oh he's lovely - he's a lovely man - very
pleasant."

.....

"He's really nice. All the dialysis
patients are really nice - usually. When
you're working in Ward _, they're all so
nice."

.....

"I found her a very nice girl."

.....

"He's fine. He's gorgeous."

When nurses did express personal reservations about, or
even dislike of a patient, the reaction was limited and
linked to an attempt to understand the patient's
situation.

"Oh - Mr _ - the most aggressive, rude
little man - and demanding - that I have
ever come across. I have not very often
come across somebody so rude. But
underneath it he's quite a scaredy-baby. .
he's a very angry gentleman, that one. .
And I thought he was just getting rid of
some of the bitterness in him at me. . . .
So we had a nice little chat after that
remark was made and we talked a bit. . .
He feels more relaxed now - getting away
from those ugly thoughts."

.....

". . . but, however, I don't like the man
for all that. He's far from easy. But,
really, he's quite good as far as we're
concerned."

.....

"I find him a very strange gentleman. I think his deafness has a lot to do with the answers you get from him which are sometimes inappropriate . . . Very amiable kind of man."

In the field data, activities which are considered 'unpleasant', such as cleaning up body discharges, were undertaken by nurses without any verbal expressions of personal distaste and negative reactions were concealed from the patient. In the following example the nurses had had to 'clean up' the bathroom floor after a patient had had a large loose bowel motion on it.

"At about 1400 hours, though, she had diarrhoea - didn't make the bathroom in time. It was positive to occult blood. And she's a bit miserable following that."

The benevolence demonstrated by patients is genuine and consistent. It is commonly expressed in conjunction with discussion of the personal ministrations of the nurse, especially at times when the patient is unable to undertake self-care. A real warmth was evident in the voices of patients as they shared their appreciation of the nursing staff - collectively or individually - in their own fashion.

"But the attention I've been getting is very good. Quite meticulous! Nice girls."

.....

"The girls are marvellous - they are. They're one hundred per cent. I told them. I did."

.....

"I make it as pleasant as I can for them and they make it as pleasant as they can for me."

"Oh I've had tremendous support from family and friends and I really think the staff here have been marvellous."

Occasionally, when patients spoke of a negative experience which involved a nurse or nurses, there was a tendency to emphasise that the incident did not detract from their positive feelings about the nurses as a group.

"Every time it [pain] went straight away as soon as they flushed it [catheter]. . Well, I asked them to do it before - to give me a flush - to flush out my kidneys again, you see. They said 'Oh no, it'll be alright.' But that's - I'm not saying much because they're all marvellous - the girls are. Honest, they're all wonderful."

.....

"These young people asking you to relax. Its just absolutely impossible. You are trying your best. Its like trying to drag a bull by its tail. You can't do a darned thing until the pain has lessened. I was a little brassed off about that but, even so, they are good girls doing a wonderful job, I must admit."

Indeed, the good will a patient feels towards the nursing staff, together with appreciation for the assistance given when needed, may hold the person back from expressing negative reactions directly to the nurse concerned.

"And, of course, getting uptight with the nurse. I didn't say anything to her. I would never do that. But um, it was probably the way I felt, you know. She hurt me a little bit when she put something in here [intravenous infusion] and little tiddly things. It was probably me being upset. But I didn't say anything to her. I just went along with it."

.....

"Not bad really, except when I got an orange cordial - this was pathetic - drink instead of a lemon drink and it upset me

because the nurse wouldn't take my order. Its wierd. Just little things. One out of a thousand times when I wanted something and got what I wanted. The service has been fantastic. . . That was the only thing - only thing!"

Some patients considered the possibility of a small gift as an expression of appreciation to the nursing staff. One elderly gentleman made little mats and distributed these to some of the nursing staff and one house surgeon, as well as the researcher. Chocolates and orchids were other gifts given to the nursing staff. One elderly lady spoke of wanting to express her appreciation with a gift but was unable to translate the thought into action.

"I wouldn't mind shouting the girls but don't know how to go about it, so I'll leave it. They are too busy. . . . If I can manage to do anything for the girls before I go I would."

Mutual Benevolence emerged from the data as a concept to signify the presence within the Nursed Passage of reciprocal good will between nurse and patient. Her motivation to nurse, and her internalisation of the humanitarian philosophy inherent in nursing, provide the nurse with the inclination to want to help and the ability to take action. The predisposition on the part of patients to think well of the nursing staff seemed to be related to the nature of work that nurses undertake. Appreciation was evident in patient interviews, especially when the patient required the kind of activities which others in the community would find it difficult to perform, such as asistance with body cleanilness and care

of body discharges. Thus, this tendency to mutual benevolence, closely related to the nature of nursing's work, has a facilitating impact on the work of nurse and patient as they relate together in the episodes which characterise the Nursed Passage.

Summary

Three factors within the nursing setting which have an influence on the nurse-patient encounter were derived from the case studies of twenty-one patients as they were nursed through the experience of planned surgery. Two of these factors are paradoxes arising from the setting for the Nursed Passage and the third is a mutually shared tendency for nurse and patient to think well of each other. The presence of all three within the theoretical framework increases its link to the complex reality of the practice setting.

This chapter ends the theoretical discussion on the Nursed Passage. Chapter 11 will discuss the theory in relation to its relevance for nursing.

CHAPTER 11

DISCUSSION

This final chapter begins with a summative discussion of the findings which emerged from the study, and then moves on to examine some of the nursing implications of the theory of the Nursed Passage. It concludes with some suggestions for further development of the theoretical framework.

Introduction

In the previous six chapters the Nursed Passage has been systematically developed. All constituent elements have been introduced and discussed in conjunction with the field data from which they emerged. This framework was generated through the application of the creative induction processes associated with the grounded theory method. Using the terminology of this method, it is a grounded theory in discussion form which awaits further development to the propositional form. At present it is best described as a theoretical framework and, as such, a theory in the process of development.

The setting for the study, five surgical wards in a large

general hospital, is a complex and challenging field for the nurse researcher. For the nursing staff it is the workplace where they exercise their nursing role with a collegial team of qualified nurses. For the patients, it is the place where problems are ameliorated by surgical means and the impact of this brings them into contact with nursing. This theory-generating research was initiated in order to formulate from this reality an interpretation of the transaction between nurse and patient while the latter is in hospital. ✓ In the field the question was posed - What is happening here? The response was a conceptualisation of the giving and receiving of nursing as a passage - the Nursed Passage - where the patient is the passagess and the nurse is the agent of nursing.

For clarity, the remainder of this summative discussion is presented in five sections: i) the research outcome; ii) limitations of the study; iv) implications for practice; iv) implications for education; and v) further development of the grounded theory. In this discussion selected references are made to current nursing literature which has relevance for this research. However, because of the large number of concepts within the framework, the discussion is limited to the major aspects of the research outcome.

The Research Outcome

Passage is a social process which can be used to describe an experience of significant change in a person's

circumstances. As discussed previously, the author had an 'aha' experience - a feeling of sudden insight accompanied by surprise and triumph - when reading Glaser and Strauss' discussion of status passage (1971). At that stage the data analysis was yielding many concepts. What was needed was an integrating pattern which would giving meaning to the whole.

A background in anthropology meant that the author had studied rites of passage previously. This previous knowledge enhanced her insight into the significance of the concept for the current research. After repeated testing that it fitted the data and the emerging theory, the concept of passage was applied as an organising process to integrate the multiple concepts discovered in the data into a theoretical framework.

The association of passage with a particular experience of change through time has been used recently by another nurse. Parker has conceptualised the pathway of patients with leukaemia as the "cancer passage" (Parker, 1985, p.96-119). This passage differs from the Nursed Passage in that it seeks to portray the patient's illness in the context of his total life situation rather than focusing on a process with distinctive nursing dimensions which includes a framework for nurse-patient collaboration.

Recently, the concept of transition has been used by two nurses to describe experiences of "passage from one life phase, condition or status to another" (Chick and Meleis, 1986, p.238). They suggest that each transition has at

least three phases: entry, passage and exit (Ibid, p.240). Although written from a different perspective, that is as a content analysis of the concept of transition as it has relevance for nursing, their paper encourages the author in the conceptualisation of passage as it emerged from this research.

Nursing practice based on a transition model would run counter to therapeutic interventions aimed only at cure. Return to a disease-free state may not be possible, and even the premorbid level of health may be unattainable. A goal for nursing is that the client emerge from any nursing encounter not only more comfortable and better able to deal with the present health problem, but also better equipped to protect and promote self health for the future (Ibid, p.244).

Within the Nursed Passage each constituent concept has its own developmental history from its origins in the margin notes entered during the process of line-by-line analysis of the field data. Most eventually received their name after a dictionary search to discover a label which best suited the identified behaviour pattern. Some retained the actual wording recorded in the data, e.g. settling in, going home, making arrangements. One concept, namely coaching, was chosen because of its use by Strauss (1970).

Critical to the Nursed Passage is the portrayal of nursing as a partnership between the patient and nurse, with each making an essential contribution to the patient's progress through the passage. Within this conceptualisation there are three distinct elements. Firstly, there is the element of time portrayed as ongoing movement and constant

change through a sequence of phases or stages. Secondly, there is the critical interactive element involving the patterned participation of nurse and patient. Thirdly, there is a contextual element which identifies three paradoxical factors inherently present in the nursing environment which influence the shape of the passage.

The Temporal Element

Four phases were identified within the Nursed Passage: the Beginning - the patient's experience with the problem prior to admission; Settling In - the transition phase of the patient's entry into the passage; Negotiating the Nursed . Passage - the passage proper which commences on admission and concludes at discharge, co-existing and interacting with the two transition phases; and Going Home - the final transition phase as the patient prepares to leave the passage and the role of hospitalised patient.

Each passage has its origins in the daily life of the patient in his home situation and ends with the patient's transition back into his usual surroundings and pattern of living. There is no simple linear progression through these phases. Instead, there is a recognition that the patient progressing through the Nursed Passage is involved in a very complex process. Within the passage itself there are a matrix of interrelated activities all of which have significance for all others and for the passage as a whole. The passage itself is closely interrelated with the patient's concurrent experiences, particularly the

surgical intervention itself. Changes in any aspect have an impact on the patient's total lived experience.

As described, this theoretical framework recognises, emphasises and values the "wonderful and frustrating complexity" of people in social situations (Mundinger, 1980, p.197). Similarly, it offers one answer to Watson's desire for the development through qualitative research of "knowledge about the lived world of human experience" (Watson, 1985a, p.2).

Each patient's ongoing passage is made up of a number of nursing episodes - encounters between nurse and patient within the immediacy of the patient's situation. Every nursing episode becomes an integral part of the whole social process, building on what has gone before and influencing what is yet to come. The pre-eminence given to situational encounters between nurse and patient as the building blocks of the passage is supported by Benner's recent work on levels of competency in nursing practice (Benner, 1984). She speaks of the expert nurse maximally applying her accumulated wisdom in moments of "meaningful engagement" with the patient (Ibid, p.215). These nurses "know how to function in the face of unpredictable situations and to adjust their plans to the contingencies of the situation" while remaining constantly aware of the place this moment has in the patient's total experience. (Ibid, p.115; p.141).

Watson also offers support for this revaluing of the individual nursing episode when she speaks of the

significance of "caring occasions" in which the nurse and patient are in contact.

The actual caring occasion in a presenting moment has the potential to influence both the nurse and the patient in the future. The caring occasion then becomes a part of the subjective, lived reality and the life history of both (Watson, 1985a, p.61).

Within the Nursed Passage the focus is clearly on the immediacy of the patient's situation throughout the ongoing passage - whatever that might be, whoever else is involved, whatever concurrent passages occur. The gerundial form is used to portray nursing's work as a range of conceptualised activities, all of which are constantly ready to respond to any aspect of the patient's immediate situation in order to progress him through his passage. Thus, both the expression and the goal of each conceptualised aspect of nursing work are constantly and dynamically changing as nursing outcomes "are achieved over and over again, in the ongoing immediacy" of the patient's experience (Stevens, 1979, p.264).

This shaping of nursing to the complexity inherent in the present and ongoing circumstances of each patient's passage, has been likened to an artist at work.

Much of artistry lies in the skillful application of general principles to specific situations. . . While general principles can be formulated to help the nurse diagnose and care for patient needs, the effective application of general principles to a specific situation will always depend to some degree on the skill of the individual nurse (Woolridge, Leonard and Skipper, 1983, p.22).

Nurses who choose to use the Nursed Passage as the theoretical framework to guide their practice would enter each encounter with the patient with two key questions in mind: /What is happening here - at this point in the passage - to the patient? /What can I, as nurse, do to beneficially progress the patient through the passage at this time? At all times the nurse is aware of a need to consider the two linked temporal dimensions - the immediate moment and the ongoing passage.

The Interactive Element

In the Nursed Passage nursing is perceived to occur within a synergistic relationship between the nurse as the agent of nursing and the recipient of nursing, the patient, as the passagee. This research has established a distinctive work for both to do. Congruence in this mutual activity is essential if the patient's path through the passage is to be maximally beneficial. However, the manifestation of this agreement in the reality of nursing practice requires clarification.

At the conclusion of her presentation on collaborative decision making at a recent conference, Kim posed the question: "If we let the patient know as much as ourselves why do we need the nurse?" (Kim, 1987 tape) Put another way the question could be: Is self-nursing, as distinct from self-care, possible? Within the hypothesised passage the answer to this question is no. Rather, the nature of patient and nurse decisions and

goals within this working relationship arise from the distinctive expertise each requires to perform their own work. Thus, nursing wisdom remains with the nurse as she gives specialised assistance to the patient in the performance of his own work. Self-care in all, or at least some, aspects of daily living is a patient goal; maximising that self-care within the reality of the patient's immediate and ongoing situation by the use of nursing strategies is the congruent nursing goal.

While congruence is essential, there is a significant asymmetry in the theorised relationship between nurse and patient during the Nursed Passage. This is reflected in the different terminology used to describe each participant's pattern of work. The patient's work focuses on self and the personal dimensions of his ongoing passage. Thus, there is more specificity in the definition of each activity, e.g. interpreting the experience, managing self. However, there is an inherent openness in each of the multiple aspects of nursing's work, e.g. attending, enabling, appraising. In each nursing episode the nurse adjusts the focus of her altruistic work to the patient's presenting circumstances.

In her description of the transpersonal caring relationship Watson also recognises this unidirectional element.

. . . a patient's personal involvement in a professional relationship . . . is directed toward the problem at hand and its effect upon his or her life. The concern is unavoidably self-directed. In

contrast, the personal involvement of the nurse/person is directed away from one's own self and towards the other's self. . . A professional relationship may and does allow for the nurse person to benefit and be influenced by the other; however, the nurse does not depend upon receiving from the patient to maintain the involvement (Watson, 1985a, p.65).

While most theoretical models ascribe work of some kind to the nurse, not all conceptualise a working patient. There is little doubt that "many nurses continue to view patients as recipients of care rather than participants in care. 'Doing for' or 'to' rather than 'working with' is a more comfortable position for these nurses" (Rosenthal, Marshall, Macpherson and French, 1980, p.138). However, the Nursed Passage requires the nurse to view nursing as a collaboration. It identifies the nurse "as a partner in practice with the client rather than a director of practice to, for or at the client" (Pearson and Vaughan, 1986, p.39).

Strauss concurs with the idea of an actively working patient when he states that "an observant person can see hospitalised patients working" (Strauss, 1984, p.127). Further support for a conceptualisation that recognises two fully involved participants is given by Berry and Metcalf who have identified the key variant between nursing models of care as the activity/passivity status of the patient (Berry and Metcalf, 1986, p.596-7). In her work on collaborative decision making Kim assumes that "clients have the resources to be active participants" in their care and to influence, as distinct from make,

nursing decisions (Kim, 1983, p.271).

However, Miller argues that it is theorists, divorced from practice, who "advocate the active involvement of patients in their own care" while "practitioners are often employed in an area where cure rather than care is the dominant orientation, and where patients are seen as passive recipients of medical and nursing interventions" (Miller, 1985, p.421). This perspective of a passive patient is not reality as it was revealed in this study. Patients could be seen to be actively working even when this was not recognised by the nurse. Denial of the presence of this work is to deny reality. Thus, conceptualising patient activity is consistent with what is actually happening rather than being an 'impractical' theoretical notion.

Every nurse-patient episode within the Nursed Passage is viewed as being "always more complex than simple descriptions of standard helping procedures imply" (Kitson, 1987, p.321). As the patient works his way through his passage the nurse is challenged to adjust her nursing work to the pattern of the patient's work at that moment in time.

The Contextual Element

Three specific contextual determinants within the nursing situation were discovered during analysis of the field data. These factors, while adding to the complexity of the emerging theoretical framework, served to increase the

'fit' between the theorised passage and the reality of the giving and receiving of nursing as it was revealed in the data. They influence the nature of the passage as it is experienced by nurse and patient.

The first, Episodic Continuity, is a keystone finding because of its impact on the nature of the nurse-patient encounter. When the experience of being nursed is viewed as a passage the consequent integration of separate nursing episodes into an overall patterned experience reflects the continuity associated with 'being nursed'. Thus, individual nursing episodes become the building blocks of a continuous passage. Although their contact is episodic, both patients and nurses view nursing as a continuous phenomenon. This finding is consistent with Watson's suggestion that nursing has a need for an objective/subjective conceptualisation that permits inclusion of the "meaning that nursing may have for the experiencing patient" as well as allowing "the nursing presence to exist in a patient's mind, even if the nurse is not present physically" (Watson, 1985a, p.3). In this case, the objective component is the verifiable episodic nature of nurse-patient contact and the subjective component is the shared feeling of continuity expressed by nurses and patients.

Anonymous Intimacy, the second determinant, gives recognition to the reality of the patient's relationship with nursing during his passage. During the 24 hours of the nursing day within a hospital, nursing is translated

into action by a number of nurses within many nursing episodes. Many nurses contribute to a single patient's Nursed Passage, and one nurse will usually have contact with many patients. There are limited opportunities for close relationships between nurse and patient. Therefore, any theoretical interpretation purporting to reflect reality must acknowledge the existence of some degree of personal anonymity in the midst of the very personal, often intimate service offered by nursing. Nurses have access to an immediate closeness with patients because of the nature of their work rather than because they are personally known.

If nursing is perceived as a passage in which the existence of some degree of personal anonymity and interchangeability of nurses is acknowledged, it follows that each patient's passage is shared among the collegial team who have episodic contact with him. Thus, it seems unrealistic to for any single nurse to regard the patient as 'my patient'. While it is worthwhile, even essential, to conceptualise a coordinating nurse role in relation to a particular patient's overall passage, this would need to be defined in a way that recognises and supports each individual nurse's responsibility for situation decision-making within every nursing episode. Such a position would be different from that of the primary nurse which is shaped by a philosophy that includes the "allocation and acceptance of individual responsibility for decision-making to one individual" (Manthey, 1980, p.31). Consequently, the nurse assigned to the patient on each

nursing shift is required to perform the "care tasks" ordered by the primary nurse (Ibid, p.34).

✓Mutual Benevolence, the third determinant, describes the good will which permeates the relationship between nursing and its recipients. Undeniably, there are instances when nurses and patients, as human beings, may experience interpersonal discord. However, this is not the norm. For the patient the nurse is a buffer, a present source of help, a companion through an ordeal. This service is usually valued and the nurse providing it is also regarded with kindness and gratitude. For the nurse, the benevolence is a major characteristic of a profession with an altruistic motivation in which specialised knowledge and skill are intertwined with compassion. Such a perspective seems incompatible with a power relationship in which one partner seeks to dominate. Benner feared this could be the case at this time as nursing is influenced by the prevailing social attitudes where "power, status, and control are taken for granted as the basic motivating forces in human interactions", but her investigation "found nurses who were skilled in avoiding power plays with their patients" (Benner, 1984, p.48).

The Nursed Passage is offered as one interpretation of nursing as it occurs. By its systematic ordering of the multiple concepts generated from the data, the theoretical framework serves to give a specific pattern to the transaction between nurse and a patient who is undergoing surgical intervention. In this way it gives a distinctive

shape to nursing as a separate human service profession.

However, it is important to note that the framework was induced from the data. The nurses and patients who participated in the study did not know of its existence but their behaviour provided the cues which eventually led to the conceptualisation. From one perspective, it can be considered an idealised vision of nursing as it 'should' be. From another, it is nursing as it 'is'. In this latter preferred view, the passage and its component elements can be identified in the real world of nursing practice but they lack recognition and integration, and thus their performance is of variable quality.

Limitations of the Study

✓ Some important limitations are recognised in this study and its outcome. These are primarily consequences of decisions made by the researcher during the development of the research protocol, while in the field and during data analysis.

✓ Data were collected in five surgical wards within one hospital, so there are limitations on the generalisability of the result. This is consistent with a grounded theory at the stage of development reached in this study. However, the concepts have been developed to a degree of abstraction that potentially lifts them beyond this single setting. Confirmation of the general applicability of the process would come through specific testing of each concept within the framework. The potential for this

expansion has been confirmed by the reactions of colleagues to the concept of the Nursed Passage. For example, when introduced to the framework, one stated "But that's psychiatric nursing"; another followed with "It's midwifery".

Because of the duration of the study and changes in patients and nursing staff, it has never been possible to share the emerging theory with the people who provided the data. However, it has been shared along the way with nursing colleagues and students as well as other people who had had recent experiences as patients. There have been many confirmatory statements attesting to the validity of the conceptualisation. Nurses have also spoken with enthusiasm of the potential significance of the research. A number have commented that it "gives new meaning to nursing".

At the outset, it was hoped that registered nurses would be the sole source of nursing data. That was not to be. Instead, a decision was made to include nursing students when these were assigned to nurse the patients in the study. Supervision was indirect so that the registered nurse with overall responsibility might not have had any contact with the patient during the nursing shift. Examination of the data from senior students and staff nurses did not reveal any appreciable differences in relation to the dimensions identified in the research outcome, certainly none that would negate the findings. Also, as these were registered nurses in the making there

was some real value accruing from the opportunity to observe nurses at different levels of development.

Another limitation, perhaps more in the retrospective perception of the researcher rather than in reality, was the decision to follow more than three patients at a time in the latter part of the field work. This decision created pressure on the researcher and led to some interviews being lost through technical oversights which were caused by the sheer amount of recording being done.

It also meant that less time was available for each patient, especially for just being there to observe incidents as they occurred. Despite this, participant observation, particularly of nurses and patients interacting, although planned to be major source of data, yielded far less than anticipated. Concern over this lack of observed nurse-patient encounters led to the finding that actual nursing time was considerably less, in amount and frequency, than expected. Therefore, the primary data for the theory were the subjective comments by patients and nurses during recorded interviews. However, these, when supplemented by nursing documentation and the incidents which were recorded, provided a rich and valuable data base.

As analysis progressed, the emergent theoretical framework became increasingly complex. Concepts produced by reduction of the multiple substantive codes required sub-concepts as their range of properties increased; phases were developed; the working partnership evolved; and,

finally, the concept of passage was applied to link the various pieces together. As a consequence, a decision had to be made on whether the focus of the outcome would be on breadth - the whole passage, or depth - a concentrated analysis of a limited number of concepts. The decision - the whole passage - was not hard to make because of the need to establish an overall shape to the novel framework which was emerging. However, this resolution did mean that discussion of each of the many concepts generated from a huge mass of data would be, of necessity, somewhat brief. Much remains unsaid. Anecdotal data have been selectively used to provide depth and relevance to the discussion of the findings. They also add a human touch giving a sense of the very real people, nurses and patients, who lie behind the generalisations. Many treasures remain hidden in the raw data awaiting further attention to reveal their value in supporting and extending each concept within the theory.

As this is a report of a research study, the findings have rightly been limited to those emerging from the analysis of the data. However, throughout the experience the researcher, as nurse, has reflected on where the theory might go from here. Constantly, there has been a temptation to say more, make more decisions, expand a concept, all on the basis of personal experience and accumulated nursing wisdom. This inclination has been overcome, albeit with some difficulty, and the research outcome remains immersed in the data from which it originated. Consequently, the nurse researcher is left

overflowing with ideas arising from the experience.

These limitations are acknowledged as part of the study, reflecting the reality that is qualitative research in action. Nevertheless, there is little evidence that they detract from the theoretical outcome.

Implications for Practice

The Nursed Passage is not a panacea for the problems which currently exist in nursing practice. However, it does offer a fresh perspective on the processes involved in the giving and receiving of nursing. In the light of the prevailing concern for the loss of experienced nursing staff from practice, there is a hope that nurses who choose to use it may experience increased job satisfaction and their patients may feel that they have benefited from being nursed.

As a field study using qualitative methodology, it produced data on both the problems and strengths of nursing in the surgical setting. Thus, the implications for nursing practice arise as much from an increased awareness and understanding of some of the problems as from the emergent conceptualisation itself.

So often, while in the field and while analysing the data, the researcher was faced with evidence that nursing could be piecemeal, disjointed, ritualised, lacking in situational judgement and lacking an integrating theoretical basis. A significant number of nurses

demonstrated either an inability or an unwillingness to complete a formalised nursing assessment on admission, few 'nursing problems' were identified, lists of disparate nursing directives were incomplete and inconsistently maintained. The recording of nursing care tended to be disjointed and failed to reflect the process of nursing judgement. In fact, nursing records were often perceived as fulfilling an administrative requirement rather than actually facilitating the subsequent work of colleagues and easing the path of the patient through his experience. Finally, there was an absence of formalised nursing-oriented discharge planning prior to the medical decision to send the patient home.

Such comments may seem harsh but they reflect the reality encountered in the field. However, as would be expected, there was also a co-existing reality in which there were moments of excellence, some evidence of continuity, many episodes of insightful nursing judgement, and safe nursing care. All these provided the cues that led to the creation of the grounded theory of the Nursed Passage. They also provide the starting point for consideration of the implications the findings could have for nursing practice.

Analysis revealed that nurses do or could attain the knowledge and skills that would permit the implementation of the Nursed Passage as the theoretical basis for nursing practice. What nurses require is access to a guiding theoretical framework for the total nursing enterprise.

Without this nursing will remain undervalued with a consequent limitation in its perceived scope and function.

While addressing a nursing symposium a doctor made a relevant comment which demonstrates that even the people who supposedly work alongside nurses may not recognise the significance of nursing's contribution to patient care.

My personal journey as a partner of nurses really began when I was confronted by the realisation of a missing component in effective care. Competent assessment of problems and accurate prescription of appropriate therapy was not enough to make many of the persons I was caring for well. In the intervals between the medical decisions I made there was a whole world I knew little of - a gap in the care of and caring for patients and their families. The clinical work of my nursing colleagues filled that gap (Hansen, 1979).

The Nursed Passage, an integrated vision of nursing practice, can help nurses to articulate this 'missing component in effective care' for themselves, their patients and their colleagues. By linking each nursing action within a patterned and purposeful process it may give nurses the confidence to assert their role in the nursing-medical partnership.

✓ Within this framework particular attention is given to the patient's prelude experience. A specific theoretical shape has been assigned to it. Nursing significance is attached to the patient's experience of living with the problem and its consequences - for days, for weeks, for months, for years. Entry into hospital and into the passage is a continuation of this experience and will have

an impact on the patient and his nursing. The patterned Beginning gives the nurse a framework to gain access to knowledge about the critical areas of the patient's prelude.

During the transition process into the Nursed Passage the nurse is able to use the patient's theorised work in the Beginning and Settling In to orientate her own work. Therefore, the conceptualisation would serve to guide the nurse through an open-ended discovery-oriented discussion as a major part of the initial nursing appraisal. Thus, a rich data base of nursing-relevant information becomes accessible to nurses at the outset of a working partnership. With this as background the nurse is able to selectively use the conceptualised nursing strategies which can begin to ease the patient's way through the passage.

When using this theoretical approach in practice, each nurse making a contribution to the patient's passage would be required to maintain an openness to the latter's ongoing experience using the dimensions of nurse and patient work identified in each phase. Cues would be sought to make nursing decisions about the patient's status in relation to each aspect of his work. The nurse entering each episode is aware that she has available the full range of her nursing resources, as defined within the framework, to progress the patient through the passage.

As the passage progresses, the changing pattern of the patient's work together with the available medical

information would prompt the nurse to recognise that the patient is entering into the Going Home phase and to instigate new nursing work to assist the patient prepare for this transition experience.

This theoretical approach requires nurses to adopt a collegial partnership in which autonomous nurses work together, each making a valuable contribution to the progress of a single Nursed Passage. Through them nursing is translated into action twenty-four hours a day as many passages take their course. This approach would preclude the perception of nursing as a continuing private transaction between one nurse and one patient, even during the one nursing shift. As this study shows it is one nurse with many patients; many patients with one nurse. Thus, the Nursed Passage would help to shape a working environment for nurses that is consistent with the reality of the practice situation. Individual nursing episodes are essentially private transactions and so the commitment of each individual nurse to seek excellence in her own practice - and consequently supporting the collaborative work of the nursing team - becomes a prerequisite for an effective qualified work force.

Benner found that "the expert nurse can interpret particular situations and make the necessary exceptions and alterations in the rules in order to individualise patient care" (Benner, 1984, p.176). Thus, a nursing approach with an associated documentation format that both requires and enables the registered nurse to practice

situational decision-making, supported by cues recorded from previous nursing episodes, will encourage professional accountability and responsibility. This behaviour is axiomatic within the Nursed Passage.

Within the hospital setting staff education programmes seek to maintain a consistent quality of work performance from the nursing staff. This work is made more difficult by the mobile nature of the nursing work force and the difficulty demonstrated in retaining expert nurses in 'hands on' nursing roles. One consequence is the continuous initiation of neophyte registered nurses into work settings where, by default, they may become the 'experts' in a matter of months as experienced nurses leave. In this environment, there is a need for nursing administration, with support from the profession, to identify and reward excellence in nursing practice using specific nursing criteria. This lack of outcome measures means there is a lack of recognition of effective nursing - by money, status or professional standing.

It is possible that the implementation of the Nursed Passage could be used to generate outcome criteria for judging the effectiveness of nursing care. The various dimensions of patient and nurse behaviour and their place in the passage could also be used as the basis for the mutual sharing of nursing knowledge and experience between nurses working in a variety of clinical settings. It may provide a common language that could vitalise nursing within the organisation, stimulating individual nurses and

increasing their commitment to their work, to their colleagues, and to their patients. Also, such a concerted approach would encourage ongoing peer review associated with an articulated set of standards for nursing performance.

Even in its present stage of development it has many implications for nursing practice. It is a tool for nurses to use creatively in the practice situation in the mutual interests of each other within the profession as well as the patients.

Implications for Education

In its present form, the grounded theory which emerged from this study proposes a perspective on nursing in the single domain of the surgical ward. However, it is likely that a group of skilled practitioners and educators could expand it into a model for use in nursing education at a basic and post-basic level. Such a development would have a number of advantages for teacher, student and the profession.

Firstly, it identifies nursing as a entity with its own scope and function. The articulation of an integrated perspective on the role of nurse and patient provides a basis for the socialisation of neophyte nurses into a profession which, together with society, increasingly demands autonomy and responsibility from its practitioners. There is a need for the educative process to develop in each graduate a strong nursing identity.

The Nursed Passage can provide considerable assistance in achieving this educational goal.

Of particular value to the nurse educator is the way in which the work of nurse and patient is articulated within the framework. Each can be developed separately for teaching/learning purposes. Learning experiences can be planned in a systematic way to develop the students' knowledge and skills in relation to each component. One curriculum model could gradually expose the students to the approach in a sequential manner from beginning to end. Another might begin by revealing the model as a whole in what are considered to be 'simple' passages with a planned transition to increasingly complex nursing situations. Yet another might focus initially on the patient's experience and then bring in the nursing component as the student's wisdom about the patient increases. The value of this theoretical framework comes from its reality-based division into parts with a known integrative patterning which consistently links them together.

✓ A curriculum based on the Nursed Passage also provides a nursing framework for the selection and organisation of knowledge from medical science as well as the biological, physical and social sciences. In this way, students are continually made aware of the purpose of this knowledge as it is presented in a supportive relationship to nursing activity. This has the consequence of reinforcing, for the learner, the essential autonomy of nursing as a profession and as a body of knowledge. At the present

time there are few effective frameworks which accomplish this with the result that nurses often feel that increasing their 'medical' knowledge is the way to make them 'better' nurses. The Nursed Passage model of nursing could minimise the prevalence of this belief, replacing it with a perspective which recognises that the value of such related knowledge. However, it also emphasises that nursing care can only be enhanced by nurses increasing their 'nursing' wisdom, knowledge and skill.

Another advantage of using this theory in nursing education arises from its emphasis on the need for the socialisation process to develop artistry and skill within the individual practitioner. Exposure to expert nurses who demonstrate the artistic application of nursing knowledge and skill within the ongoing passages of individual patients is one essential for student learning. A series of planned relationships with practitioners presents the student with knowledge of the boundaries and possibilities of nursing action. This process of role-modelling places the student's learning in the context of the everyday world of nursing practice.

✓ Concurrently, nurse educators use their expertise in nursing and education to plan an integrated programme of incremental learning experiences to develop within each student the ability to make situational nursing judgements consistent with the theoretical approach.

The curriculum using this approach would emphasise discovery and minimise the suggestion that nursing can be

routinised into a set of known rules and procedures which can be applied without situational nursing judgement. However, this discovery process would be associated with the development of responsibility in the learner for justified autonomous action and collaborative accountability. Throughout the learning experience the student is confronted with the reality that all nursing behaviour has meaning for the patient, the passage and subsequent nursing action. This is a consistent theme permeating every aspect of the theory.

Further Development of the Grounded Theory

✓ An image of nursing in action has been proposed, its major dimensions identified and described in relation to the field data from which they were derived. * The grounded theory of the Nursed Passage stands as the outcome of this particular study. As such, it is already a useful tool for nurse practitioners and nurse educators. However, its very nature opens many research possibilities which would continue its development.

Perhaps the first research option is confirmation of the theory - in part or in whole. Replication is not necessary, nor is it possible, because of the impact the present theory would have on the researcher's openness to the data. However, there is a place for the systematic examination of each element - concept, phase, pattern of work, or contextual determinant - in order to establish a set of definitive descriptive criteria.

One research study of major significance would be an analysis of the theory in action. This would require a nursing unit to decide to use it and set up a study to evaluate its impact on patients, nurses and the unit. Individual passages could be examined and analysed in detail. Such a study would generate many insights into the relationship between nursing action and patient behaviour. Facilitating and non-facilitating nurse actions associated with each concept could be identified in the context of the Nursed Passage. Indicators of nursing effectiveness in progressing a patient through a Nursed Passage are required as well as a set of diagnostic criteria to assist the nurse in judging the effectiveness of the work of the patient within the circumstances of his situation.

There is a need to continue the development of the theory from its present stage to a set of propositions positing relationships on a variety of levels. Predictive and explanatory relational statements are required. These could arise as hypotheses based on the many relationships implied in the presentation of the findings of this study.

A valuable contribution to the development of the theory would come from a systematic examination of the relationship between the different patterns by which a problem may surface during the Beginning phase and its impact on the work of patient and nurse during the passage. While distinctive patterns were not discernable in this study, a specific project organised to investigate

this may discover a link.

As stated, many questions remain to be answered as a result of the findings of this study. Each one is worthy of an answer in the interests of nurse and patient. What nurse behaviours facilitate patient progress? What nursing behaviours fail to progress a patient through his passage? What nursing criteria indicate a patient is ready to leave the Nursed Passage? How does nursing time vary between patients, between shifts? Is there an optimal number of nurses which will maximally progress the patient through his passage at critical times e.g. immediately before and after surgery, when ongoing teaching programmes are required? Can there be 'too many' nurses or 'too few' nursing episodes? What are the characteristics of nurses who are particularly valued and identified by patients? In what way is a patient's passage beneficially progressed by nurses whose personal and professional qualities are especially valued? What kind of nursing documentation supports the Nursed Passage?

In essence, further research on the grounded theory of the Nursed Passage is dependent on the imagination of those who wish to investigate it. There are many possibilities.

Summary

After a study of this kind in which a large topic has been examined using a creative methodology, much remains unsaid. The work remains incomplete. During the course of the analysis many worthwhile avenues of enquiry were

opened and then discarded as the decision was made to concentrate on developing the Nursed Passage. Alternative perspectives on the data remain unexplored. However, there is an abiding sense of satisfaction that the study has generated a perspective on nursing which challenges nurses to reflect on their practice.

The Nursed Passage had its origins in the question: What is happening here? It is a theory at an early stage of development. This journey of discovery has been interrupted to write this report, to share the emerging grounded theory in its present form of a theoretical framework. Hopefully others, having read this study, will share in its further development. The journey will continue.

APPENDICES

APPENDIX 1: CONSENT FORM TO PARTICIPATE IN STUDY

Area of study: The nursing needs of persons undergoing surgery

Brief description: A number of persons on the waiting list for surgery will be visited before or on admission and interviewed by the researcher. After admission the person will be visited daily and another home visit will be made about one week after discharge. Up to five persons to be admitted to each of a group of surgical wards will be invited to participate in the study

Researcher: Judith C. Christensen
Doctoral student, Massey University

Relevant background: Registered nurse with 21 years of experience including 13 years as a teacher and experience as a charge nurse in a surgical ward

Nature of patient involvement in this study:

- a. An interview before or at time of admission to hospital and after discharge
- b. Interviews during hospitalisation - short interview at approximately 7am, 3pm and 9pm daily
- c. Observation - the researcher will make observations of activities involving the person at various times during the person's stay in hospital

Consent statement:

1. I have read the above and have had the opportunity to discuss the study and my part in it with Miss Christensen
2. I understand that this study has been approved by the hospital administration and by a special hospital board committee
3. I understand that my doctor is aware of my participation in this study
4. I know that Miss Christensen will discuss with me any time she wishes to observe activities during my hospital experience, and will seek my permission to do so on each occasion
5. I understand that I may withdraw from this study at any time
6. I agree to take part in this study

Signed: _____ Date: _____

APPENDIX 2: GLOSSARY OF NURSING AND MEDICAL TERMS

- Charge nurse: The nurse in charge of a hospital ward
- Chronic renal failure: Progressive loss of kidney function
- Corneal graft: Replacement of a damaged cornea in eye by cornea from a donor
- Cubicle nursing: A system for delivering nursing care by allocating patients to nursing staff according to room or cubicle
- Enrolled nurse: A graduate of a one year basic nursing programme who works under the supervision of a registered nurse
- Gastric ulcer: An ulcer on the inner wall of the stomach
- General surgical ward: A ward in which a variety of types of surgery are performed
- Genito-urinary: The organs of reproduction together with the organs concerned with production and excretion of urine
- Glaucoma: Group of eye diseases characterised by an increase in pressure within the eye
- Haemodialysis: Removal of toxic wastes from the body through a semipermeable membrane while the blood is circulated outside the body
- Hodgkins disease: A malignant disease in the lymph nodes, spleen and lymphoid tissue
- Hospital-based student: A nurse student within a school of nursing operated by a hospital board
- House surgeon: A doctor employed by a hospital during the first or second year after medical school
- Malignant: A condition that tends to worsen so as to cause serious illness or death if not treated, as in case of cancer
- Melanoma: A tumour containing dark pigment that arises from a nevus [mole]
- Oesophageal varices: Varicose veins in the lower gullet caused by liver disease
- Ophthalmology: Area of medicine concerned with the eye

Primary nursing: A system for delivering nursing care in which patients are assigned to one nurse who plans the nursing and other nurses adhere to that plan while the primary nurse is off duty

Rectal fissure: A painful lineal ulcer at the margin of the anus

Registrar: A doctor three or more years out of medical school employed by a hospital who is undertaking advanced training in a branch of medicine

Renal dialysis: Same as haemodialysis

Staff nurse: A registered nurse within a ward nursing team

Task assignment nursing: A system for delivering nursing care in which nursing work is divided into tasks for distribution among different levels of nursing staff

Technical institute: A tertiary college within the system of general education

Urinary tract infection: An infection in the kidneys, bladder, ureters or urethra

APPENDIX 3: STAGE 1 INTERVIEW GUIDE AND OBSERVATION SCHEDULE

Interview Guide

The interview will commence with an initiating question but the conversation will then be determined by the nature of the responses made by the subject and the guiding of the researcher as issues are explored. It is realised that some persons will need more probing and prompting than others. However, it is the researcher's intention to listen and probe appropriately rather than tightly structure the interview.

Primary theme: The internal and external world of the person

Initiating question: "I would like to learn something about you and the kind of life you live. . . ."

Probes: Daily pattern of living
Self
Self in relation to others

Secondary theme: Personal health, nature and consequences of change in health status

Initiating question: "Can you tell me about your own experience of health and illness. . "

Probes: Health maintenance activities
Experience of family health problems
Attitude to illness and disability
Present health problem

Observation Schedule

Completed after first interview -

1. Apparent physical state
2. Evidence of health problem
3. Stature and build
4. Posture and mobility
5. Dress and grooming
6. Communication - speech and mannerisms
7. Manner and mood
8. Social and physical environment
9. Other impressions

APPENDIX 4: STAGE 2 INTERVIEW GUIDE AND OBSERVATION SCHEDULE FOR PATIENT

Baseline Data

Time

Day of hospitalisation

Interview Guide

The nature of this guided conversation will be determined by the status of the person and his [her] ability to speak. The interview may be very short or may cover a number of issues of current concern to the patient as raised by him [her] in response to the initial question

Theme: Reflections on past eight hours and own present state

Initiating question: "How have you been since I saw you last?"

or

"How are you feeling now?"

or

"Can you tell me what has happened since I saw you last?"

Probes: Perception of events and own state
Feeling about self
Sense of control of - self
- events
Personal concerns
Perceived sources of support

Observation Schedule

Description of person - appearance
Equipment in use
Vital signs
Recordings currently in use
Mood and manner during interview
Other significant observations

APPENDIX 5: STAGE 2 INTERVIEW GUIDE FOR NURSE

Baseline data

Date
Time
Type of registration
Year of registration
Training school
Time employed - in hospital
 - in ward

Interview Guide

Theme: Nurse's perception of the patient and his nursing care

Initiating question: "Can you tell me about _ and the nursing care he [she] has required this duty. . . "

Probes:	Patient's status
	Changes during the duty
	Nursing care given to patient
	Individualisation of nursing care
	Information available to nurse
	Relationship with patient
	Perception of nursing
	Anticipatory nursing
	Reactive nursing

APPENDIX 6: NURSING HISTORY FORMAT (2 IN USE)

1. NURSING HISTORY FORM IN GENERAL USE

Patient's perceptions and expectations related to illness and hospitalisation:

- a) What do you expect is going to happen to you while in hospital?
- b) How long do you expect to be in hospital?
- c) Has your illness affected your lifestyle?
If yes, in what way?

Mobility

- a) Independent
- b) Dependent: Walking stick
Walking frame
Wheelchair
Other

Hygiene

- a) Bath or Shower
Morning or Evening
- b) Independent or Dependent
- c) Oral care - Brushes own teeth or Dependent
- Dentures
- d) Dressing - Independent or Dependent
- e) How often do you usually wash your hair?

Rest & Sleep

- a) What time do you normally retire to bed?
- b) Do you have trouble going to sleep or staying asleep?
- c) Do you have anything to help you sleep?
- d) How many pillow do you like?
- e) Do you like ventilation at night?

Elimination

- a) Bladder - Continent or Incontinent
- Frequency
- b) Bowels - Do you take a laxative? Regularly
Occasionally
Frequently
Never

Communication

- a) Eyes: Do you wear spectacles? Yes or No
If yes, why?
If appropriate, what way does your limited eyesight handicap you?
- b) Hearing: Do you have any difficulty in hearing? Yes or No
If yes, do you wear a hearing aid?

Nutrition

What fluids do you prefer to drink?

Do you have any food or fluid dislikes?

Are you on a special diet? Yes or No

If yes, what kind?

Do you have any problems with your diet? Yes or No

Does the condition of your teeth or mouth limit your eating?

Social Needs

Do you live alone? Yes or No

What is your home situation?

Will your relatives/friends be able to visit you? Yes or No

Will you have help from your relatives/friends on discharge? Yes or No

Would you like the hospital chaplain to visit you? Yes or No

If yes, what denomination?

Has any member of the health services been attending you or any member of the household? Yes or No

District Nurse or public Health Nurse or Social Worker or Other (specify)

Nurse's Observations During Interview:

Hygiene: Skin condition

Nails

Chiropody - Yes or No

Communication Patterns

Quiet

Talkative

Anxious

Depressed

Comfortable

Cooperative

Confused

Summary of Main Points

2. SURGICAL NURSING HISTORY

Diagnosis

Previous Hospital Admissions:

(Take from med. notes and keep it brief)

Do you remember anything particular about your stay?

Patient's Expectations of Hospital Stay:

Why have you come to hospital?

What is your health normally like?

Has anyone explained your surgery/tests to you?

What do you understand by their explanation?

How long do you think you will be in hospital?

Activities of Daily Living:

A. Pain

Have you any pain?

Describe

B. Sleep

Hours of sleep per night

Do you need to get up at night?

If unable to sleep, what do you do?

C. Hygiene

Do you have dentures?

Are they in good condition?

D. Continence

What are your usual bowel habits?

Do you have bowel irregularities?

What do you take at home for this?

Usual bladder habits

Do you have any trouble with your water?

E. Feeding

Were you on a special diet?

Any problems?

F. Ambulation

Do you use walking aids?

Do you have difficulty with seeing and hearing?

Assessment of Capabilities:

Name of NOK [next of kin]:

Do you mind my discussing your condition and progress with him/her?

Has your being admitted made any difference to his/her life?

If alone, are you worried about pets, cancelling orders, rent etc.

Do you do your own shopping or housework?

Community Care:

List community services received prior to admission

Summary:

Further Comments:

APPENDIX 7: NURSING CARE PLAN - SURGICAL

Name _____ Consultant _____

Birth Date _____ Age _____ Sex _____

Patient No. _____ Ward _____

Diagnosis _____

Date	Nursing Problems	Nursing Aims	Date Resolved
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(17 lines)

Activity	Date	Nursing Orders	Signature
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Mental State (7 lines)

Nutrition (11 lines)

Observations (8 lines)

Hygiene (5 lines)

Mobility (7 lines)

Elimination (2 lines)

Special Cares (22 lines)

APPENDIX 8: STAGE 3 INTERVIEW GUIDE AND OBSERVATION SCHEDULE

Baseline Data

Date
Time
Place

Interview Guide

This final interview will be very unstructures with a free exploration of issues as they arise. Additional questions will be formulated according to patient responses.

Initiating Question: "I wonder if you could look back and comment on this experience. . . "

Probes	Nurses
	Nursing care
	Hospitalisation
	Present status
	Value of surgery
	Fulfilment of expectations
	Influence of surgery on life
	Satisfaction

Observation Schedule

Apparent physical state - appearance
Evidence of recent surgery
Posture and mobility
Dress and grooming
Communication - speech and mannerisms
Manner and mood
Other significant observations

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