EXPLORING HISTORICAL AND CONTEMPORARY FRAGMENTS OF NURSES' INVISIBLE PRACTICE

by

Kim Macfarlane

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(Signature)

Department of Educational Psychology and Special Education
The University of British Columbia
Vancouver, Canada

Date Oct 29, 1983
Abstract

The social context in the hospital setting is fraught with competing and contradictory versions about who nurses are and what they do. Using a sociocultural framework, this thesis provides an analysis of historical and contemporary texts related to hospital-based nursing, and argues that many themes operative in these "official versions" of practice have rendered the breath and complexity of nurses' everyday practices "in/visible." Given that "official versions" of nursing practice are reified in nurses' job descriptions, this research develops a necessarily partial response to the following question: What are nurses' ideas about their in/visible practice within a hospital setting? Nurses' in/visible practice is, here, defined as the disparity between their "actual" practices, and the job description's "textual representations" of their practice (Smith, 1987 & 1990). This investigation took place in an acute care hospital in British Columbia. Seven nurses comprised the primary research group. The research methods used to investigate nurses' in/visible practice included: career autobiographies, direct observation, journals, unstructured one-on-one interviews and concurrent group discussions. Data obtained from these methods underwent qualitative analysis, and both the researcher and the researched (nurses) jointly constructed thematic interpretations of nurses' in/visible practice. This particular analysis of nurses' in/visible practice suggests that there are "profound" disparities between nurses' actual practices, and those represented in their job description. Nurses appear to have resisted such textual representations and, in turn, have (re)invented complex theories of "thinking-in-practice," interwoven with an informal "learning with/in practice curriculum."
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Chapter 1: Developing a Concept of Nurses' In/Visible Practice Within a Sociocultural Framework

Introduction

As a nurse, I have always been amazed by the complexity and scope of nursing practice. Yet, I have become increasingly concerned and, frankly, dismayed about how nursing and nurses are portrayed in their workplace, and in the media. Many nurses have said to me, that they never get credit for what they "really" do. In fact, many suggest that it is only the nurses, themselves, who know the real extent of their practice. Many patients acknowledge nurses' care and compassion, but have little understanding of the complexities of their practices (CNA, 1990). Also, some physicians cast nurses in the role of secretary or the follower of doctor's orders, and do not acknowledge the crucial patient care decisions that are made in their presence or absence (Jenny, 1990). Despite the facts that one out of every 118 Canadians is a nurse, and that nurses represent the largest number (52%) of health care professions, their practice remains in/visible (RNABC, 1990b). The following anecdote from my own experience helps to clarify the concept of in/visible practice:

As a critical care nurse, I have become experienced in dealing with cardiac arrest situations. During one such event, I saw that the physician who was supposed to be "in charge" of this situation, was unsure of what to do, so I chose to take charge. Thus, in response to the particular and potentially heart rhythms that the patient experienced, I ordered specific drugs and treatments. When the patient was stable, the physician left the patient's bedside, and went to the nursing station to get the patient's chart. I saw him writing down the patient's medical number from the chart, and asked him why he was concerned about getting this number. He said that he needed this number so that he could bill the government for this patient's cardiac arrest management. I was shocked.
My experience, recounted in this example, is not usual. Both the voices of my colleagues and empirical research such as that conducted by Griffith, Thomas and Griffith (1991) suggest that: "Far and wide, nurses are performing -- mostly without MD supervision [or acknowledge] -- exactly the same services for which physicians are being reimbursed" (p. 22). What I wish to expose, in recounting the above example, is that through specific governmental billing practices, physicians are positioned as the legitimate "experts" in relation to other practitioners like nurses. Administrative practices such as these, particularly in hospital settings, serve to maintain doctors' superior position vis a vis the caregiver hierarchy and, at the same time, make in/visible the important contributions of nurses.

To clarify this idea about in/visibility, it should be emphasized at the outset that this word should not be taken literally. Visibility and invisibility (hence, in/visibility) are construed, here, as necessarily co-constituted aspects of practice; aspects that are always operating simultaneously and, apparently, in a contradictory relation to one another (Apple, 1986; Britzman, 1991; Lather, 1991; Van Maanen, 1988). In the above example from my clinical practice, if I look at my cardiac arrest management practices as they are construed by specific aspects of government billing, my practices seem to be "invisible." However, I know that I have performed this practice and, thus, it is "visible" if only to me. In the following discussion, I will provide an overview of the directions and theoretical propositions that will guide this work. At the same time, I will refine and define the core concept of nurses' in/visible practice, and delineate the research question operative in this investigation.

**Overview and Refinements**

The intent of this chapter is to develop a framework which provides a basis for a contextualized understanding of nurses and their in/visible practice. Recognizing
that this chapter is rather lengthy, the next few paragraphs are devoted to an overview of the main points brought forth in this work, and to the rudiments of a definition of nurses' in/visible practice. Nurses are construed, here, as purposeful beings situated in particular historical, cultural, political and institutional contexts; contexts which are intimately linked to both the constitution of, and their understanding of everyday practices (Bruner, 1986; Lave & Wenger, 1991; Luria, 1979; Vygotsky, 1978; Wertsch, 1985 & 1991). After elaborating further on this sociocultural view of practice, I provide a review of Canadian hospital-based nursing practice. An analysis of a small sample of historical texts presents some of the "official versions" of nursing practice, and provides the basis for the argument that these versions serve as the foundation for nurses' contemporary in/visible practice. Like women's history, nurses' history is usually written by people who hold positions of authority and power (Chua & Clegg, 1990; Foucault, 1980; Hubbard, 1988; Reverby, 1987). The primary focus, here, is on the specific aspects of historical documents that pertain to conceptions of nursing practice. In particular, the analysis emphasizes how these authors portray nurses, and how these characterizations serve to obscure or make in/visible the nature and scope of nursing practice (Freire & Faundez, 1989; Smith 1987 & 1990; Van Maanen, 1988). The historical descriptions of nurses and their practices tend to be structured in relation to the following themes: 1) self-sacrifice and altruism (e.g., the patient always comes first); 2) loyalty, subservience and unquestioning obedience (e.g., to the doctors and hospital); 3) de-intellectualization (e.g., nurses are "doers" and not "thinkers"); and 4) amorality and promiscuity (e.g., in comparison to men, nurses, as women, have an inferior character) (Aaronson, 1989; Gibbon & Mathewson, 1947; Growe, 1991; Hubbard, 1988; Melosh, 1982; Reverby, 1987). The core concept that nurses can neither be trusted to complete the job, nor really understand the rationale for it, provides a justification for hospitals' and doctors'
strict monitoring and control over nurses (Cockburn 1985; Freidson, 1970; Warburton & Caroll, 1988). Themes that relate to self-sacrifice, legitimate the idea that, no matter how lamentable their working conditions may be, nurses are obligated to do the job and not to complain (George & Larson, 1988). The de-intellectualization theme is especially powerful because it suggests that nurses really do not know what they are doing, so there is really no point representing nurses as practitioners or as authors of complex practices (Campbell & Bunting, 1991; Hubbard, 1988; Reverby, 1987). Hence, nurses must have their history and practice written for them. Although these themes are presented in more detail in the body of this chapter, I mention them here to illustrate how history establishes prescriptive social norms for nursing practice. What is lost in these historical texts is a contextualized understanding of what nurses' felt, thought and did. However, at times, these texts also reveal how nurses have resisted hegemonic renderings of their practice (Gramsci, 1988).

Moving from the historical to contemporary context, I use aspects of current research to describe how the historical themes continue to operate, and point to some alternative ways to construct and emphasize the complexities and richness of everyday nursing practice. In these discussions, two varying versions of nursing practice are developed: 1) the "official" and decontextualized ones, which have been written by people who are, by the nature of their positions, both physically and mentally removed from everyday practice; and 2) the "unofficial" and contextualized ones, which are based upon limited research and my own understandings of nursing practice (Bateson & Bateson, 1987; Hutchinson, 1990; Lather, 1991; Wertsch, 1985 & 1991). Although the unofficial versions are quite incomplete (due to the lack of research in this field), they are different from the official ones. This difference suggests that, within their own peer group, nurses have learned and developed other versions of nursing practice, which resist and
defy some of the prescriptive historical myths and norms imposed on them (Apple, 1989; Ball, 1990; Goffman, 1961; Hutchinson, 1990; Lave & Wenger, 1991). The research problem, however, becomes a question of how to refine ideas about nurses' in/visible practice in a way that provides a greater understanding of the nurses' versions and then, specifically, captures the disparity between the nurses' and official versions?

Since I am interested in a contextualized understanding of nurses' in/visible practice, the site of this research will be in a hospital, and the focus is a description of nurses' versions of their actual practices. With this first refinement in mind, the question becomes one of what document in this setting represents the hospital's official version of nursing practice? In the hospital, nurses are evaluated on the basis of standards for practice identified in their job description (Ball, 1990; Smith, 1987 & 1990). Besides containing general statements about what nurses "should" do in their everyday practice, this document also serves three institutional functions: 1) to categorize the nursing labour group; 2) to define and, thus, scope their practice; and 3) to coordinate and, thus, separate their practice from other disciplines, like medicine (Apple, 1989). Thus, its basic functions are analogous to the historical texts written about nurses -- to define and confine nursing practice within a seemingly "natural" social order (power relations) within the hospital setting (Apple, 1989; Ball, 1990; Giroux, 1988; Smith 1987 & 1990). In addition, most job descriptions contain some of the historical themes of nursing practice (as outlined above), which obscure the actualities of everyday nursing practice.

Given its functions and its reification of historical themes, the hospital's job description represents the institution's theory of nursing practice, and is the official document that makes certain aspects of nursing practice institutionally sanctioned and visible and, by means of exclusion, makes other aspects of nursing practice in/visible (Apple, 1989; Ball, 1990; Giroux, 1988; Smith 1987 & 1990). By situating
nurses in their everyday work world, this research seeks to uncover a preliminary
and necessarily partial response to the following question: What are nurses' ideas
about their in/visible practice within a hospital setting? Nurses' in/visible practice
is, here, defined as the disparity between their "actual" practices, and the job
description's "textual representations" of their practice (Smith, 1987 & 1990). This
definition, however, extends beyond identifying the practices that remain
unacknowledged in nurses' job descriptions, and includes descriptions of
contextual or social circumstances that are involved in shaping nurses' agency and
resistance at local levels of practice (Britzman, 1991; Hall & Stevens, 1991; Rogge,
1986). The following section provides a theoretical underpinning for constructing
nurses' in/visible practice as a socially defined and distributed phenomenon.

**A Sociocultural Approach to Nurses' In/Visible Practice**

During the last two decades, various models of so called "human thinking" have
been proposed within the parameters of an "information processing" theory of
cognition (e.g., Anderson, 1990). Such models typically model posit a number of
mechanistic mental structures, as well as a number of general and domain specific
operations/strategies for thinking (Anderson, 1990). In effect, such models aim to
explain the internal workings of the "mind." But, framing definitions of thinking
around the notion of individually owned or objectified mental processes only serve
to limit our understanding of human thought. Such analyses, say little about how
social contexts shape minds (Bruner, 1986; Lave & Wenger, 1991; Wertsch, 1985
& 1991; Vygotsky, 1978). Given this profound constraint, I will focus on "how"
social contexts shape what we typically refer to as "the mind." The importance of
social contexts in the formation of thinking will unfold, here, with the help of
Vygotsky's (1978) and Wertsch's (1985 & 1991) theoretical perspectives. Arguing
that thinking has social and not individual foundations, sociocultural theorists work
from a(n) inclusive and contextual approach to human thought; an approach which simultaneously considers the person's thinking and his/her social experiences (Wertsch, 1985 & 1991; Vygotsky, 1978). From this perspective, thinking is placed in relational and contextual terms which opens the door to a more complex and multifaceted interpretation of human thought (Bateson, 1979; Belenky, Clinchy & Tarule, 1986; Lindesmith, Strauss & Denzin, 1988; Rohrkemper, 1989).

Central to this sociocultural approach to thinking is an account of the role of language. Both Vygotsky (1978) and Wertsch (1985 & 1991) view human thinking "as a world processed through language," (Bruner, 1986, p. 70); and argue that language is not most productively viewed as "neutral" or "innate" but, rather, as a product of our specific historical and cultural locations. From this perspective, language and the ways that we use it reflects our culture's storehouse of historical knowledge (Luria, 1979). As a point of clarification, here, this discussion is not meant to suggest that to be a member of a particular society is to know all, or to suggest that people are the passive recipients of historiocultural knowledge. Nor is this an attempt to suggest that all people think in the same fashion. What it is meant to suggest is that people are instrumental. In other words, they have the mental capacity to mediate experience, but the origins of these capacities, the ways in which we learn to think, are reaffirmed, limited and empowered by our experiences within the social context -- our social interaction through language (Bruner, 1986; Luria, 1979; Wertsch, 1985). Thus, the "mind" cannot be conceived as something that works in isolation "inside the skull," but rather as something that extends to and develops within a social context. The "mind," construed thus, is socially constructed and distributed (Lindesmith, Strauss & Denzin, 1988). To expand upon the notion of the socially constructed mind, I will discuss two interrelated concepts developed by Vygotsky as follows: 1) the zone of proximal development; and 2) the general genetic law of cultural development. To Vygotsky
(1978), the social context, be it the home, school or workplace becomes an ongoing zone of proximal development (ZPD) (Lave & Wenger, 1991; Rohrkemper, 1989). Specifically, the ZPD represents the gap between what an person can do independently, and what the person can do with the help of others (Vygotsky, 1978). It is a place where mental apprenticeship occurs; a site of learning where with the help of others, a person learns his/her culture's language -- the specific ways and means of knowing that are defined as historically, culturally and institutionally acceptable. A key assumption underlying the ZPD is that the precursors to any person's mental functioning are situated within his/her social context. The idea that the foundations for thinking are contextual is further explained and refined by Vygotsky's general genetic law of cultural development which he describes in the following terms (quoted in Wertsch, 1991, p. 26):

Any function in the child's [or adult's] cultural development appears twice, or on two planes. First it appears on the social plane and then on the psychological plane. First it appears between people as an interpsychological [intermental] category, and then within the child's [or adult's] intrapsychological [intramental] category. This is equally true with regard to voluntary attention, logical memory, the formation of concepts, and the development of volition. . . [I]t goes without saying that internalization transforms the process itself and changes its structures and functions. Social relations or relations among people genetically underlie all higher functions and their relationships.

Vygotsky's law of cultural development makes a number of assertions. First, it underscores the central role of language as the mediator of both "intermental" and "intramental" thought. Second, it goes beyond the notion that intramental functioning involve mere duplications of intermental ones. He underscores the importance of conceptualizing internalization as a process through which intermental activities are reconstructed within intramental ones. This suggests that particular intermental functioning leads to related intramental ones. In this way, the
nature of intramental functioning remains quasi-social; it is derived from the language or "voices" of others (Wertsch, 1991). To make this point clearer, I will use this paper as an example and pose Wertsch's (1991) question: "Who is doing the talking?" (p. 63). Of course, the obvious answer to this question is that I am the author of this text and, therefore, that I am doing the talking. But is this really so? The structure of this paper is modeled upon the university's requirements for such papers, and the constraints delineated within Publication Manual of the American Psychological Association (1983) guidelines. These standards for writing represent a particular discourse that is based upon specific and situated normative assumptions. In addition to deriving the structure of this paper from such locations, I am also intertextually using the knowledge of the authors cited in the text of this paper. Thus, the research question I am asking as well as the structure and content of this paper has its roots in a particular social context. Returning to the question: "Who is doing the talking?" I shall answer it here, provisionally by saying that I am doing the talking, but my voice has been shaped by, and superimposed over, the voices of many (Wertsch, 1991).

Third, although Vygotsky's law of cultural development seems somewhat politically neutral, the social contexts are not necessarily liberating; oftentimes, they become restrictive through prescriptive norms that define acceptable forms of thinking and action. I shall use my paper writing example to expand upon this point. Besides adding credence to the idea that the mind is socially constructed, this example also speaks to a broader issue and to the heart of this work. It underscores the idea that particular modes of thinking, like the way to structure a research paper, must meet some culturally acceptable norms in order to be seen as valuable (Aronowitz & Giroux, 1991; Hubbard, 1988; Lather, 1991; Wertsch, 1991). These norms become unquestionably predominant and in this process, hegemonic; they assume that there is only one right way, even though there are possible and
feasible alternatives (Goodman, 1989; Gramsci, 1988; Wertsch, 1991). And the consequence for violating these norms, like using an alternative way for presenting a research paper, would surely result in some form of social sanction (e.g., the rejection of the work). But, of course, given the right set of social circumstances, people do begin to question norms like these, and do learn to explicitly or implicitly resist and violate them (Lewis, 1990; Wertsch, 1991). Thus, the idea explored in this thesis of nurses' in/visible practice arises from a lived commitment to transformative resistance (Lather, 1991; Weiler, 1988).

In keeping with the sociocultural traditions of Vygotsky and Wertsch, the intent of this literature review is to establish the historical, cultural and institutional precedents of nurses' contemporary in/visible practice. In so doing, this analysis focuses on the language or "discourse" that purports to describe nursing practice. By focusing on language, I will attempt to expose the particular social norms or conceptual filters that place selective attention on particular aspects of nursing practice, while ignoring and silencing others (Wertsch, 1985 & 1991). In addition, where the historical texts allow, I analyze aspects of nurses' practices that focus on their agency and resistance to specific oppressive social circumstances.

Before I begin, however, it is important that I make explicit particular assumptions about history and language that I am using to guide this historiocultural review. History is here viewed as "stories a culture tells itself about itself" (Lather, 1991, p. 2). The notion of history as "stories" is an inviting one, as it assumes that each rendering of history is incomplete. No story can tell all and, in this sense, history is always fragmentary in nature (Foucault, 1980). It also assumes that any account of history is constrained by the author's position in the culture, his/her conceptions about the audience to whom (s)he is writing, and by the language and literary devices that (s)he uses (Van Maanen, 1988). The following history of Canadian hospital-based nursing has been written by people in
dominant positions (e.g., priests, physicians, sociologists, as well as nursing theorists and researchers) "for" nurses. With this in mind, my guiding questions for interpreting and trying to uncover the thinking and experiences of nurses across time are: "What is missing from these historical texts?" and "Why is the unsaid important?" (Aronowitz & Giroux, 1991). I do not intend to provide an extensive historical review; however, I will focus on historical fragments that seem to be noteworthy, precedent setting or cyclical.

**Historical Context: A Past for the Future**

Through Jacques Cartier's numerous voyages across the Atlantic, in the 1500's, France laid down its colonist rights to Newfoundland and vast areas along the St. Lawrence River (Kerr, 1988a). However, it was not until the next century that Samuel de Champlain selected Quebec as the first Canadian site for colonization, and that nursing began within a specifically Canadian context (Kerr, 1988a). Within these beginnings, I discuss the French and British origins of Canadian nursing, and select a few textual fragments to discuss how this discourse constructs and constrains nursing practice.

**Early French Nursing Traditions**

The French monarchy, in consultation with the Jesuit priests, decided that the establishment and organization of health care services, in the new land, should precede widespread colonization (Kerr, 1988a). To achieve this goal, the first doctors (some with their wives), and Jesuit priests arrived in the late 1610's, and eventually established a "sick bay" with immigrant male attendants at a garrison in Port Royal (Gibbon & Mathewson, 1947). At this point, these people provided "health care" to Native Indian populations. This latter statement does not suggest that Native Indians did not have their own forms of health care; indeed, they practiced extensive healing rituals, and used herbal remedies for various ailments.
(Gibbon & Mathewson, 1947). But, as the priests explored the country side on their mission to spread Christianity to these people, they idealized and legitimized their religious practices by relating them to the "care and cure of the sick." As Parkman (1897, p. 179) wrote:

The Jesuits singly or in pairs traveled in the depth of winter from village to village, ministering to the sick and seeking to commend their religious teachings by their efforts to relieve bodily distress.

As the Jesuits continued their ministry and "care of the sick," they were increasingly concerned about the "propriety" of men, like themselves, caring for sick women. As Father LeJeune (1634) wrote in the Jesuit Relations (Jesuit journals that were sent back to France):

As to men, we will take care of them according to our means; but, in regard to women, it is not becoming for us to receive them into our houses (quoted in Kenton, 1925, p. 49).

When the news of this concern reached France, a call for nurses to immigrate to the new world ensued. At this time, "young women of good character, who came from reputable families" were recruited by the Catholic Church and were trained as both nuns and nurses (Kerr, 1988a, p. 11). In 1634, three nuns/nurses landed in Quebec. Kenton provided this account of the circumstances upon their arrival and in the ensuing months (1925, p. 157):

Scarcely had they disembarked before they found themselves overwhelmed with patients. The hall of the hospital being too small, it was necessary to erect small cabins, fashioned like those of the savages, in their garden. . . The sick came from all directions in such numbers, their stench was so insupportable, the heat so great, the fresh food so scarce and so poor, in a country so new and strange, that I do not know how these good sisters, who almost had no leisure in which to take a little sleep, endured these hardships.

Beyond the explicit descriptions of the environmental conditions within this text, there are some glimmers of the social values pertaining to nurses of this time.
Nurses were supposed to sacrifice their own needs for the sake of their patients. This notion of self-sacrifice appears to be a universal theme, which transcends historical as well as sociocultural nursing contexts (Aaronson, 1989; Gibbon & Mathewson, 1947; Growe, 1991; Melosh, 1982; Reverby, 1987). Although the above author writes in an empathetic tone, he is silent about: 1) the courage that these women must of had to travel to a(n) "new and unknown world;" 2) how these nurses cared for their patients; and 3) what they thought and felt about their circumstances. The latter point tends to be consistent in most historical writings about nursing (Jones, 1988). There are descriptive images of nurses, but no insights into the particulars of their practice or discussions of what their nursing experiences meant to them.

In the subsequent years leading up to the Seven Year War (1756-1763) between the English and French, immigration and health care services markedly increased. Two hospitals were established under the Catholic Order at Quebec in 1639 and at Montreal in 1644, and were both called Hotel Dieu (Dock, 1920). The widespread immigration of initially men followed by an influx of young women who were to become these men's wives, brought numerous epidemics of small pox, yellow fever, plague, and so on. Typically, these diseases were introduced to the New World by the passengers from Old World ships. The worst case on record was of a small pox outbreak, occurring in 1703, which killed 25 percent of the nuns at the Hotel Dieu of Quebec. As the archivists of the Hotel Dieu recounted (quoted in Gibbon & Mathewson, 1947, p. 35):

Our sisters fell ill in such numbers from the very first that there were not enough of those who were to look after the infected cases in our rooms and wards. We accepted the offer of service from many good widows.

Beyond the horrific circumstances described in this text, it is also important to note that additional lay nurses were selected on the basis of their "single" or
"widow" status. Nursing, for the nuns and lay women alike, was supposed to be a "calling" far beyond husband and most wifely obligations; and, at this point, nursing was construed to be a "self-sacrifice" extending beyond life itself (Dock, 1920). The former theme strongly reemerges in Florence Nightingale's writings, and follows nursing up until the 1960's (Dolan, 1979).

During the Seven year war, the nuns in Quebec were close to the front lines of the war. In fact, the final battle was literally fought around their hospital. Importantly, the nuns administered care to injured soldiers of both English and French armies (Gibbon & Mathewson, 1947). Although they must have feared retribution from the French government, the nuns' sense of "caring" seemed to take precedence over competing political agendas. Historical texts of this time tend to represent these nuns as "angels of mercy." However, this characterization obscures the fact that these women were actually exerting a form of autonomous regulation over their nursing practice, and actually resisting their government, in that they were caring for "enemy" soldiers (Kalisch & Kalisch, 1978; Morawski, 1988).

The history of the early French traditions of nursing care in Canada is quite prestigious. French nursing, under the Roman Catholic Church, brought to Canada: 1) a philosophy of humanitarianism; 2) a legacy of high status which had the autonomy to question; 3) a fortitude to undermine political authority; and 4) a training program, which had "invented" sanitary practices to prevent the spread of disease (Gibbon & Mathewson, 1947). The latter point was especially important in relation to the many epidemics. There was, for an example, an outbreak of plague introduced to the New World by a disease infested ship in 1740. The Hotel Dieu admitted 241 plague stricken patients of which only 28 died (Gibbon & Mathewson, 1947). This low death rate (12%) was solely attributed to the nuns' sanitary practices. The death rate of those in the community was astronomically higher. In
addition, the physicians mostly practiced in the community and, as a consequence, the nuns had autonomy over the administration of their practices hospitals settings (Gibbon & Mathewson, 1947). The key elements of hospital-based nursing within this period are that the nursing profession was overwhelmingly represented as female, and with strong affiliations to the church. Nursing, thus construed, typifies the female traits of "caring and compassion," and the church's requirements of "self-sacrifice, altruism and chastity" (Church, 1990). However, unlike the British tradition, which follows, nursing has some elements of autonomy, respect and political authority.

**Early British Nursing Traditions**

In contrast to the French, the British who subsequently settled in the Maritimes, Ontario, and the West, brought a significantly different approach to nursing. During the reign of Henry VIII (1491-1547), the Catholic Church was renounced and the nursing orders of nuns, who trained and worked in the large London hospitals, were asked to leave (Jamieson & Sewall, 1940). Their replacements were typically poor and illiterate women who were put to work without any training. In the absence of the nuns' guidance and expertise, hospital care deteriorated. As a consequence, these women were construed as "incompetent," and the hospitals in which they worked were now called "death houses" (Gibbon & Mathewson, 1947). At the same time as hospital nurses were to a large extent discredited, the women healers (lay nurses) in the community received ongoing praise and support from the peasant groups who received their care (Gibbon & Mathewson, 1947). Lay nurses were illiterate, and their nursing education was informally handed down from generation to generation through story-telling practices. These nurses "discovered" a number of "tried and true" herbal remedies, some of which are still
being used today (e.g., digitalis for heart problems, belladonna for abdominal spasms, ergot for pain) (Ehrenreich & English, 1973).

Given their compassionate and, oftentimes, successful care of the sick, these nurses had developed a strong power base within the peasant populations; a power base that dramatically clashed with the upper class' designs to establish male physicians as the only valid health care providers (Bunting & Campbell, 1990). To erode the power base of women healers and other politically powerful women, the church and state typically labeled them as "witches." Church sermons were scripted around the "witch persona," with the intention of frightening the general public into believing that these women were evil. The church described them as follows [Kramer & Springer, 1928 (1484), p. 25]:

All witchcraft comes from carnal lust, which in women is insatiable. . . Wherefore for the sake of fulfilling their lusts they consort with devils. . . it is sufficiently clear that it is no matter for wonder that there are more women than men found infected with the heresy of witchcraft. . . And blessed be the highest who has so far preserved the male sex from so great a crime. . .

What this text makes clear is that the devilish "amoral" character of women is "contagious," and that men through their relations with women can become infected with this "amoral disease" just as Adam was represented as having been afflicted by Eve in the Garden of Eden (Ehrenreich & English, 1973).

For their supposed crimes of witchcraft elderly women, young women and female children were usually burned live at the stake. Common charges against these women included: first, sexual crimes against men --- basically, they were accused of possessing an agentive form of female sexuality; second, crimes related to being organized --- which usually amounted to organizing social gatherings; and third, crimes related to the possession of magical powers for healing---oftentimes, woman healers were specifically charged with having medical
or obstetrical skills (Ehrenreich & English, 1973). Sadly, the witch/nurse of these
times was usually poor and illiterate; thus, her history was only recorded through
the eyes of the educated elite, in fact, her persecutors.

The witch hysteria in England started in the mid 1600's and lasted throughout
the 1700's. The empowerment of women by the peasants represented a political,
religious and gender threat to the upper class and the church (Daly, 1978;
MacPherson, 1985). They orchestrated the fearful witch persona, that ultimately,
legitimized the slaughter of "millions" of women, whose only crimes were political
activism and caring for the sick poor. Although the medical profession reaped
some of the benefits of the witchcraft campaign, namely the suppression of the
female nursing profession, it was not of their own design (Dolan, 1978; Ehrenreich
& English, 1973; Jones, 1988). The witch hunts were "...well-ordered, legalistic
procedures that were financed and executed by the church and state institutions"
(Bunting & Campbell, 1990, p. 17), with the general goal of maintaining social
control -- that is to say, maintaining the various subservient roles of women (Daly,
1978). And, the social construction of the nurse in the hospital setting served as a
means to maintain this social order.

In the 1800's, poor and illiterate women were still working in deplorable hospital
conditions. In the hospital wards, overcrowding (some open wards held as many
as 100 patients) created the need to put beds so close together that it was
impossible to clean between them and, as a consequence, garbage and excreta
collected. The mattresses were either straw or feathers and were not always
changed between patients. These dirty beds promoted the growth of many
pathologic organisms as well as ticks, bedbugs and roaches (Jamieson & Seawall,
1940). In addition, popular medical treatments of this period included blood letting
and purging (Ehrenreich & English, 1973). Thus, poorly kept beds, floors and walls
were further contaminated with blood and feces. The women who worked in these
conditions received very little pay, yet were expected to work 12 to 48 hours in a row (Jamieson & Sewall, 1940). Moreover, their reputations were maligned as "drunken, heartless, amoral and incompetent" women (Jones, 1988). Dicken's [1968, (1844)] character of "Sairey Gamp" in his novel *The Life and Times of Martin Chuzzlewit*, seems to be exemplary of common views about nurses of this era. Like the witch persona, this character was more concerned with her personal and sexual pleasures than with the welfare of her patients (note: this character/image of the nurse resurfaces in the 1970's) (Kalisch & Kalisch, 1978; Jones, 1988). This, however, was only one perception of reality. According to another source (London Times, 1857), these women were represented as the victims of their class and gender (quoted in Gibbon & Mathewson, 1947, p. 110) as follows:

They [nurses] were sworn at by the surgeons, bullied by the dressers, grumbled at and bossed by the patients, insulted if old and ill-favoured, talked flippantly to if middle-aged and good-humoured.

In this text, nurses are "not" portrayed as having deficient character traits (e.g., like the Sairey Gamp image), but rather as a group of women who have had particular oppressions imposed on them (Melosh, 1982). Nurses are not creators, but rather recipients of these forms of oppressions.

**Returning to Canada**

While the French Roman Catholic nuns played a major role in the establishment of early Canadian hospitals, the British Anglican, Presbyterian, and Methodist Churches were more involved with the establishment of hospitals in the Maritimes, Prairies and British Columbia (B.C.). Although Canadian nursing was spared from "witch hunts," the British legacy of poor hospital conditions and the Sairey Gamp image became integrals part of Canadian nursing history.

By the 1800's, Canada's major cities were settled by Loyalists who had left the United States after the Civil War, and by immigrants from mostly the British Isles
and France (Kerr, 1988c). This constant immigration, coupled with the industrial revolution which encouraged people to leave their country homes and move into the cities, created overcrowding. As a consequence, it was difficult for cities to develop and maintain adequate public sanitation. Thus, many epidemics broke out, because of contaminated water supplies (Kerr, 1988c). These persistent epidemics resulted in overcrowded hospitals (Gibbon & Mathewson, 1947).

The dismal state of the British hospitals was paralleled in Canada. Lay women who were, for the most part, poor and illiterate worked long hours in overcrowded and filthy wards (Kerr, 1988c). And like their British counterparts, they were described in terms of the "Sairey Gamp" image, as evident by the following text written by a physician (Gibbon & Mathewson, 1947, p. 146):

> In my day, age and frownsiness seemed the chief attributes of the nurse, who was ill-educated and was often made more unattractive by the vinous odour of her breath. Cleanliness was not a feature, either of the nurse, the ward or the patient... Armies of rats frequently disported themselves about the wards, and picked up stray straps left by the patients, and sometimes attacked the patients themselves... Many of them [meaning nurses] were so well described by Dickens...

Although this physician makes explicit the terrible hospital conditions of the mid 1880's, he has no sympathy in his voice for the nurses or, for that matter, the patients. It is as if the nurses were "responsible" for these conditions, when in fact, they had nothing to do with creating them. Given that they worked up to 19 hours a day, it seems implausible to suggest that these women had the time or the inclination to enact the "Sairey Gamp" image (George & Larsen, 1988; Gibbon & Mathewson, 1947).

In these historical fragments, I have addressed the origins of Canadian nursing practice. In these discussions, the French nurses have resisted the political agenda of their government, and discovered the sanitary practices, which are still being implemented today. In addition, the British lay nurses have pioneered some
of the drug therapies still in use today. However, this heritage of creativity is muted by or overlaid with the discursive themes of amorality, self-sacrifice and altruism. As hospital conditions deteriorated, these themes become instrumental in silencing nurses' forms of resistance, and in silencing the practices that they may have invented (George & Larsen, 1988). The next section presents a discussion of Florence Nightingale's impact upon nursing practice. As this discussion unfolds, I interconnect the impact of the "witch hunts" and "Sairey Gamp" image on Florence Nightingale's designs for nursing education, administration and practice.

**Florence Nightingale**

No history of nursing, be it British, American or Canadian, can be put into perspective without an understanding of Florence Nightingale's influences. Nightingale's prescriptions for nursing education, administration and practice continue to have profound impacts on contemporary nursing practice. Thus, to understand today's renderings of nursing practice, it is important to trace the history that influenced Nightingale's reforms to British health care.

Florence Nightingale was born into an upper class English family and, through the help of her father, received an extensive classical education (Welch, 1990). Although her written work spanned across numerous fields including translations of Plato, bio-statistics, children's stories and, of course, accounts of nursing (Whittaker & Olesen, 1964), there are two early themes that merit special attention with respect to her influence upon nursing: women's rights and faith in God. In her early writings in the *Cassandra*, Nightingale (1930) voiced her frustrations with society's disregard for, and suppression of, the gifts and talents of women, as follows: "why have women's passion, intellect and moral activity. . . been ignored . . . there is no place in society where these talents can be exercised" (p.395-396). The other important theme found in her early work was that of her relationship to
God (Corbett, 1990). In 1837, she reported in her diary a "vision from God" that convinced her to devote her life to "God's" service (Cook, 1913).

Nightingale introduced herself to nursing education by, first, attending the Institution for Nursing Deaconess in Germany. Finding this education less than adequate, she then went on to the Paris hospitals and studied with nuns (the same orders that had originally settled in Quebec). Here, she learned about the sanitary practices that she eventually operationalized in the Crimean War (Gibbon & Mathewson, 1947).

In 1854, persistent reports of the conditions at the Scutari hospital (in the Crimean) flowed back to England. Through the influence of her friend, Sidney Herbert the Secretary of the War, Nightingale was commissioned to establish better hospital conditions (Chua & Clegg, 1990). She and 38 other nurses went to the Crimean and, after their establishment of sanitary practices, the mortality rate dropped from 47 percent to less than three percent (Gibbon & Mathewson, 1947). The news of this momentous success rapidly returned to England, and Nightingale became a celebrity.

In the Victorian era, the main literary themes were romanticism and humanitarianism, and Nightingale's Crimean mission appealed to these popular themes (Whittaker & Olesen, 1964). As a result, she received many literary tributes including Longfellow's poem (1857) "Santa Filomena," which represented her as nothing less than a "saint" (quoted in Jones, 1988, pp. 237-238). In this poem, Nightingale was depicted as a heroine -- an "angel of mercy" of the sick and wounded men who sacrificed life and limb for their country. However, the other metaphor operating in this text was the extension of the Victorian mother role (Reverby, 1987; Welch, 1990). Instead of caring for her own sick children, this nurse was caring for the sick and injured sons of England.
Upon her return to England, Nightingale was less concerned about her literary accolades and more concerned about the "incompetence" of the Crimean nurses. In writing to a friend, she described these women as needing "constant supervision" and "discipline;" they were "unable to learn from experience," and "incapable of autonomous thought" (Cook, 1913). These writings, which in essence built a deficit model for nurses, were an extreme departure from her ardent concerns for the rights of women found in the *Cassandra*. Given the conditions she witnessed in the Crimean War and her beliefs about the incompetence of nursing personnel, Nightingale, now, thought that the health care of British people and service to God should take precedence over the women's rights (Nightingale, 1954; Palmer, 1977). Put another way, she thought women's rights must be sacrificed for the greater Christian good -- better hospital care for all British citizens. This transformation in her thinking had a powerful impact on how she set up hospital-based nursing education and administration.

In 1860, Nightingale opened a two year nursing education program at the Saint Thomas Nursing School. Here, she instituted a "militaristic discipline" and a "moral code" that reflected her experiences in the Crimean as well as her religious beliefs (Pelley, 1964; Stevenson, 1990). Her nursing students, whom she called "probationers," underwent a rigorous training program, and devoted 12 hours during the day or night to schooling (Nightingale, 1954). Students' ward work was under the direct supervision of experienced nurses. This form of training was akin to the apprenticeship models that were popularized by trade occupations of this time (Chua & Clegg, 1990). Students spent most of their time on the drill and practice of numerous psychomotor skills (e.g., dressings, applying leeches, making beds, etc.), as evident by the performance appraisal form found in Table 1 (see section entitled Clinical Performance p. 23).
Table 1: Performance Appraisal Criteria For Nursing Students at the Nightingale School.

**Moral Character:**

1. Sobriety  
2. Honesty -- especially as to taking petty bribes from patients.  
3. Truthfulness

**Clinical Performance:**

1. Punctuality--especially as to the administration of food, medicine and wine  
2. Quietness  
3. Personal neatness and cleanliness  
4. Dressing of blisters, burns, sores, wounds, fomentations and poultices  
5. Applying leeches, internally and externally  
6. Enemas for men and women  
7. Management of trusses and uterine appliances  
8. Rubbing body and extremities  
9. Moving, changing, cleaning, feeding, and preventing bed sores of helpless patients.  
10. Making bandages and lining splints  
11. Making beds  
12. Waiting for operations  
13. Sick cooking--making gruel, arrowroot, egg flip, puddings and drinks  
14. Cleanliness of utensils for cooking and secretions  
15. Keeping the ward fresh  
16. Observations of the sick -- secretions, expectorations, pulse, skin, appetite, intelligence, delirium, stupor, breathing, sleep, states of wounds, eruptions, effects of diet, stimulates and medicines, and signs of approaching death

- On each clinical criterion, a student received an (E) for excellent or an (I) for imperfect.

Item 16 in Table 1 (observations of the sick), was not meant to suggest that students or, for that matter, nurses were "never" to consider making a medical diagnosis. This function was the sole right of the physician. As Nightingale wrote (1954, p. 165):

A nurse should never diagnose. . . A nurse who realizes her part of the work may be of invaluable service to the doctor and the patient. . . We nurses are and never will be anything but servants of the doctors and good faith servants of the doctors we should be, happy in our dependence which helps accomplish great deeds.

As the above quote indicates, Nightingale saw the role of nurses as "passive." Nurses were the vehicles "through which" physicians learned about patients' symptoms and, then, drew the appropriate conclusions. This idea polarized the physician-nurse relationships in two ways. First, it divided nurses' work into acts of "mindless doing," and physicians' work into acts of "thinking" (Reverby, 1987; Stevenson, 1990: Welch, 1990). Basically, nurses were to have "good faith" and, thus, never think about or dare to question the conclusions of physicians. Second, nurses' roles were not autonomous but, rather, "subservient" to that of physicians. Thus, Nightingale reified Victorian era definitions of gender roles, seeing female nurses as subordinate to male doctors. In addition, the polarization between nurses and physicians was symbolized by the clothes they wore (Goffman, 1956 & 1961). The above reference to the image of nurses as "servants" was reinforced by their clothing. Students of the training school wore white frilly starched aprons that tied into a bow in the back, and a rounded white linen hat (Cook, 1913). This style of uniform and hat closely resembled those worn by servants who worked for the upper class (Dolan, 1978; Jones, 1988). Furthermore, like the military, the nurses' uniforms indicated rank. Students' uniforms were of a different colour and style than those of graduate nurses. In contrast to nurses, physicians simply wore their everyday clothing to the hospital.
The "witch hunts" and "Sairey Gamp" regime, which were particularly devastating to nursing, played major roles in Nightingale's methods for reforms. Learning from this history, she used two general strategies to uplift nursing: 1) make it nonthreatening, especially to medicine and the church; and 2) make it into a moral domain (Melosh 1982; Stevenson, 1990). As discussed in the last few paragraphs, Nightingale defined nursing in subservient terms in relation to medicine. This strategy served to offset any concerns that doctors might have about maintaining their dominance in health care and, also, served to legitimize the profession by reference to a "higher authority." The latter point was consistent with the "ideologies of work" of this period (Chua & Clegg, 1990).

Using the second strategy, that of making nursing moral, Nightingale refused to admit any women into her training program who appeared to resemble the "Sairey Gamp" image. She frankly wrote: "I must bar these fat, drunken old dames." (quoted in Gibbon & Mathewson, 1947, p. 110). Although she placed no admission restrictions in relation to class, religion, or race, Nightingale only admitted women who were "single and of high moral character" (Nightingale, 1859 &1954). She enforced this moral standard throughout the program, as evident in the performance appraisal form (see Table 1: Moral Character section, p. 24). Any breach in sobriety, honesty or truthfulness was grounds for automatic dismissal (Nightingale, 1954). In addition, Nightingale required "all" students to live in a supervised residence on the hospital grounds. This ensured the sexual propriety of a convent (in heterosexual terms), and served as a recruitment strategy to establish respectability, so that women from "good homes" (e.g., upper class) would be attracted to the school (Chua & Clegg, 1990). The living-in system also excluded married women and widows from the school (Nightingale, 1954). Thus, like for the nuns, nursing was a calling that went before husband, and family obligations.
Through the efforts of Nightingale to reverse the Sairey Gamp image, nursing became a socially acceptable form of work for women of all classes. However, it was the upper class women who were promoted within the nursing departments of hospitals (Warburton & Caroll, 1988). As a point of clarification here, these nursing management positions like matron or supervisor, were under the authority of male hospital administrators and under the supervision of physicians (Warburton & Caroll, 1988). It was basically the same set-up as the male/priest and female/nun hierarchies found within the church (Reverby, 1987). After graduation, these upper class women rapidly became heads of wards or even heads of nursing departments (Chua & Clegg, 1990). Although the female hierarchies expanded within nursing departments, the division of labour was based upon class distinctions: the upper class nurses were administrators; and the lower class nurses were "ward workers" who provided direct patient care (Reverby, 1987; Warburton & Caroll, 1988). Like their relationships with physicians, ward nurses were supposed to be "subservient" to their elite bosses. "Unquestioning loyalty" and "silent obedience" were the "militaristic" prerequisite traits of the "good" ward nurse (Chua & Clegg, 1990; Reverby, 1987; Stevenson, 1990). In public, hospital administrators spoke of nurses' work in terms of performing "distinctly women's work," comparing it to "...mothering adults who were, when sick, all babies;" and authors spoke of the profession in terms of the "...quick eye, the soft hand, the light step, and the ready ear of woman" (Chua & Clegg, 1990, p. 140).

Nightingale defined the nurse as female and nursing as an art, rather than a science (Baly, 1986 & 1989). It was the practical application of female traits dedicated to the service of humankind (Mellar, 1989; Nightingale 1859 & 1954). In essence, she professionalized the domestic roles of the Victorian woman (Hughes, 1990). The popular conception of a "female nurse" became a kind of metaphor for "mother;" the "male physician" became a metaphor for "father;" the "patient"
became a metaphor for "child;" and the "hospital" became a metaphor for "house" (Ashley, 1976; Schattshneider, 1990). Although Nightingale dramatically reformed the hospital system for British citizens, it was paradoxically at the expense of nurses' and women's rights. In her later writings, she admitted to this last point, as follows: "I am brutally indefinite to the wrongs of my sex" (quoted in Cook, 1913, p. 92). Unlike other women reformists of the time, she spoke in the language of "duty" and not in terms of "rights" (Reverby, 1987; Welch, 1990). In fact, her model for nursing was built upon the concept of militaristic duty, and duty was interpreted, here, in terms of an adherence to orders passed through the hierarchy of female administrators and male physicians. Nightingale left the nursing profession dominated by physicians, and hospital bureaucracies (Welch, 1990). The discussion that follows addresses Nightingale's specific impact on Canadian nursing.

**Canadian Adoptions and Adaptations**

News of improved hospital conditions, nursing education and patient care reached Canada directly from England, and indirectly through the United States. Using a Nightingale "blueprint," the first school of nursing was established in 1874 at St. Catherine's (Gibbons & Mathewson, 1947). Two nurses who had graduated from the Nightingale program assisted with the school's educational development and implementation. Subsequently, schools opened at Toronto General Hospital (1881), and Montreal General Hospital (1884) (Gibbon and Mathewson, 1947).

In Canada, the first nursing schools were attached to hospitals and were financially dependent upon them, unlike Nightingale's school, which had financial independence and educational autonomy (Gibbon & Mathewson, 1947; Nightingale, 1954). Hospital administrators soon recognized the advantages of having a nursing school, as it provided them with a cheap labour force of young,
disciplined women, in exchange for room, board and education (Reverby, 1987; Wotherspoon, 1988). Nurses-in-training worked on the wards for up to 19 hours a day (Nightingale, 1954; Dolan, 1978). Like Nightingale's program, Canadian nursing schools emphasized discipline, obedience and self-sacrifice (Lock, 1970; Nightingale, 1954). Thus, students' long hours were legitimized as "necessary evils" to meet patients' needs (Reverby, 1987). As one nurse said about her training at Montreal General in 1890:

Thinking of those days so long ago, I think I hear Miss Livingston say --- Nurse the patient ---- the patient always comes first! (Mathewson & Gibbons, 1947, p. 149).

As nursing schools came into being, hospital mortality rates and operating costs dramatically declined (Dock, 1920). Education in sanitary practices, and the use of students to more adequately staff hospitals accounted for these changes. In relation to the former change, nurses were specifically credited with making hospitals safe places for patients. As a result, the profession had become popular. For the women of this time, nursing offered a socially acceptable career, and the demand for nurses' training increased (Gibbon & Mathewson, 1947). By 1909, Canada had 70 hospital-based schools of nursing (Gibbon & Mathewson, 1947). Of these 70 schools, 10 offered a two year program; three offered a two and a half year program; and 57 offered a three year program. By 1930, the number of schools had rocketed to 220 (Wotherspoon, 1988). However, the national and provincial nursing associations had no legal authority to regulate or standardize curricula, or to set minimum lengths of programs for these schools (Dock, 1920). Thus, the quality of education and program lengths varied from school to school.

Interestingly, most of the graduates from these schools rarely found employment in their training hospitals. Hospital administrators continued to exploit nursing students to the point that most hospitals were totally staffed by them. Thus,
graduate nurses turned to the community for work (Growe, 1991). Here, they provided care to patients in their homes, and their practice was, for the most part, independent and autonomous (Gibbon & Mathewson, 1947). Although their nursing practice certainly involved caring for the sick, their major focus was on health promotion (e.g., nutritional consulting and establishing hygienic and other sanitary practices to prevent disease) (Mellor, 1989). But, as would appear inevitable, this changed. Like their historical counterparts in medieval times, community-based nurses posed a threat to doctors' professional practice and control. Nurses' practices were based upon health promotion, which was in direct opposition to doctors' practices of the diagnosis and treatment of diseases (Gordon, 1992).

**Putting Nurses Back Into Their Proper Place -- The Hospital**

The increasing popularity of nursing practice in the hospital and community settings was perceived by doctors as a threat to their control of health care. In relation to hospital-based nursing, one physician wrote in 1906 (quoted in Aaronson, 1989, p. 275):

> Every attempt of initiative on the part of the nurses. . . should be reproved by the physician and by the hospital administration.

As is made evident by this quote, doctors had a strong influence in the hospital setting and, thus, their strategy became one of moving the community nurses back into the hospital where they could be "controlled" (Kalisch & Kalisch, 1978; Melosh, 1982; Wotherspoon, 1988). However, to understand how doctors were able to do this, it is important to address specific parts of their professional history.

By the turn of the nineteenth century, doctors had a fairly strong foothold on health care knowledge and delivery. Pasteur's articulation of Germ theory in 1863; the discovery of anesthetics like nitrous oxide in 1844; and Lister's subsequent
surgical reforms in 1889, established medicine as a science, and created the disease/cure model (Dock, 1920). In addition, physicians had established themselves as the only group who could admit patients to hospitals. In legal terms, they had set up a relationship with nurses called "nested differentiation" (Aaronson, 1989). This concept meant that physicians (the first party) arranged for nurses (the second party) to provide care to patients (the third party) (Aaronson, 1989). Given this legal arrangement, nursing was further legitimized as an appendage of medical practice. But, most importantly, this arrangement provided physicians with absolute control over patients' access to nurses, and nurses' access to patients.

With respect to doctors' goal of confining nursing to the hospital setting, two fortuitous historical events worked in their favour. First, the Weir (1932) and Eaton (1938) reports articulated the inadequacies of hospital-based nursing education programs, and nurses' poor working conditions. In particular, Weir (1932) documented explicit admissions by hospital administrators that their nursing schools' major purpose was to supply hospitals with a "cheap" or even a "slave" labour force. Weir further concluded that these schools had extended students' ward hours to such a degree that they had insufficient time for study or recreation. Reaffirming this latter point, Eaton (1938) documented that students spent anywhere from 12 to 19 hours a day on the wards. He recommended that students' and graduate nurses' work be reduced to eight hours per day. Both of these authors argued that nursing education should be removed from the hospitals, and placed under the auspices of provincial education systems (Wotherspoon, 1988). To prevent this outcome, hospital administrators appeased critics by reducing student and graduate nurses' daily work hours (Wotherspoon, 1988). However, this reduction in hours created a need to employ more nurses (Growe, 1991). The Depression and Second World War created economic hardships for Canadian people (Gibbon & Mathewson, 1947). During this time, a series of social
reforms, including health care insurance plans, were introduced to pacify
generalized public unrest (Baumgart, 1988; Warburton & Caroll, 1988). These
plans included medical care and hospitalization but, interestingly, did not cover
payment for community nurses' care. As a result, these nurses faced
unemployment, and returned to hospitals for their economic survival (Growe, 1991).

As an outcome of the Weir (1932) and Eaton (1938) reports, and as a
consequence of hard economic times, a majority of nurses ended up working in
hospitals. Here, administrators and physicians constructed and constrained
nursing practice (Waitzkin, 1989; Freidson, 1970). The institutionalization of
nurses in hospitals was, for the most part, complete.

For nursing, the movement of the community nurses back into the hospital
setting marked the end of the profession's last arm of independence (Growe,
1991). Community nurses no longer had an autonomous relationship with their
patients (Baly, 1989). In fact as hospital employees, nurses had three competing
and, oftentimes, conflicting loyalties: 1) they were supposed to follow doctor's
orders even though they were not employed by them; 2) they were supposed to
follow administrators' policies and procedures because these people were, indeed,
their employers; and 3) they were supposed to provide the best possible nursing
care, as they were entrusted to do by their patients (Corcoran, 1988; Hutchinson,
1990; MacPhail, 1988; Schutzenhofer, 1987; Slote, 1990). These conflicting
loyalties provide one important basis for nurses subsequent unionization and
labour unrest.

**Unionization and Uprisings**

The infusion of community nurses into hospitals led to widespread criticism of
hospital conditions and functions, which resulted in the development of collective
bargaining units for nurses. Community-based nurses, who had enjoyed a fairly
autonomous practice, were troubled by restrictions placed upon them by hospital administrators, physicians and debilitating working conditions (Growe, 1991). These nurses acted as the catalysts, who encouraged other nurses speak out about their conditions and demand changes. By the mid 1940’s, nurses went to their provincial and national associations to establish collective bargaining units to improve hospital working conditions and salaries (Kerr, 1988b). In 1944, the Canadian Nurses Association approved collective bargaining with two stipulations: first, it was to be formed by the provincial associations; and second, strike action was prohibited (Jensen, 1988). The latter point was overturned in 1972 (Kerr, 1988b). In 1945, the Registered Nurses Association of British Columbia (RNABC) became the first provincial bargaining unit in Canada. They achieved this position rather quickly, because they were afraid that nurses would join the trade unions, which were organizing other hospital employees during this time (Growe, 1991). All other provincial associations slowly followed suit, with the exception of Quebec (Jensen, 1988). By contrast, Quebec nurses went to their association with collective bargaining in mind, but the association refused to support such efforts. In 1946, these nurses turned to the Quebec Federation of Labour (a trade union), and formed one of the most politicized and militant bargaining unions in the country (Growe, 1991).

Although it took 10 years for the RNABC to establish collective bargaining for their nurses, initial results were impressive. The slogan at the time was "Collective bargaining for nurses by nurses" (Jensen, 1988, p. 463). With this process in place, the nurses made 10 major gains, as follows: 1) salaries doubled; 2) job security increased; 3) grievance procedures were established; 4) vacation time increased; 5) communication between hospital administrators and nurses increased; 6) discrimination about hiring married women stopped; 7) nurses with experience and postgraduate degrees received differential salaries; 8) yearly pay
increments were started; 9) nurses received a stronger voice in identifying changes necessary to improve their working conditions; 10) shifts were reduced to eight hours (Hood, 1956). Note that the latter improvement had already been recommended by Weir (1932) 23 years earlier. Although the RNABC members were satisfied with this success, other provincial associations did not do as well (Growe, 1991).

At the same time as RNABC nurses received their collective agreement, other nurses from different provinces expressed disillusionment with their professional associations (Melosh, 1982). These associations were typically comprised of a nursing "elite;" comprised mostly of nurses who worked as hospital administrators. Not all nurses were happy with their collective bargaining arrangements (Growe, 1991). Nurse administrators had the power to hire and fire ordinary nurses, and it seemed that asking administrators to improve working conditions represented a conflict of interests (Growe, 1991). Needless-to-say, some associations did nothing to improve working conditions of hospital nurses until nurses strongly pressured them to do so in the 1960's (Growe, 1991). During this time, nurses were petitioning the courts about this apparent conflict of interests, and in 1973 the Supreme Court ruled that the associations could no longer act as bargaining agents for them. It was, indeed, a conflict of interests (Jensen, 1988). In the following years, nurses established provincial unions that were separate from their professional associations (Kerr, 1988b). The primary difference in the mandates of these organizations is that: 1) the professional association is concerned with protecting the public (from incompetent nurses); and 2) the union is concerned with protecting nurses from poor working conditions (HLRA & BCNU, 1989; Jensen, 1988; RNABC, 1990a). As the nurses were asserting themselves in their workplaces, their professional associations were beginning to assert themselves
within the political landscapes of Canadian health care. Associations were trying to establish nursing as a "legitimate profession."

**Professionalization**

The history of nurses' attempts at professionalization can be viewed as an attempt to duplicate that of physicians. Since medicine was particularly successful at professionalization, nurses have tried to emulate the doctors' strategies, with the assumption that full professionalism will be the outcome (Wotherspoon, 1988). As a consequence, nurses have closely adhered to the criteria within the Flexner report (1910), which was widely credited with finalizing doctors' professional dominance in health care. Flexner's recipe for professional control and autonomy included the following six criteria (1915, pp. 578-581):

1. It is basically intellectual, carrying with it high responsibility.
2. It is learned in nature, because it is based on a unique body of knowledge.
3. It is practical rather than theoretical.
4. Its techniques can be taught through educational discipline.
5. It is self-regulating and well organized internally.
6. It is motivated by altruism.

Of particular importance to professionalization is a relation of autonomy (self-regulation) vis a vis professional education/practice, and the articulation of a highly specialized knowledge base (Abbott, 1988; Baer, 1987; Freidson, 1970). The following discussion will confine itself to these two points. With regard to autonomous regulation of education, the Canadian Nurses Association (CNA), since its inception, has been trying to achieve this goal (Growe, 1991). Like the Canadian Medical Association (CMA), the CNA had set educational standards, but unlike the CMA, they were unable to enforce them because they had no legal control over hospital-based nursing schools (Growe, 1991). In the late 1950's, the CNA commissioned a review of nursing schools, which found that only 16 percent
of schools met their standards, and concluded that provincial associations should have the legal authority to standardize and regulate nursing schools (Mussallem, 1960). The educationally unsound practices of these schools were reaffirmed by the Royal Commission on Health services (Mussallem, 1964). As a result of these reports, nursing education was established in post-secondary settings under the control of provincial governments, and hospital-based programs were eventually phased out. Finally, after years of fighting against the vested interests of hospital boards and physicians, the CNA was able to enforce the very same recommendation that had originally been articulated in the Weir report (1932).

Recently, the CNA and provincial associations have established that a bachelors degree ought be a minimum standard for nursing practice by the year 2000 (CNA, 1984 & 1990). It should be clarified, here, that Canada has had university-based programs since 1919, but for numerous reasons (e.g., under funding, competition with hospital-based programs that offered stipends, society's beliefs about the need for women to receive higher education and so on) these programs have been under-utilized (Baumgart, 1988; Growe, 1991). Even today, only 12.8 percent of nurses have a bachelors degree, while the rest have diplomas from community colleges or hospital-based schools (Statistics Canada, 1986). The strategy for all nurses to have university degrees in order to practice nursing is probably a further attempt to legitimize nursing as a profession (Beletz, 1990; CNA, 1984).

In relation to the second criterion, that of possessing a unique knowledge base, nursing has tried to divorce itself from the medical disease/cure model, and has developed two types of nursing models, as follows: "declarative" and "procedural" (Anderson, 1990; Lister, 1990; Fawcett, 1990). Declarative models are supposed to represent nurses' "world views of patients" (e.g., the patient's physiological and psychological needs and desires), and there are a number these models to choose
from [see Orem's (1985); Roy's (1984); Henderson's (in Adams, 1980)]. Clinical problem solving models like the nursing process, are supposed to represent nurses' procedural or "how to" knowledge (Anderson, 1990; Moorehouse, Geissler & Doenges, 1987; Radwin, 1990). The nursing process is typically represented as having four "stages" in which nurses: 1) assess patients for problems; 2) develop a plan to correct these problems; 3) implement the plan; and 4) evaluate the effectiveness of the plan (e.g., did the patient's problems get better, as a result of the nursing care plan?) (RNABC, 1992; Woolley, 1990). Both types of models represent "grand theories" for nurses' knowledge about patients (declarative), and nurses' clinical problem solving (procedural) (Lather, 1991). As "grand theories" for practice, these models have been developed in the academic community, and are based upon the presupposition that these models can be applied to all forms of nursing practice (Lister, 1990). In other words, irregardless of context, these models posit that nurses will describe and interpret their patients and practices in basically the same ways. However, Tanner's (1992) and Benner's (1992) preliminary research findings suggest that within nurses' personal narratives or phenomenological accounts of their practice, there is no evidence of support for these models. Researchers have found that nurses, in a manner not unlike teachers, speak about their practice in detailed, contextualized and differing ways, which are in direct opposition to the generic and decontextualized assumptions inherent to the current grand theories for nursing practice (Britzman, 1991; Tanner, 1992).

Although it is difficult to argue against nurses' general goal to achieve autonomy and a specialized knowledge base, the reasons underlying the professionalization criteria to achieve this goal seem to have been left unexplored. Socialized to conform to rules, most nursing leaders have never questioned the facts behind the myth of medical professionalization or even why, given the present criteria, it would
constitute a desirable outcome for nursing (Cockburn, 1985; Meyer, 1982; Newman, 1990; Pavalko, 1971; Purcell, 1990; Stevenson, 1990; Roberts, 1983). Instead, they continue to keep a running total on how close nursing is coming to meeting the professionalization criteria, and to this point, nursing has not achieved this goal (Lambert & Lambert, 1989). Nursing is just following the rules set down by their "medical leaders" and, in so doing, nursing has only built a deficit model for the profession. It seems clear that nursing ought, ideally, to generate its own version of, and standards for, professionalization (Abbott, 1988; Becher, 1989; Thompson, 1987).

In this partial and tentative analysis of some historical texts, I have identified a number of themes that obscure or render in/visible the scope and complexities of nursing practice: self-sacrifice and altruism (nurses are angels of mercy); subservience and silent obedience (to people in positions of authority); de-intellectualization (nurses are doers, not thinkers); amorality and chastity (except for the nuns, nurses have questionable characters) (Aaronson, 1989; Chua & Clegg, 1990; Church, 1990; Gibbon & Mathewson, 1947; Growe, 1991; Hubbard, 1988; Melosh, 1982; Reverby, 1987). In the next discussion, I move into the contemporary world of nursing practice. In these discussions, I centre on some of the contemporary social forces affecting nursing, and describe some of the current social circumstances operating in hospital contexts. In addition, questions are raised about how nurses' job descriptions construct and constrain their practice and, thus, promote their in/visible practice.

Contemporary Context: The Past as Present

Feminism and Nurses' Image

Before moving into the hospital setting, I discuss aspects of two contemporary issues which affect nursing: feminism and nurses' image. Although male doctors'
domination of the female nursing profession (98 percent of nurses are women) can perhaps most profitably be represented as a feminist issue, historically feminists and nurses have had, at best, tenuous relationships (Gordon, 1991; Growe, 1991). These relationships have been strained, in part, because both feminists and nurses have seen each other in stereotypical terms (Growe, 1991). Feminists have construed nursing as the profession that most typifies the domestic hand-maiden image of women. At times, they have been impatient with the in-place relationship between a dominant physician and a subservient nurse. In this instance, feminists have viewed nursing as the "ultimate female ghetto," from which women should be encouraged to leave (Vance, Talbot, McBride & Mason, 1985). Occasionally, feminists have, also, ignored the specific contributions that nurses have made to the movement (Bunting & Campbell, 1990). As an example, Judy Chicago's art project "The Dinner Party" gave tribute to many woman who have made important contributions to society, included in this work was Florence Nightingale and Margaret Sanger. Although Nightingale was identified as a medical reformer, policy-maker and statistician, and Sanger was identified as a social reformer, neither of these women were identified as nurses (Vance, Talbott, McBride & Mason, 1985). Nurses have, also, tended to see feminists in stereotypical terms. Nurses have proven cautious vis a vis the feminist movement, because of the misconception that joining the movement meant abandonment of the essence of nursing -- that is to say, abandonment of caring (Chinn & Wheeler, 1985; Gordon, 1991). In recent years, feminists and nurses have overcome some of their misconceptions of each other, and are beginning to work together as allies. The first joint nursing and feminist conference was held at Queen's University in the fall of 1991 (Miller, 1992).

Interestingly, concurrent with the rise of feminism, there has been a demise in nursing's image. The historic "Sairey Gamp" image was reprised under the
contemporary image of "Sex Object" (Kalisch & Kalisch, 1978). This image was especially damaging to nurses, as it promoted myths like nurses lack morality; nurses see nursing as a means to find a man (doctor); and nurses have no sincere interests in their careers. Such television shows as "Trapper John," "M.A.S.H." and "Nightingales" are examples of this image. However, on a defiant note, in 1989, nursing associations in Canada and the United States successfully organized a political lobby that removed "Nightingales" from the air.

The Hospital Setting

In the 1980's, health care came under financial constrains and, in keeping with this trend, the metaphor of hospital as "house" changed to the hospital as "factory" or, more specifically, a cost effective corporation (Curran & Miller, 1990; Foucault, 1980; Kaufman, 1990; Melosh, 1982; Shaw, 1989). During this time, language related to titles of positions within the hierarchy changed. The hospital Administrator's title changed to the "President and Chief Executive Officer;" the Director of Medicine's title changed to "Vice President for Medicine;" the Director of Nursing's title changed to "Vice President for Nursing;" and the Head Nurse's title changed to "Unit Manager" (Curran & Miller, 1990). Nurses were still called nurses, but within this metaphor they, now, were the "workers" in the business of supplying a "cost effective product" -- patient care (Campbell, 1988; Melosh, 1982; Silver, 1981).

Although titles have changed, there is not an appreciable difference in hospital positions and their interrelationships (Melosh, 1982; Murray & Smith, 1988; Zaleznik, 1989). Even though both nurses and doctors have supposedly equal vice president level positions, doctors actually have more power in the organization. These new terms just serve to disguise the same power relations (male/female hierarchies) established by the Catholic Church (male priest/female nun
hierarchies) (Chau & Clegg, 1990; Zaleznik, 1989). Also, the relationships within
the female nursing hierarchy are consistent with the Nightingale period (Chau &
Clegg, 1990). On the whole, vice president and nursing unit managers unilaterally
set policies and procedures that ward nurses must follow (Kane, 1990; Schmieding,
1990). With respect to hospital wards, doctors' and nurses' unequal roles remain
unchanged. Physicians are supposed to have ultimate authority and responsibility
over decisions about patient diagnosis and treatment, while nurses are supposed
to continue in a caregiver role which generally includes patient comfort, monitoring
patient status, providing patient education, and helping the patient and family cope
with their health care problems (Baumgart, 1988; Campbell, 1988; Schutzenhofer,
1987; Waitzkin, 1983 & 1989). In the following sections, I will critique some current
research that addresses: nurse and nurse administrator relationships; and nurse
and doctor relationships.

**Nurses and Nursing Administration**

The quality of the interpersonal relationships between nursing administration and
nurses is an important factor in determining job satisfaction (Curran & Miller, 1990;
Kennedy, Camden & Timmerman, 1990, Nyberg, 1990). Because of the high job
turnover rates amongst nurses, many studies have looked at this relationship in
more detail. Job turnover is defined as the number of resignations of nurses
divided by the total number of nursing staff within a hospital (CNA, 1990). These
studies have found that nurses are dissatisfied with nursing administration,
specifically in relation to: 1) excessive workloads; 2) inflexible shift schedules; 3)
excessive paper work which takes them away from their patients; 4) poor
communication between nursing administration and nurses; 5) lack of support with
respect to interdisciplinary conflicts between nursing and medicine; 6) lack of
opportunities for advancement; 7) lack of reward; and 8) lack of accurate tools to
measure work performance (Alberta Hospital Association, 1980; Barry, Soothill & Francis, 1989; Carson, McGuire & Lamb, 1987; Hiscott & Connop, 1990; Kennedy, Camden & Timmerman, 1990; Kramer & Hafner, 1989; Murray & Frisina, 1988; Murray & Smith, 1988; Robinson & Lewis, 1990; Schmieding, 1990). Most of these studies nicely itemize and categorize the end products of nurses thinking (e.g., their problem representations), but few address the thinking processes or contexts behind these conclusions. As a consequence, these studies obscure the underlying substance and issues behind nurses' thinking, and tend to build deficit models of either nurses or nurse administrators (Campbell & Bunting, 1991; Parker & McFarlane, 1991; Roberts, 1983; Thompson, 1987). In addition, because these studies focus on nurses' complaints, they are silent about the ways in which nurses resist and defy some of these organizational constrains (Lather, 1991; Rogge, 1986).

**Nurses and Physicians**

The historical relationship between nurses and physicians has been construed as physician dominance and nurse subservience. However, in the contemporary context, nurses are socialized upon mixed messages about their relationships with physicians (Allen, Jackson & Youngner 1980). On one hand, in their post-secondary education programs, they are taught to believe that their relationships with physicians are collaborative, meaning that both physicians and nurses have unique knowledge bases, which are of equal value for patient care (Katzman, 1989; Trueman, 1991). On the other hand, when nurses enter the hospital setting, they are oftentimes confronted by physicians who have been socialized to believe that they are the "natural" leaders of the hospital and health care system (Webster, 1988). As a result of these role disparities, interprofessional conflicts develop. Recent studies show that some nurses are verbally abused (being yelled at or
insulted), physically abused (pushed, slapped or struck), or simply ignored by physicians (Diaz & Macmillan, 1991; Katzman & Roberts, 1988; Kennedy & Garvin, 1988; Kerr, 1986). In addition, when nurses report these conflicts to the hospital administration, most of them are resolved in favour of the physician (Murray & Smith, 1988). However, these studies have the same constraints as the ones mentioned in the nurse and nursing administration section. By focusing on products of nurse/doctor conflicts and by constructing nurses as "passive" recipients of "doctor abuse", these studies tend to build deficit models of nurses, and do little to reveal the ways in which nurses resist their historically prescribed subservient roles (Lather, 1991; Parker & McFarlane, 1991; Roberts, 1983; Thompson, 1987).

**Nurses and Medical Technology**

Over the past few decades, hospitals have acquired more and more technology with the intend of innovating and improving patient care (Romano, 1990). However, there is increasing evidence to suggest that in some situations technology does not benefit nurses or patients (Coile, 1990; Lindsay, 1991; Misener, 1990; Morgan, 1983). Nurses, especially in the critical care units, have been encouraged to become "high tech, low touch" caregivers (Growe, 1991; Knaus, Draper, Wagner & Zimmerman, 1986). In other words, nurses must now divide their time between caring for the technology and caring for the patient, and sometimes the technology takes up more time than the patient. For many nurses, time spent with machines only translates into more dissatisfaction with their jobs, as it takes away from the thing they value the most -- their relationships with patients (Moccia, 1988; Robinson & Romano, 1990). Furthermore, nurses witness many situations in which technology can prolong terminally ill patients' lives, but in the process inflict much suffering (Morgan, 1983). It is physicians who order this
equipment, but it is nurses who must watch their patients suffer. When they know there is no hope, and patients have expressed their wishes to terminate the uses of the equipment, some nurses challenge physicians' decisions to keep patients alive. Eventually, the equipment will be shut off but, in the interim, nurses are torn between watching patients suffer, and maintaining the equipment that is creating the suffering (Corcoran, 1988; Hedin, 1989).

In this cursory examination of the contemporary hospital context, I have identified some of the ways, in which current research has socially constructed nurses' relationships with nurse administrators and physicians. These renderings seem to silence any of the nurses' attempts to resist this social ordering. In addition, I have addressed a few examples of how medical technology constructs and constrains nursing practice. The following discussion will describe how nurses have had their practice defined for them by hospital-based job descriptions. These descriptions will be briefly analyzed in terms of how they represent and misrepresent nursing practice (Apple, 1989).

**Nurses’ Job Descriptions**

In B.C., hospitals' job descriptions for nurses are developed from a number of external documents: the CNA Code of Ethics for Nursing (1991); the RNABC Standards for Practice in B.C. (1992); the Canadian Council on Health Facilities Accreditation standards for Acute Care: Large Community and Teaching Hospitals (1992); the Master Collective Agreement (HLRA & BCNU, 1989) and relevant legislation (e.g., B.C. Nurses Registered Act, the Medical Practitioners' Act, the Criminal Code of Canada, the Canadian Charter of Rights and Freedoms etc.). In writing the nurses' job description, a hospital administrator (usually a Director or Vice President of Nursing) incorporates these external documents in a way that meets the hospital's organizational needs. Although there will be some variation in
nurses' job descriptions from hospital to hospital, their primary intent remains the same -- to define and confine nursing practice within the natural social order (power relations) of the organization (Apple, 1989; Ball, 1990; Smith 1987 & 1990). In the following discussions, I outline some of the key components of these job descriptions, and argue that these renderings of nursing practice remain true to the historical myths surrounding nursing, and that they do little to articulate the constitutive work of nurses.

One of the fundamental assumptions embedded in nurses' job descriptions is a(n) decontextualized and individualized account of both professional practice and education (RNABC, 1992). Job descriptions tend to focus on individual attributes and actions without examining the social circumstances that create and define them (Apple, 1988). As a result, nurses' practices are measured against decontextualized standards in their job description, and can be judged in simplistic and dualistic terms: the "good nurse" obeys or conforms to these standards; whereas, the "bad nurse" disobeys or does not conform to these standards. Unfortunately, these types of interpretations tend to build deficit models of nurses who do not "conform" or live up to the established standards, and through the language of deficits, some nurses are blamed for contrary ways of thinking and acting, that are not necessarily good or bad, but need to be situated and explained within the complexities of their work context (Belenky, Clinchy, Goldberg & Tarule, 1986; Wertsch, 1985 & 1991). In addition, conceptualizing nursing practice in individualistic terms, precludes discussions about how nurses collaborate with, and learn from each other (Lave & Wenger, 1991).

Each hospital typically has only one job description for nurses, and this document is supposed to represent all nurses' practices. As a consequence, the job description establishes basic standards for practice and, therefore, makes no distinctions between what constitutes novice or experienced nursing practice
(Apple, 1988; Smith 1987 & 1990; RNABC, 1992). Because of this standardization, it is easy to see how many nurses may never be acknowledged for their clinical expertise (Benner, 1984 & 1992). In addition, these standards are usually written in behaviorist terms. Thus, each standard (statement) about nurses' practices starts with an action verb (e.g., plans, organizes, observes, etc.). The use of this behaviorist language in job descriptions reifies the historical myth of representing nursing practice as acts of "mindless doing" instead of acts of "thinking-in-practice" (Wertsch, 1991).

In articulating what nursing practice is, the content of most job descriptions centres around the two types of nursing models that I have discussed earlier. The first type of model provides a particular "world view" of patients and, thus, is supposed to represent nurses' declarative knowledge. The second type of model provides a particular "world view" of nurses' clinical problem solving and, thus, is supposed to represent nurses' procedural knowledge. As grand theories for nursing practice, these models universalize and, thus, decontextualize nurses' thinking-in-practice (Lather, 1991). Thus, like the historical descriptions of nurses, these models over-simplify and, in effect, de-intellectualize nurses' thinking (Apple, 1989). Furthermore, these models obscure questions about how the diverse specialty areas in which nurses work shape their practice (e.g., Hemodialysis, Bone Marrow Transplantation, Intensive Care, Pediatrics and so on). Surely, a nurse who works with bone marrow transplant patients is going to have different forms of practice in comparison to a nurse who works with hemodialysis patients.

In addition to constructing nursing practice, job descriptions like the historical texts, represent nurses' practices as subservient to those of doctors. Unfortunately, this institutionally sanctioned unequal power relationship denies nurses the right of collaborative practice with doctors, and silences discussions that focus on the
conflicts that arise between nurses and doctors when their plans for patient care differ (Trueman, 1991).

In this chapter, I have argued for an inclusive way of looking at nurses' thinking and practices; one that unites and situates nurses' minds/practices within their social contexts: historical, cultural and institutional settings. By providing a small sample of texts from these social contexts, I have presented aspects of official versions of nursing practice, and have argued that these versions obscure or make in/visible the richness and complexity of everyday nursing practice. Since most authors of nursing history and theory do not actually practice nursing, they tend to provide only decontextualized versions of nurses' practices. As a consequence, there is little understanding about how nurses "actually" practice nursing. Within a specific hospital setting, I am interested in developing a beginning and necessarily partial understanding of nurses' in/visible practice by identifying some disparities between nurses' "actual practices," and their job description's "textual representations" of nursing practice (Apple, 1986; Ball, 1990; Smith, 1987 & 1990). In the following chapter, I will discuss the research methodology that will provide the basis for articulating fragments of nurses' in/visible practice.
Chapter 2: Methodology

In the last chapter, I developed a partial and fragmentary analysis of the historical, cultural and institutional contexts for Canadian hospital-based nursing (Aronowitz & Giroux, 1991; Foucault, 1980; Lather, 1991). In this, I have examined aspects of certain texts, and argued that these texts have consistently misrepresented nurses' work across time, within our culture and institutions. In this chapter, I will develop a framework for research which emphasizes and problematizes nurses' practices within their everyday work life (Smith, 1987 & 1990). By situating nurses in their everyday world, this research seeks to uncover a beginning understanding of the following question: What are nurses' ideas about their in/visible practice within a hospital setting? Nurses' in/visible practice is, here, defined as the disparity between their "actual" practices, and the job description's "textual representations" of their practice (Apple, 1986; Ball, 1990; Smith, 1987 & 1990). As argued in the last chapter, the nurses' job description is a(n) official and contemporary text that limits and misrepresents the breath and scope of nursing practice. Although job descriptions are supposed to represent the art and science of contemporary nursing practice, they seem to remain true to the historiocultural myths of nursing [e.g., the de-intellectualization of nurses' thinking into acts of mindless doing; nurses' subservience to the greater authority (doctor) and so on] (Reverby, 1987; Warburton & Carroll, 1988). To uncover a preliminary understanding of nurses' in/visible practice, I will take a feminist and institutional ethnographic approach; thus, this investigation is interested in the subjective realities and lived experiences of female nurses in a specific hospital setting (Anderson & Jack, 1991; Belensky, Clinchy, Goldberg & Tarule, 1986; Lather, 1991; Personal Narratives Group, 1989a & 1989b; Smith 1987 & 1990; Van Manen, 1990). Prior to detailing the particulars of this research process, I shall begin by
describing the central philosophical and theoretical assertions that underlie this particular methodology.

**Philosophical and Theoretical Assertions**

In the last chapter, one of the basic and critical arguments presented is that people (e.g., priests, doctors, nurse theorists etc.) who purport to understand and write about nursing practice have no intimate knowledge of it. They provide the "official" textual versions of nursing practice; yet, ironically, the positions that they hold are both physically and mentally removed from the everyday actualities of nursing practice (Britzman, 1991; Lather, 1991). Thus, in order to bring to the fore any understandings about nurses' in/visible practice, I must turn to the people who experience practice -- the nurses, themselves (Personal Narratives Group, 1989b). Given this proposition, I am working from the assumptions that nurses are "expert practitioners" in their everyday work world, and that they have intimate understandings of how it is put together, and how their everyday practices are accomplished (Freire & Faundez, 1989; Smith, 1987 & 1990; Strauss & Corbin, 1990; Van Maanen, 1988; Van Manen, 1990). Thus, this research project will focus on nurses' interpretations of their actual practices, and develop preliminary contextualized accounts of nurses' perspectives on their in/visible practice (Anderson & Jack, 1991; Lewis, 1990; Lindesmith, Strauss, Denzin, 1988).

Situating nurses within their social context (the historical, cultural and institutional) is a predominant theme throughout this work and needs to be revisited as the conceptual foundation for the research process. The key point that I am reinforcing here is that learning about what it means to be a nurse is, in itself, a socially constructed and contextually defined activity (Bruner, 1986; Lave & Wenger, 1991; Luria, 1979: Vygotsky, 1978; Wertsch, 1985 & 1991). For the nurses in this study, the hospital is their social context. This context is fraught with
competing and contradictory messages about who nurses are and what they do (Gordon, 1992; Hutchinson, 1990; Melosh, 1982; Moccia, 1988; Nelson, 1988). At the heart of the institutional process of definition is the nurses' job description. Job descriptions not only set prescriptive norms for what nurses should do, but also establish nurses' position at the bottom of the hospital hierarchy (Smith, 1987 & 1990). This document, however, is not a stagnant piece of paper that is placed on a shelf somewhere; it is inherently social, and its language comes alive every time nurses engage in conversations with hospital personal (particularly those in positions of authority) (Apple, 1988; Ball, 1990; Smith, 1987 & 1990). Within these conversations, nurses learn about what is expected of them, and how they should expect to be treated by others (Goffman, 1956 & 1961). Importantly, within this complex web of social expectations, there is another group of voices, those of the nurses' peer group.

In the hospital setting, nurses are socially interconnected by their position at the bottom of the hospital hierarchy, and by their practice. They are members of a group or community that practices nursing (Lave & Wenger, 1991). Within their "community of practice," nursing practice is socially constructed and, as such, does not reside in the "mind" of an individual nurse (on the intramental plane); rather, it is interwoven into the intermental plane, socially distributed amongst nurses (Lave & Wenger, 1991; Vygotsky, 1978; Wertsch, 1985 & 1990). The social nature of this community is similar to Vygotsky's (1978) concept of the zone of proximal development; it is the social place where nurses, with the help of other nurses, learn about their heritage, practice and position within the hospital (Bruner, 1986; Lave & Wenger, 1991; Luria, 1979; Wertsch, 1985 & 1991). In the hospital setting, nurses' ideas about their practice are mediated by the people who live inside, as well as outside of their community (Lave & Wenger, 1991). In particular, nurses' ideas about their practice are mediated by their peers who actually practice
nursing, and by nurse administrators who author the prescriptions for nursing practice in the job description. Within the community of nursing practice, it is the disparity between the "actual," and "prescribed" practices that is the interest of this work. At one level, this research is interested in articulating the "actual" practices that are enacted by nurses, but have been silenced by their job description. At another level, the whole concept of in/visible practice assumes that nurses have developed actual practices that differ from the ones in their job description which, in turn, speaks to their degrees of agency and resistance within their everyday practice -- within their community of practice (Britzman, 1991; Freire & Faundez, 1989; Lather, 1991; Van Maanen, 1988).

The intent of the research project is to seek a beginning understanding of nurses' in/visible practice as socially defined within a community of nursing practice in a specific hospital setting (Lave & Wenger, 1991). In this project, nurses as "experts" of their own work world are asked to share, enact and analyze their "actual" practices to provide a(n) collective, or intermental understanding of their in/visible practice (Lather, 1991; Wertsch, 1985 & 1990; Vygotsky, 1978). This does not mean, however, that there will be one agreed upon or unified perspective on their in/visible practice (Aronowitz & Giroux, 1991; Lather, 1991). Given the complex context in which nurses work, I would expect the opposite -- multiple versions of their in/visible practice. However, within all of these versions, nurses are speaking from the "truths" of their social experiences (Personal Narratives Group, 1989b). To expand upon this last point, I must emphasize that the research question I am asking strives toward a contextualized explanation of nurses' in/visible practice, and not an evaluation of nurses' thinking in relation to dualistic terms like "true" and "false," or "right" and "wrong" (Lather, 1991; Van Manen, 1990). Contrary and differing ways of conceptualizing nurses' in/visible practice cannot be reduced to discrete notions of right or wrong, but need to be situated and
described within the multifaceted nature of nurses' social experiences (Leonard, 1989).

Thus far, I have spoken about some of the central philosophical and theoretical assertions of this research project. However, I have yet to discuss my roles and relationships, as researcher, within this social learning process. The traditional hierarchical relationship between a researcher and a given study's participants is inadequate; in fact it would detrimental to this study. Given nurses' long history of authority figures who speak for them, it would be absurd to place this asymmetrical relationship within this work (Hall & Stevens, 1991). Indeed, it would establish the same social conditions that, as I have argued, promote nurses' in/visible practice.

Instead, the research process described here was developed and implemented within a horizontal and, thus, a democratized relationship across the traditionally hierarchized roles of researcher and (nurse) participants (Lather, 1991). Within this social arrangement, all involved became co-researchers and collaborators in this investigation. Besides participating in the data collection phase, the nurses had equal input into the data analysis phase (Hall & Stevens, 1991; Lather, 1991; Mishler, 1986). This meant that all participants assisted in the development and critique all drafts of the results of this study, and that all edits, deletions and revisions were mutually agreed upon by the group. Within this nonhierarchical social structure, all co-researchers learned about their in/visible practice with the help of each other and, as a group, they mutually negotiated and jointly constructed the meaning, breath and scope of their in/visible practice (Freire & Faundez, 1989; Lather, 1991; Mishler, 1986; Personal Narratives Group, 1989a; Van Manen, 1990). This approach to the research process emphasizes that thinking/learning as well as authorship is multivoiced (Wertsch, 1991).

For the co-researchers in this study, one of the important things that their history has taught them is that speaking out against the hospital system usually has
professional and personal costs (Growe, 1991; Reverby, 1987; Stevenson, 1990; Welch, 1990). Thus, in conducting this study, I was acutely aware of the double binds nurses felt between their desires for their voices to be heard, and the potential threats they saw for raising their voices (Bateson, 1979; Bateson & Bateson, 1987; Lewis, 1990). Although their anonymity was secured and the research process itself established some level of comfort in speaking out, I thought that it was crucial that the prevailing value within these discussions was that they only shared what they felt comfortable sharing (Patai, 1991). With this in mind, the topics for all group sessions (the details will be discussed in the next section) were made known in advance, and required some preparatory work. This work gave them a chance to reflect upon what they would like to say: indeed, to reflect upon what they felt comfortable saying (Lewis, 1990). The following sections will address the research sample and methods.

**Sample**

To facilitate the accessibility of nurses to this study, I advertised and presented an information session about this research project in the specific hospital where it took place. In this section, I discuss various relevant characteristics of the participants. I, also, include issues related to informed consent and anonymity.

**Participants**

Given that the nurses' job description constructs nurses and their practices in generic and homogeneous ways, I used a purposive sampling technique which is based upon a fundamental notion of diversity. In particular, the research sample is here composed of seven registered nurses who: 1) have diverse personal and professional backgrounds; 2) work in the same hospital; 3) practice in one of three nursing specialty areas; and 4) have volunteered for the study (Goetz & LeCompte, 1984) All participants are women. In Chapter Three, I have reported the following
demographic information about the participants: average age, educational and ethnic backgrounds, average years of experience, years of experience in their current nursing specialties, and the group’s cumulative years of experience.

**Informed Consent**

Following the approval of the research protocol by the University of British Columbia Behavioral Sciences Screening Committee For Research and Other Studies Involving Human Subjects, I secured an "informed consent" from all participants before the research began. To enable the nurses to make an informed judgment about entering (or not entering) this study, I advertised and presented an information session which discussed the following points (McMillan & Schumacher, 1989):

1. participation is voluntary, and anyone can withdraw at anytime from the study (without penalty).
2. the purpose and nature of the study.
3. the roles and relationships between the researcher and participants.
4. the anticipated time and work commitments of participants.
5. the strategies used to maintain participants' anonymity (discussed below).

Since this research took place in a hospital setting, I also obtained an "informed consent" from patients, unit managers, doctors and secondary nurse participants. The above criteria were applied to these participants' informed consents. In the next section, I address the strategies used to safeguard participants' anonymity.

**Issues of Anonymity**

In this research, I was responsible for maintaining the anonymity of both the participants, and hospital involved in this project (Goetz & LeCompte, 1984; McMillan & Schumacher, 1989; Strauss & Corbin, 1990). Information about the people participating in this study was held in the strictest confidence. This meant that no one outside the research project had access to the names of the
participants, or any individual data about them. In addition, the researcher assigned a number to all primary nurse participants, and instructed them to use it (and not their names) on any written work. Only the researcher knew the assigned numbers given to the participants (McMillan & Schumacher, 1989; Strauss & Corbin, 1990). In relation to reporting the results of this study, some examples of verbatim conversations were used. However, when reporting these conversations alias names were used for all participants (Goetz & LeCompte, 1984; Van Manen, 1990).

This research project, also, has an obligation to the hospital to maintain its anonymity. This issue particularly relates to the use of quotes from the nurses' job description as the basis for comparing prescribed and actual practices. Although the gist of each hospital's job description may have similar roots, each one has its own institutional emphasis and wording. The idea that quoting from a specific job description may pose a threat to hospital's anonymity is unfounded, because these documents are not public (Canadian Council on Health Facilities' Accreditation, 1992). However, as an extra means of protection for the hospital involved in this research, I will refer to it in obscure terms -- as an acute care hospital in B.C. Thus, given that job descriptions are not public documents, and the researcher's additional measure of referring to the hospital in vague terms, it is unlikely that the hospital's identity can be determined.

Methods

This section describes and provides rationale for the research methods used to investigate nurses' in/visible practice: career autobiographies, direct observation, journals, one-on-one interviews and group discussions. Besides providing the means for qualitative analyzes, these methods are consistent with the overall philosophical and research goals of this work: 1) to provide a historical
understanding of the participants; 2) to locate the analysis of in/visible practice within the nurses' everyday work world; 3) to name the practices which are rendered in/visible by the nurses' job description; and 4) to explore the social circumstances that facilitate nurses' degrees of agency and resistance in their community of practice.

**Career Autobiographies and Group Discussion**

The starting point of this research began by asking the nurses to write an autobiography about the histories of their nursing career. By starting this project with an unobtrusive method, I tried to establish an initial and ongoing precedent, meaning that the interest of this work was in attending to nurses' personal experiences, and not to the researcher's conceptions of them (Anderson & Jack, 1991). The following questions were given to the nurses in this study:

1. Tell a story about the events, and people that encouraged you to enter nursing school. At this time, what did this decision mean to you?
2. Tell a story about one vivid experience from your nursing education. Talk about the people involved. What is it about this experience that makes it stand out?
3. Tell a story about your clinical practice in this hospital, one that you keep thinking about over the years. Talk about the people involved. What is it about this experience that makes it so memorable?

These questions were purposefully stated in general terms, so that the nurses could reflect upon their own careers, and choose for themselves the stories that they viewed as central to understanding their past (Benstock, 1991; Brady, 1990; Corbett, 1990).

Beyond establishing the unobtrusive intent of this work, these autobiographical questions are linked to this work's theoretical foundations, and seek to uncover fragments of the nurses' own implicit theories of practice (Bryson, 1990; Chanfrault-Duchet, 1991). The theoretical linkage is twofold. First, the idea of starting off with the nurses' own histories is linked to the theoretical proposition that a prerequisite
to understanding the present begins with an understanding of the past. Second, these questions are tailored to identifying some of the social circumstances and prescriptions that impact upon nurses' ideas about their actual practice, thereby underscoring the social nature of the nurses' knowledge (Bateson, 1979; Wertsch, 1985 & 1991; Van Manen, 1990; Vygotsky, 1978).

The specific content of these autobiographies was extremely important in identifying some of the social values, beliefs and defining features of the nurses' implicit theories of practice (Benstock, 1991). Making these ideas more explicit with group discussions, nurses began, in general terms, to compare their own theories of practice with those of the hospital's, as implicitly and explicitly stated within their job description. Thus, the ultimate purpose for these autobiographies was to build a beginning and partial conceptual framework for nurses' in/visible practice that articulated some of the theoretical disparities between the nurses and the hospital. Other research methods (discussed later on) established: 1) how these theories potentially changed and expanded over time; and 2) how the disparities between the nurses' and the hospital's perspectives formed the basis of, and determined the actualities of, their day to day in/visible practice (Goetz & LeCompte, 1984).

The first group discussion centred on articulating nurses' implicit theories of practice, and comparing them with their job descriptions. This group session, as well as the ones that followed, was based upon the notion of nurses' community of practice, wherein nurses create and recreate their practice (Lave & Wenger, 1991). Here, the nurses were asked to share their autobiographies, and collectively identify some of the overriding theoretical tenets implicit to their stories. After doing this, the group turned to their job descriptions, and engaged in the same analytic processes. Now, knowing some of the major theoretical positions of both
themselves and the hospital, the nurses identified, and discussed some of the main disparities between them.

At the end of this session, the nurses gave me their written autobiographies. When there were subsequent clarifications that I needed to make in relation to this written work, I contacted the nurse(s) and conducted one-on-one interview(s). Both the group session, and interview(s) were audio taped and transcribed (Goetz & LeCompte, 1984; McMillan & Schumacher, 1989). To facilitate ongoing reflection between this and subsequent group sessions, each nurse received a photocopy of her own autobiography, and a transcript of this group session (when it became available). No names appeared on these transcripts.

**Direct Observation**

After the completion of the first group session, I entered the nurses' clinical settings and observed their "practice-in-action." In comparison to some of the other methods used (e.g., autobiographies and journals), the direct observation of nurses in their clinical setting captured an array of situations and circumstances which, in turn, added variety, specificity and immediacy to the nurses' contextualized understandings of their in/visible practice. And, because this method was localized within the nurses' "natural" (clinical) setting, it provided opportunities for identifying some of the spontaneous, and more subtle forms of in/visible practice, which did not appear in their journal work, or within group discussions (Goetz & LeCompte, 1984; McMillan & Schumacher, 1989; Smith, 1987 & 1990).

Direct observation allowed me to witness, first hand, nurses' lived practices, and involved accompanying each nurse to her clinical nursing unit, and following along with her as she engaged in her daily routines, activities and conversations with hospital personnel and patients (Van Manen, 1990). This method was extremely helpful as it provided me with an opportunity to ask the nurses questions about
their practices as they were engaging in them, and about their interpretations of conversations with specific people in the hospital (Bateson, 1979; Goffman, 1961).

Based upon my observations and ongoing discussions with each nurse, I wrote daily field notes which included (Goetz & LeCompte, 1984; McMillan & Schumacher, 1989):

1. a description of the setting(s)
2. a description of the nurse's actual practices along with her interpretations of them.
3. verbatim accounts of conversations that she had with hospital personnel and patients, along with her interpretations of them.
4. verbatim accounts of conversations that the nurse and I engaged in.

At the end of each day, I shared my field notes with the nurse so that she had an opportunity to corroborate and potentially extent their content (Mishler, 1986). The intent of this meeting was to be short (after all it is the end of the day) and, initially, focused on the actualities of the nurse's practice. However, as my residency with each nurse continued, these discussions developed a more expanded focus which included discussing some preliminary ideas about her in/visible practices. These meetings were audio taped and transcribed.

All nurses received a photocopy of each day's field notes, and a transcript of each "end of the day" meeting. As a means for preparing for the concurrent group sessions, it was important that the nurses continued to have access to this information so that they had an opportunity to review it, continue to reflect upon it, and try to develop some ideas about their in/visible practice that could be shared during the concurrent group sessions (Allen, Bowers, & Diekelmann, 1989).

I spent at least two or three days directly observing each nurse in her clinical setting. This time limit, however, was flexible and was extended as necessary. The decision to extend this time was based upon the nurses' belief that the information gathered, thus far, did not adequately reveal the subtleties,
complexities and scope of her practice. In other words, I continued to directly observe the nurse's clinical practice until she determined that the information obtained reflected prototypical experiences and key aspects of her practice (Hall & Stevens, 1991).

**Journals**

The main purpose of the journals was to provide additional information about the nurses' personalized understandings of their everyday conversations and practices. When they were not being directly observed by me in the clinical setting, they were asked to keep a journal of their interactions with physicians, unit managers, patients and other nurses on a daily basis for two days. Within these journals, they wrote down these conversations, described their ideas about the role relationships inherent to them, and discussed their feelings about them (Goffman, 1956 & 1961). At the end of each journal, they were asked to describe a particular practice that they did well, but did not receive recognition for. As they were completed, these journals were collected (by me), photocopied and returned to their respective authors. When there were subsequent clarifications that I needed to make in relation to this written work, I contacted the nurse(s) and conducted one-on-one interview(s).

These journals were returned to the nurses so that they could reflect upon their written work and, over time, develop some ideas about: 1) how the expectations of their job description came alive through everyday conversations; and 2) what types or aspects of their practice seemed to be unacknowledged (Allen, Bowers, & Diekelmann, 1989; Cissna & Sieberg, 1981; Kennedy & Garvin, 1988; Heineken, 1982). These ideas could, then, be shared during the concurrent group sessions.
**Concurrent Group Discussions**

The main functions of the concurrent group sessions were twofold: to construct multivoiced understandings of nurses' in/visible practice, and to democratize the research analysis process (Lather, 1991). Initially, the discussions focused on uncovering the specifics of their in/visible practice, and were guided by, but not limited to, the following preliminary questions:

1. How are your implicit theories of practice operationalized in everyday practice? Under what social circumstances are these theories and actions (in)consistent?
2. How do the whats, whys and wherefores of your actual practice compare/contrast with the job description?
3. How are your conversations with other hospital personnel and patients linked (or not linked) to the roles and relationships outlined in the job description?

These questions break down the overall research question into its component parts by: 1) linking the nurses' implicit theories of practice to their actual practices; 2) comparing/contrasting their theories and practices with those inherent to their job description; and 3) underscoring the social nature and circumstances within all of these perspectives.

The nurses were given these questions prior to attending the first concurrent session, and were asked to keep them in mind as they reviewed and reflected upon the information within their autobiographies, field notes, journals, interviews, ongoing group discussions and other experiences that were not captured within the aforementioned methods. These questions were purposefully stated in general terms so that the nurses could reflect upon their own experiences, and choose for themselves the instances that they viewed as central to describing and understanding their in/visible practice.

During the ongoing group discussions, each nurse had an opportunity to share her thinking and practice with the other group members, and the group members
had opportunities to ask questions about, or generally comment on, each other's stories. Within this dialogue, the discussions were be guided by the above questions and focused on uncovering a collective understanding of the nature and scope of nurses' in/visible practice. Initially, these sessions were more directed to the specifics of the nurses' in/visible practice (data collection); however, as more and more examples of their in/visible practice were presented, the group began to develop preliminary and ongoing themes (data analysis). Working as a group to uncover the patterns and themes of the nurses' in/visible practice located this analysis in the minds of the "experts," the nurses themselves, and thus maintained the horizontal power relations between the researcher and nurses. This collaborative analysis also facilitated a(n) increased flexibility, mutuality, diversity and authenticity in the overall results of this work (Hall & Stevens, 1991).

Using the information collected through the various methods, the group (including the researcher) looked for emerging patterns and possible categories/themes that refined and described their in/visible practice. Finding similar and recurrent themes about nurses' in/visible practice certainly added to the rigor of this work but, it was further strengthened by finding exceptions within these themes (Yin, 1989). Themes are developed at certain levels of generalization, which in turn can limit or ignore some of the contextual complexity and plurality of nurses' in/visible practice. Thus, attempts to establish consensus in themes did not circumvent variety within or divergence from them. Given the differences in the nurses' experiences, differing views of their in/visible practice do and must coexist (Lather, 1991). These differences, however, needed to be explained within the social circumstances that created them (Wertsch, 1985 & 1991). Thus, as these themes were developed we, as a group, continued to ask: "What aspects of y/our in/visible practice are misrepresented or not represented in this theme?" (Strauss & Corbin, 1990; Strauss, 1997). This question not only sought to find alternative
explanations of nurses' in/visible practice, but it also sought to expose and validate the diversity of ideas within the group.

These concurrent group discussions were held on a biweekly basis during the data collection phase and triweekly during the analysis phase. However, given that nurses work a variety shifts and all of the days of the week, it was quite difficult to get the group together. Hence, these time frames were flexible. Moreover, all group sessions were audio taped, and transcribed. To facilitate ongoing reflection between these concurrent group sessions, the nurses received a transcript of each session (when it became available). No names appeared on the transcripts given to the nurses.

Based upon these ongoing group sessions, I developed working drafts, which were presented to and critiqued by the group. These sessions concluded when the group agreed that there were no new ways or means of representing their in/visible practice, and when they approved the final draft of the results (Hall & Stevens, 1991).

**Closing Group Discussion**

This last group discussion brought closure to this research project by reflecting upon the group's collective accomplishments, and by determining the impact of the research project on the nurses' lives (Lather, 1991). I, also, established the time when I will present all members with a copy of the final research project. This session was audio taped and transcribed.

Throughout this section, I have discussed a research methodology plan that sought to uncover preliminary, contextualized and subjective understandings of nurses' in/visible practice, and that embraced a democratized research process in which nurses learn from each other, and analyze their own practices. I think that this blueprint for research must been seen as flexible. Although I will write about
the circumstances that maintained and changed this overall plan, I think it is also important to talk about the analytical processes or decision-making trails that were used throughout the course of this investigation (Van Manen, 1990). This discussion leads quite naturally to the next one, which addresses issues of validity.

**Issues of Validity**

Validity, as traditionally construed, is typically discussed in relation to the question: "do researchers actually observe what they think they observe?" (McMillan & Schumacher, 1989, p. 191). In relation to this study, validity issues pertain to the degree to which the researcher can "authentically" represent nurses' phenomenological realities of their in/visible practice (Leonard, 1989; Van Manen, 1990). In attending to validity issues, I built in a number of safeguards into the data collection process which include:

- reciprocal relationships between the researcher and nurses directed toward jointly constructing meaning.
- directly observing nurses in their "natural" clinical setting, which reflects the immediacy and realities of their lived experience.
- individual and group discussions that were mechanically recorded and, thus, preserved as quasi-authentic discourse.

With respect to analyzing and reporting the results, the following strategies were used to attend to the validity of this work:

- establishing relationships amongst nurses' implicit theories of practice, their actual practices, their job descriptions and the social conditions within their community of practice, which enables agency and resistance.
- detailing how the group used the triangulation or constant comparison process to sort data, and identify themes around nurses' in/visible practice.
• describing the contextual circumstances around affirming and diverging from these themes.

• providing a variety of verbatim conversations and descriptions of practices that support, extend or refute the various themes.

• identifying the similarities or differences between the multiple data sources (e.g., spontaneous compared to elicited; individual compared to group).

• explaining the group's analytical processes or decision making trails throughout the course of this investigation.

• discussing how the researcher influenced the content as well as, the decisions made within this study.

• corroborating the nurses' perspectives through ongoing discussions, and by giving them all drafts to critique.

What I hoped to achieve with these safeguards/strategies was a credible description and explanation of nurses' in/visible practice that could be understood by the nurses in this study as well as, anyone who reads this work (Campbell & Bunting, 1991; Goetz & LeCompte, 1984; Hall & Stevens, 1991; McMillan & Schumacher, 1989; Yin, 1989).
Chapter 3: Sites of Nurses' In/Visible Practice

Setting and Duration of Study

The research project took place in an acute care hospital in B.C. on the following nursing units: Emergency Room (ER), Intensive Care (ICU) and Operating Room (OR). However, all group sessions were held away from the hospital site, and in the nurses' homes. On an alternating basis, each nurse opened her home to the group. This project spanned over a two and a half month time period. During this investigation into nurses' in/visible practice: 136 hours (or 17 days) were devoted to direct observations of the nurses in their clinical setting; eight and a half hours were devoted to one-on-one interviews; and 12 hours (or seven group sessions) were used to analyze the nature and scope of nurses' in/visible practice. In addition, the nurses spent on average four hours writing career autobiographies, and six hours writing in journals.

Framing an Analysis of Nurses' In/Visible Practice

There are several converging ideas that are interwoven into the structure and analysis of this research project. In the following discussion, I will articulate the conceptual framework that structures the ways in which this study's findings will be presented. I will revisit the notion of nurses' in/visible practice, discuss some of the theoretical perspectives within this ethnographic work, and close with an overview of how the data analyses are presented.

One of the primary points that was made in Chapter One was that the twin notions of visibility and invisibility should not be taken literally; hence the use of in/visibility. In the prior chapters, I have used the question -- "What is left unsaid?" -- as an analytical tool for exposing what might be lost or rendered in/visible by the official paradigms for nursing practice described within historical texts, and the nurses' job descriptions (Aronowitz & Giroux, 1991). In the following discussion, I
describe a framework that focuses on articulating and analyzing nurses' phenomenological realities of practice -- their implicit theories of practice and their actual practices. From the nurses' perspectives, I can begin to describe what is visible within their paradigms of practice, and at the same time, contrast these with the ones articulated within their job description. At one level, this analysis will point to the types of practices that are rendered in/visible by the nurses' job description. But, at another and more provocative level, this analysis will point to nurses' resistance (Apple, 1986; Lather, 1991). Within the hospital setting and its inherent power relations, nurses have developed degrees of control and resistance within their everyday practices (Britzman, 1991; Growe, 1991; Lather, 1991). Thus, my primary consideration for structuring the analysis of this work is to represent nurses' practices in a way that not only makes their practice visible, but also demonstrates their commitment to transformative resistance within their everyday work world (Lather, 1991; Smith, 1987 & 1990).

As a general research framework, I re-introduce here the notion of institutional ethnography -- looking at nurses' ideas about their in/visible practice from their vantage point within a specific hospital setting (Smith, 1987 & 1990). Within this hospital, the nurses' vantage point is from the bottom of the organizational hierarchy. As a consequence, there is an unequal power relationship between the nurse administrators who live at the top of the hierarchy and write the nurses' job description; and the nurses who actually practice nursing, but live at the bottom of the hierarchy. But even when people are at the bottom of a power structure, they do have degrees of control and degrees of resistance at a local level of practice (Freire & Faundez, 1989; Giroux, 1988; Lather, 1991; Smith, 1987 & 1990). As Van Maanen (1988) argues the task of ethnographic work is to "... display the intricate ways individuals and groups understand, accommodate and resist a presumably shared order" (p. 14). He assumes that knowledge and power
relations may be prescribed by people in positions of power, but that these edicts from above have degrees of flexibility and negotiation at local levels of practice (Britzman, 1991). Considering that this research takes place within the local levels of nursing practice, it is important that I make explicit the assumptions that I am using to frame the social structure or fabric of nurses' work lives.

At this local level, nurses are bound together by their position at the bottom of the hospital hierarchy, and by their practice. They are members of a social group or community that practices nursing (Lave & Wenger, 1991). Thus, in comparison to nurse administrators who work within a community that practices management and prescribes nursing practice, nurses' community of practice is based upon "actual" practices (Lave & Wenger, 1991). Nurses' knowledge within this community of practice is relational; it is based upon nurses' actual practices as lived and shared experiences (Lave & Wenger, 1991). Within this community, the nurses have varying perspectives, interests, and degrees of participation. Nurses talk and learn about: their individual and community identities; the historical legacies of their practice; and the ways their practices can be shaped and transformed (Lave & Wenger, 1991). Through these interactive means, the community produces and reproduces itself (Lave & Wenger, 1991). I do not want to leave the impression that nurses create this community by formal conventions -- they do not schedule and hold discussion groups on the nature and plight of their practice. Their discussions occur informally as they practice with each other, or as they talk with each other over meal and coffee breaks. In this community of nursing practice, nurses' understandings of practice do not occur in isolation or without outside influence. In the hospital setting, their community of practice is interconnected to: other communities within nursing like nursing administration; other professional communities like medicine; and the broader community or society (Lave & Wenger, 1991). These communities, also, have prescriptions for
nursing practice that must be examined by individual nurses, and the community of nursing practice (Van Maanen, 1988). It is the disparities between the "prescribed," and "actual" practices within the community of nursing practice, that is the interest of this work. How (and why), at their local level of practice, have nurses learned to resist some of these prescriptions for their practice and created new ways of knowing?

In the last few paragraphs, I have presented some of the theoretical perspectives that are interwoven into, and provide direction for, this research project. Now, I would like to turn to the general considerations for structuring and presenting this data analysis. As the nurses talked about their practice in our ongoing group discussions, a recurrent pattern or theme began to emerge. The nurses made ongoing contrasts between their current practices, and those that they had learned in their post-secondary education. In addition, they also made ongoing contrasts between their actual practices, and the ones outlined in their job descriptions. Given their own intuitive path for analyzing their in/visible practice, I will present the findings of this work as the disparities with/in: 1) the practices that the nurses learned about in their post-secondary education programs; 2) the practices outlined in this hospital's job description for nurses; and 3) the nurses' actual practices. This triangulation method will trace nurses' learning across time, and will serve as the springboard for rendering nurses' actual practices visible within this hospital setting (Strauss, 1987; Strauss & Corbin, 1990). As the foundation for this triangulation method, I will summarize and extend some key points brought forth in the first chapter about nursing education, and then I will take a critical look at the specifics within this hospital's job description for nurses.
Nursing Education

The primary purpose of this discussion about nursing education is to provide background information on, and a critique of, the nursing curriculum, and the teaching practices used to impart this knowledge. As articulated in Chapter One, nurse educators have built curriculum models around two types of theories: one type represents nurses' declarative knowledge about patients and the other represents nurses' clinical decision making or procedural knowledge (Bevis & Watson, 1989). Within this educational framework, students' learning is construed as passive and linear as their "minds" are receptacles for inserting and extracting prescribed knowledge, which is measured by acts of mindless doing. When learning is attributed to behavioral acts and the absence of learning is attributed to not displaying the proper observable behavior, education and learning become narrowly focused on decontextualized knowledge (Belenksy, Clinchy, Goldberg & Tarule, 1986). There is no emphasis placed upon how students might construct their own knowledge; there is no emphasis placed upon what students might learn from their conversations and experiences with patients and other students (Freire & Faundez, 1989; Vygotsky, 1978). As a consequence, contextualized meaning, multiple meanings and contrary ways of knowing become washed away into objective and, thus, decontextualized traits or behaviors (Britzman, 1991; Lather, 1991). Thus, students' understandings that fall outside of these generic behaviors become silenced or unrecognized; these understandings become illegitimate (Bevis & Watson, 1989).

In general terms, I have discussed some of the authoritative and oppressive circumstances within nursing education, but this abstract analysis has little meaning until it is made concrete within nurses' specific experiences. So, I would like to break from the convention of putting all of the research findings into one discrete section and mention one of Leah's experiences in nursing education.
Leah's remarkable story is about resilience and resistance under inauspicious educational circumstances; her story is about creating new ways of knowing:

When I was in training, there was this "meanie" instructor. She screamed at the students in front of patients, visitors, nurses and doctors. She would make the students do things that made them look stupid . . . She failed five students out of seven within six weeks. I hated going for my interviews with her each week, because she always gave me negative feedback. At one point she told me that I would never make it to be a nurse. I felt very down and upset, and did reconsider if nursing was for me. I withdrew, but I returned the next semester after some good talks and thoughts. I believed the problem was not in me, but in her. She failed to do her job, to teach, guide and give support.

There is an interesting contradiction between the philosophical frameworks and behaviorist modes of teaching within most nursing education programs. As Bevis and Watson (1989, p. 5) argue:

Nursing education is out of step with its philosophy . . . For, as it currently exists, schools write out a philosophy that is human science human experience valuing, holistic, qualitative and caring orientiated, yet plan a curriculum that is based upon behavioral objectives and oppressive. This inconsistency is a handicap to nursing.

This inconsistency not only fragments philosophy from practice, but it also fragments and distances (student) nurses' experiences from the curriculum (Britzman, 1991). Considering that nursing is an inherently social, relational and esthetic practice, the profession's insistence on grand theories for practice, and authoritative and behaviorist modes of education, leaves much of what students learn and practice unexpressed or in/visible (Benner, 1984; Bevis & Watson, 1989; Freire & Faundez, 1989).

Nurses' Job Descriptions

In this hospital, the nurses' job description has a remarkable resemblance to the ways in which nursing education constructs nursing practice. This document uses
grand theories to articulate nursing practice, and reduces nursing practice to
generic behavioral traits (e.g., all statements about nursing practice begin with
action verbs). However, the purposes of this job description are not educational.
The nurses' job description is a two page document that serves three primary
functions: 1) to define and thus scope nursing practice; 2) to identify the nurses' position within the nursing and hospital hierarchy; and 3) to make clear distinctions between nursing and medical practice. Table 2 (on the next page) presents the text of the nurses' job description. In the following discussions, I will use some key quotes from this job description, which focus specifically on nurses' practice, and argue that these renderings of practice do little to articulate the constitutive work of nurses.

Within the nurses' job description, their practice is defined by the following statement: "(nurses) implement Henderson's model for nursing through the use of the nursing process." Like nursing education, this hospital defines nursing practice within the constrains of two universal or "grand theories" (Lather, 1991). "Henderson's model" represents nurses' declarative knowledge about patients, and the "nursing process" represents nurses' procedural knowledge or clinical decision making (Adams, 1980; Moorehouse, Geissler & Doenges, 1987). I have talked about the constraints of these theories in Chapter One, and I will revisit a few points. Within these theories, there is no room for variations within nurses' practices or across nursing specialties. In this hospital setting, nurses work in specific specialty areas like intensive care, emergency room, surgical and operating room nursing. Given that these theories are context-free, they present nurses' practices as if there are no differences across these specialties. But, the contextual realities within these specialties are quite different. As an example, the knowledge of a surgical nurse who cares for pre-operative and post-operative patients, is going to be quite different from that of an intensive care nurse who
Table 2: The Hospital's Job Description for Nurses.

### Job Summary:

Using Henderson's model, the nurse assesses, plans, implements and evaluates nursing care for assigned patients; plans, organizes and completes assignments to meet priorities for patients' care; assists with staff and patient teaching, and supports research. All activities are carried out in accordance with: the philosophy of the hospital; the hospital, division and unit beliefs, objectives, policies, procedures and standards.

### Responsibilities:

#### Practice:
- Implement Henderson's model for nursing through the use of the nursing process.
- Collect data about assigned patients by observation, interview, physical examination and review of records.
- Analyze data by determining the interrelationship between variables, and determines patients' actual or potential problems.
- Plan nursing care by setting priorities, writing desired outcomes and selecting nursing interventions which have the highest probability of success.
- Implement the medical plan of care.
- Document the care given and the patient's response, and report significant changes to the physician or unit manager.

#### Management:
- Participate in the development of unit and division statements of beliefs, objectives, policies, procedures and standards by being a member of a nursing committee.
- Organize equipment, supplies and medication to provide care.
- Delegate specific tasks to auxiliary personnel.
- Ensure a safe environment for patients and other staff.

#### Education:
- Maintain clinical competence by regularly attending continuing education programs.
- Interpret to new staff the hospital, division and unit beliefs, policies, procedures, standards and ward routines.
- Include patient teaching as a part of the plan of care.

#### Research:
- Change practices or procedures to reflect current research findings.
- Participate in approved research projects.
In/Nvisible Practice

cares for critically ill patients. In the intensive care setting, the critical nature of a patient's illness and the technology [e.g., electrocardiogram (heart rhythm) monitoring or mechanical ventilators (machines used to help patients breath)] used to treat these illnesses are absent from the surgical nurse's world. But, when grand theories are used to articulate nursing practice, these differences across nursing specialties are obscured or rendered in/visible. In addition, given the generic and behaviorist nature of the nursing process (assess, plan, implement and evaluate), this model does not distinguish nurses' procedural knowledge from other disciplines. The nursing process could be applied to any discipline like secretaries, plumbers, physicians, and so on. At some general level, all of these disciplines assess, plan, implement and evaluate what they do (Ball, 1991; Smith, 1990).

The nurses' job description stresses the idea that theory (and implicitly research) must be developed outside of nursing practice and then applied to nursing practice. This idea is further reinforced by two statements within the job description as follows: "(nurses) maintain clinical competence by regularly attending continuing education programs;" and "(nurses) change practices or procedures to reflect current research findings." Like nursing education, this job description defines and confines nurses' learning to received knowledge from official sources within the academic community. Thus, situated learning within nurses' everyday practices, and the ways in which nurses are instrumental in helping each other learn is rendered in/visible. Moreover, considering that the entire job description uses generic statements that are supposed to apply to all nurses, there are no distinctions between what constitutes beginning or experienced nursing practice (RNABC, 1992). Thus, nurses may never be acknowledged for their learning endeavors aimed towards clinical expertise (Benner, 1984).
Thus far, I have looked at some of the central statements within the nurses' job description. These statements represent the administratively prescribed and constrained practice for nurses (Ball, 1991; Smith, 1990). The power of these statements cannot be over emphasized. Not only do they identify the normative prescriptions that define the expectations of the "good nurse" (Goffman, 1961) but, more importantly, they explicitly define what is to be observed, reported and evaluated as nursing practice (Smith 1987 & 1990). In other words, these statements form the hospital's institutional theory of nursing practice, and are the pivotal ingredients that make certain aspects of nursing practice institutionally sanctioned and visible; and at the same time, exclude other aspects of nursing practice. This job description, also serves another primary function. It establishes the power relations between nurses and doctors.

The discrete nature of the following statement within this job description serves to disguise nurses' knowledge of, and authority within medical practice (Smith, 1987 & 1990): "(nurses) implement the medical plan of care." In practice, nurses do critique medical interventions. As an example, although the doctor's role is to prescribe medications for patients, nurses are legally responsible for the medications that they administer (Johnson & Hannah, 1987). This means that if a doctor orders a medication for a patient which a nurse deems as inappropriate (e.g., say, she thinks the dose of the drug is too high), she is legally mandated to refuse to give it. Yet, in determining that this drug dose is unsafe for the patient, this nurse has really taken on the medical role of prescribing medications. However, within this job description the above statement serves to subordinate nurses in their relationships with doctors, and makes in/visible the overlap between nursing and medical practice (Smith, 1990). It obscures the notion that, beyond providing nursing care, nurses are also responsible for critiquing aspects of
medical care and, therefore, nurses are not subordinates at all (Warburton & Carroll, 1988).

Furthermore, the above quote from the job description implicitly speaks to the status and value the hospital places on medical and nursing care. Doctors are seen as the 'master planners' of patient care; whereas, nurses are seen as the people who simply carry out this plan. Nurses, also, develop a plan for patient care, and implement a number of practices that are independent of the medical regimen. However, the importance placed on the medical plan and the de-emphasis placed upon the nursing plan maintains and legitimates an asymmetrical power structure between nurses and doctors -- nurses are supposed to work in concert with doctors making sure that their care is consistent with the overall medical plan (Gordon, 1992). But, the reverse is not necessarily true. Having the ultimate institutional authority as the master planners of care, doctors are not required to be aware of or consistent with the nurses' plans for patient care. Like in the Nightingale (1954) days, doctors have no obligations to nurses, but nurses are obligated to do, and not question what physicians say (Melosh, 1982; Warburton & Carroll, 1988; Wotherspoon, 1988). Unfortunately, this institutionally sanctioned unequal power relationship silences nurses' medical practices, and inhibits discussions that focus on the conflicts that arise between nurses and doctors when their plans for patient care differ (Trueman, 1991).

Although this job description is supposed to represent the art and science of contemporary nursing practice, it remains true to the historiocultural myths of de-intellectualization, and subservience to the greater authorities (like nurse administrators and doctors) (Gordon, 1992; Growe, 1991; Hughes, 1990; Melosh, 1982; Reverby, 1987). By characterizing nurses as doers and not thinkers, it justifies the power relationships between nurse administrators and nurses. Nurse administrators must monitor nurses' practices, and ensure that the official theories
of practice are adopted (Apple, 1989; Ball, 1990; Giroux, 1988). And by not acknowledging the idea that nurses have an integral role in the medical management of patients, doctors can still take credit for patient care and maintain their position as the natural leaders in the health care system (Abbott, 1988; Freidson, 1970; Griffith, Thomas, & Griffith, 1991; Warburton & Caroll, 1988; Wotherspoon, 1988). In these respects, this job description legitimates and maintains the power base of others (Smith 1987 & 1990). This job description may be developed "for" nurses, but this does not necessarily mean that this document represents the everyday life and work of nurses.

I have spoken about how the nurses' job description defines and confines nurses' practices, and how this job description legitimates nurses' positions at the bottom of the hospital hierarchy. I would like to leave this preliminary discussion with an account of Jan's feelings and ideas about living at the bottom of the hospital hierarchy. Her story is about herself, OR nurses (that she works with), seagulls and hospital administrators:

We are looking out for a mother and baby seagull. We call our baby Harold Hospitalla. They nested on a perch under our OR deck. We haven't mentioned a word of this to anyone outside of the OR nurses. Last year, a mother seagull built a nest at the other end of the deck, and laid two eggs. Some people from the administration offices complained to maintenance because the gull kept shitting on their windows. Next thing we knew the nest was gone. The maintenance men had come up, and thrown the nest to the ground, eggs and all. They killed the babies, the poor mom. We were shocked when we found out. We told them, too. This is a hospital. We are supposed to help life and look what our administrators did for clean windows. They won't find out about baby Harold this year!

In Jan's story, this baby seagull (who is now learning to fly) seems to represent a metaphor for the care and attention she might bestow on a colleague, and for how the OR nurses see their positions at the bottom of the hospital hierarchy. Within
this community at the bottom of the hospital hierarchy, there seems to be a lot of care and support for nurses and, of course, seagulls.

Before I begin to move away from the official accounts of nursing practice and into the lived experiences of nurses, I would like to emphasize one of the central themes within nursing education and the nurses' job description. The theme that nurses are a homogeneous group. The use of grand theories for practice and the behaviorist renderings of nursing practice leaves the impression that nurses constitute a homogeneous group. There is no variability within each nurses' practice or across nursing specialties. I would like to begin deconstructing this notion of homogeneity by introducing the nurses who participated in this study.

A Look At the Nurses and Their Practice

Given the emphasis on homogeneity within nursing education and the nurses' job description, my primary criterion for this purposive sample is based upon a notion of diversity (Goetz & LeCompte, 1984; Lather, 1991). The nurses who participated in this study come from diverse personal and professional backgrounds, and practice within one of three different clinical nursing specialties. In this discussion, I will present some demographic information about these nurses and, then, present some excerpts from their autobiographies, journals and group discussions, wherein, each nurse talks about her personal and professional identities (Personal Narratives Group, 1989a & 1989b).

Including the researcher, eight nurses are the primary participants in this study. The average age of this group is 38 ± 7 years old, and the ethnicity of the group is diverse. Although most are of European descent (e.g., Italian, Welsh, British, Dutch, Scottish and Irish), one nurse is of Chinese heritage, and another is a mixture of Irish and Native Indian heritage. In addition, four nurses have been raised in other countries: Brazil, New Zealand, South Africa and Hong Kong.
The nurses' educational backgrounds were varied. Although most received diplomas in nursing from college-based programs, one received her diploma from a hospital-based program, and three received Bachelor of Science degrees in Nursing from university settings. Five nurses attained post-basic certificates: one in Hospital and Health Care Administration; one in Post-anesthetic Nursing; one in Neurological Nursing; one in Critical Care Nursing; and one in Operating Room Nursing.

All nurse participants are full time employees, and have worked in this hospital for an average of 5 ± 3 years. Each nurse practices in one of the following clinical specialty areas: Emergency Room (ER), Intensive Care Unit (ICU), and Operating Room (OR) nursing. They have an average of 5 ± 4 years work experience in their chosen specialty area, with an average overall work experience of 12 ± 6 years. The group's collective work experience is "103" years. In addition to this primary nurse group, 39 patients, 20 doctors, three unit managers and 21 secondary nurses participated in this study.

In the above paragraphs, I have presented demographic information about the primary nurse participants. This information gives an extremely limited glimpse of these women. To speak about them as a collection of numbers, averages, and ethnic and educational backgrounds oversimplifies the complex identities that these women embody. They have identities which are interwoven across their professional and personal lives (Belenky, Clinchy, Goldberg & Tarule, 1986; Personal Narratives Group, 1989a & 1989b). In their autobiographies, journals and group discussions, they have talked about some of their identities. To introduce these women and their identities, I have compiled some excerpts from these sources. I have, also, included excerpts about myself to stress the point that the researcher is an in/visible member of this group:
Sue: Susan is 47 years old, and has been practicing nursing for 17 years. "I entered nursing after the breakup of my marriage. I wanted to be independent. I needed to support my family. I was a single parent, raising two kids, two dogs and six cats who were having kittens . . . I didn't have much time to study. The kids would be going in the front door and out the back door. It's just a blur to me. After nursing school, I worked in intravenous therapy and emergency nursing. For five years, I have worked in the intensive care unit. I just get right to the point. I know I am bossy. I know I have a big mouth . . . but I love our little unit and I want things to go right. Two years ago my son was in a major car accident. It was just devastating. It took a year, but now he's better, so I am trying to concentrate on my daughter, now -- to help her get started."

Leah: After high school, Leah immigrated to Canada from China. She is 33 years old, and works in the emergency room. "I graduated from 12, then I got married and had two kids, and later on I went into nursing school. After graduation, I worked on a surgical unit for eight years. It got so boring, it became so straightforward . . . So, I left (nursing) and went into sales. After a year, I found that I just didn't have the personality for it. I'm too shy. So, I came back to nursing. I work day and night shifts to spend more time with my kids."

Kara: Kara is 40 years old, married and has always worked in critical care settings. "I was in the first graduating class from Cape Town University's degree program for nursing. One experience that has impacted on me is how the older doctors reacted to the starting of the degree program. The older doctors said, 'we'd end up to be half baked doctors;' others said, 'we'd just be good for sitting at the desk, getting further and further away from our patients.' This made me wild, and I think has influenced me, to a large degree, to stay with beside nursing -- to prove them wrong. I have two kids. My daughter developed a serious and chronic illness when she was very young. We take turns being sad and depressed about her condition. It's steadily worsening. When I'm down he helps me; when he's down, I try to comfort him. I don't know what will happen if we are ever down together."
Jan: Jan is 43 years old, and single. She graduated from a hospital-based nursing program in New Zealand, 17 years ago. "At 18, I was in charge of a ward, and yet I lived in a nurses' residence. We were weighed every six months to make sure we were not pregnant. Now there's chastity for you. About five years ago, I went back to the place I trained, and worked there. I found I was much too outspoken. I felt very uncomfortable, so I left. No matter where I've worked, I have always considered myself as an OR nurse. Now, I live in a Co-op, and my best friend who is an ex-nurse, lives just a few doors down from me. We have our own space, but we have helped each other through some difficult times. We look after each other's cats, too."

Liz: Liz is 31 years old and single. She has worked for many years in surgical and medical nursing. Last year, she decided to enter intensive care nursing. "Don't misunderstand me, I love what I do. But, I don't always like what I see around me. I had a dream last night about going to one of those nursing department meetings -- the ones that we are supposed to share our ideas in. All of the nurse managers were sitting around a table talking to each other, and I was kneeling on the floor silently folding napkins. It was a bizarre, but revealing dream about where I see my place in the scheme of things. I keep thinking about it. I have many friends who are nurses. We talk about what goes on, and we support each other. . . Sometimes, I get rid of my frustrations through painting . . . around midnight, I'll turn up the classical music and paint all night. I ponder. Just because I'm fairly quiet, doesn't mean much passes by me."

Tye: Tye grew up in Brazil and moved to Canada in 1978. She is 30 years old, and single. Most of her work experience is in critical care, and most recently in the emergency room. "The past few years that I have been in nursing have been difficult ones for me; mainly because of my personal life. I know work is work and home is home, but it's hard to separate them. I know I have learned a lot, and there still is a lot more to learn. It's okay to give yourself credit. Often, I have not realized I have made a difference until much later. One day I went out with my sister for lunch and this gentleman comes up to me. As it turns out, I looked after him as a patient. He remembered everything about
me. How I spent a lot of time explaining things to him, and how much he appreciated all of this. He has never forgotten me."

"I'm so thrilled about becoming a mom soon. If Joe wants to be involved that's fine, if he doesn't that's fine, too."

Ann: Ann is 40 years old, and married with two young children. Before coming to the intensive care unit, Ann had worked on a medical unit. "When I decided to go into nursing, I had been in the work force for 13 years. I had held various clerical positions and had worked the majority of the time in libraries. Although most of my jobs were out of the ordinary and challenging, the business world with its cut throat and smile persona was sickening. I wanted to get completely away from it. Since nursing school, my husband has gone back to school, too. We both have new careers." Most of the time, I enjoy nursing, but the cut throat business world has followed me into to the hospital. My kids help me stay sane."

Kim: "I am 37 years old and have practiced nursing since 1978. With the exception of my first year of work experience, I have worked in critical care. Over the past eight years, I have straddled between bedside nursing and nursing education, in a purposeful attempt to not loose my roots. The past year has been very difficult for me, as five of my family members have died. I have some dear friends and a wonderful partner who has helped me. I also have two delightful pet rabbits named Natalie Bunny and Denise Hopper."

Creating a Community of Practice Without an Official Identity

I have structured this analysis around the disparities within: 1) the official renderings of practice in nursing education; 2) the official renderings of practice in the nurses' job description; and 3) nurses' actual practice. As I mentioned at the beginning of the chapter, this focus on disparities between the official renderings of nursing practice and nurses' actually practice takes on two interrelated meanings. First, it suggests that these nurses are resisting the official prescriptions for their practice, and second, it suggests that they are creating alternative or new forms of
practice (Lather, 1991; Van Maanen, 1988). These differing ways of knowing are "created" and "recreated" within these nurses community of practice (Lave & Wenger, 1991). When reading about the nurses and their practices, notice how the they refer to themselves. Occasionally, they speak in the first person singular, "I," but most oftentimes, they speak in the first person plural, "we." Their emphasis on "we" is a subtle, yet, significant testimony to their membership within a specific community of practice (Lave & Wenger, 1991). But, this community of practice will not have an official identity, until its members' practices are visible. In the following sections, I will discuss nurses' philosophies/practices of caring and nurses' theories of/in actual practice.

In this analysis of nurses' in/visible practices, I would like to underscore the notions that this work is by nature fragmentary, partial and multivoiced (Foucault, 1980; Wertsch, 1991). It is a collection of stories about nurses and their practices (Britzman, 1991; Lather, 1991). I have become the narrator with/in these nurses' stories. As story tellers, we (meaning myself and the nurses) are constrained by what we think can and should be told, and we are constrained by the particular time-frame in which this study was conducted.

**Philosophies and Practices of Caring**

Throughout my discussions of nursing's history, one of the primary adjectives that is used to describe nurses' practices is "caring" (Gibbon & Mathewson, 1947; Growe, 1991). Nurses are not really nurses unless they care. And, even nursing practice was (and is) synonymous with nursing "care" (Morse, Solberg, Neander, Bottorff & Johnson, 1991). One of the first things that the nurses noticed about their job description is that it did not mention caring. Interestingly, if you turn back to Nightingale's performance appraisal for nursing students (see p. 23), you will see that caring is not mentioned there either (Nightingale, 1954). One of the
problems with Nightingale's criteria for judging nursing practice, and the nurses' contemporary job description is the behavioral renderings of nursing practice. Moreover, in most of contemporary nursing literature, nursing practice is researched within scientific and behaviorist models (Bevis & Watson, 1989). Within the constraints of these quantitative and decontextualized paradigms, the quality of caring becomes difficult to represent (Belenky, Clinchy, Goldberg & Tarule, 1986; Hall & Stevens, 1991; Van Manen, 1990). So, oftentimes, like in this hospital's job description, caring is ignored (Bevis & Watson, 1989). Even in the face of this omission from this job description, caring is still in the forefront of the nurses' everyday practices. From this point on, I will focus on what the nurses have learned about caring in their post-secondary education; and how they practice caring, today. At the end of this section, caring will be re-situated in its historical context, and then re-evaluated and problematized within the nurses' everyday practices. In these discussions, I will develop a beginning and partial understanding of caring within the constraints of the following questions: how does caring become personalized within nurses' lived experiences?; in what ways might caring take on different forms across the nursing specialties?; and when and how does caring become problematic in nurses' everyday practices? (Smith, 1987 & 1990; Van Manen, 1990).

One of the frank omissions within nurses' job description is that it mentions nothing about caring. Yet, this quality seems to be at the heart of each nurse's practice. During our second group discussion, Liz, Leah, Kara and Sue comment on this omission from their job description:

Liz: It's amazing that this job description doesn't mention caring. This document was drawn up by women administrators, but it takes all of the female qualities out. And, it's those qualities that makes nursing so special. This thing (job description) de-feminizes us.

Leah: Yeah, it makes our jobs look dull and bleak.
Kara: Totally uninteresting.
Sue: That's right. It makes us look like we are uncaring robots.
Liz: Have you ever noticed that if you emphasize the tasks and leave out people's feeling and emotions, you'd be done in no time?

As their conversations indicate, caring seems to be a quality that these women see as the driving force within their practice. Focusing on situations from their nursing education and current practice, I will look at some of nurses' practices of caring. In these first examples, Sue and Ann share recollections from their nursing education:

Sue: Jill kept coming into hospital because of a huge ulcer on her buttock. She was a paraplegic. Each time she came in, she was usually there for three or four months. All the staff members would make her feel welcome. The staff would bring her presents . . . The most important thing was the kindness, attentiveness and individuality we gave this woman. She wasn't just a room number or a name; she was a person. . . The final blow came when she was to have surgery to debride the huge ulcer. According to the surgeon, the ulcer was so big that a human hand and half an arm could be put in. . . Apparently maggots had set in. Jill died on the operating table at age 35. I remember this shook me up for months. It still brings tears to my eyes.

Ann: At the end of my training, I was working with a buddy -- one of the regular nurses. We were warned by the previous shift that this man was probably brain dead and was pretty awful to look at. We approached the bedside in the dimly light room and saw a very bloated man with blood oozing from his eyes, ears, and any puncture site or bruise. He had an inflated catheter in his nasal passage to stop the bleeding (in his esophagus) and was on a ventilator (a mechanical breathing machine). Beside him was a very distraught old woman with two canes. She was trying to comfort him, and he just lay there, occasionally experiencing small seizures. While Rachel assessed the patient, I took the woman out of the room and tried to comfort her. She really didn't want to know about his condition. She just reminisced about how he used to be. Mostly, we discussed her feelings and fears. I remember that I felt very ineffectual and wasn't really helping her much, but later she sent me a personal thank you note for just listening.
In Sue's story, she seems to place specific emphasis on certain aspects of caring: seeing a patient as a person, and not as a collection of deficits like a diagnosis or an ulcer. She, also, appears to point to one of the paradoxes within caring. She speaks about how heart wrenching it is for her to care about this woman and, then, have to mourn and still mourn her death. In Ann's story, she underscores the idea that caring is a holistic concept that moves beyond the boundaries of a patient to the patient's family (Morse, Solberg, Neander, Bottorff & Johnson, 1990). It is interesting that, at first, she thinks that "just listening" did not seem valuable, but then she learns that it is. Although Sue's and Ann's stories talk about how they have learned about caring from their patients and other nurses, Kara points out, that she has also learned about caring from their instructors:

They (instructors) would ask us about how this patient feels?; or what is the patient really telling you? We were being taught about empathy and respect for people -- seeing things from our patients' perspectives.

But, as Leah indicates, caring is also idealized in nursing education:

I remember having to write a paper on one patient. I wrote 50 pages and the instructor said I needed to write more. It's so idealistic . . . You can't know every little detail about every patient . . . You would never have the time to care for anybody.

Leah's emphasis on the way caring is idealized in nursing education is a common element across all of the nurses' educational experiences. However, as Leah says:

I can only say this because of what I've learned at work.

Before looking at some of the inherent contradictions within the concept of caring, I will draw from my field notes and interviews with Jan and Tye to discuss a few examples of their caring-in-practice.

In this first example of caring, the conversation is between two OR nurses, Jan and Gwen, and their patient Penny. Penny is about to undergo a breast biopsy.
This conversation opens as Gwen brings Penny into the OR theatre for her surgery:

Gwen: Penny says I look like the nurse from the movie "Misery!"
Penny: It’s your voice.
Jan: Gwen, you’re losing your reputation as a kind and loving nurse (laughing)!
Gwen: To bad I don’t have her Academy Award (laughing)!
Jan: Yeah, you could start a new career!
Penny: Yeah (smiling and peering around at Jan and Gwen).
Dr. Ons: I’m just going to give you some medication to help you sleep (injects some medication through Penny’s intravenous).
Jan: Just close your eyes and have nice dreams -- just let yourself go (Jan holds Penny’s hand until she is asleep).

After Penny was anesthetized and her surgery had started, we talked about this conversation:

Kim: That conversation with Penny was just incredible. In the beginning, she was so scared . . .
Gwen: I think that the most important thing we can do for our patients is help them have a restful sleep (under anesthetic).
Jan: We try to help them calm down, divert their attention away from the anxiety of the surgery. And, if I think they’ve got a sense of humour, I’ll go with it.
Gwen: Yeah, sometimes you can ask them about their jobs, their families -- anything to help them relax.

In this next example of caring, Tye escorts her patient Rose into a chair in the ER. Rose has come to the ER, because her breasts are sore and swollen. This conversation opens as Tye kneels down beside Rose, and starts to talk to her:

Tye: When did your breasts get sore?
Rose: About two weeks ago.
Tye: Have you had a mammogram?
Rose: No.
Tye: Are both breasts swollen or sore?
Rose: Just this one (pointing to her left breast).
Tye: Okay, I’ll just take a look, and then I’ll ask the doctor to examine your breasts.
A little later, when Tye had a few minutes to talk, I asked her a few questions about her initial conversation with Rose:

Kim: I noticed that once Rose was sitting in the chair, you kneeled down beside her and then started to ask her questions.

Tye: Yeah, I can't imagine anything worse than the power of having someone towering over you. So, I was just trying to equal the playing field. Most of our patients are on stretchers, so you can't do that, but it's nice when you can.

Kim: You can do breast exams. I was wondering why you left Rose's breast examine for Dr. Holt?

Tye: I was just trying to save her some pain. No matter if I do one or not, Dr. Holt will do one. So, I just thought that she shouldn't have to go through this pain twice.

In these examples, there are partial pictures of some of the ways in which Jan, Gwen and Tye practice caring. Jan's use of humour is fascinating. Based upon Penny's remark about "Misery," Jan has improvised and created a set of social circumstances to put Penny at ease. But, Jan is also quick to qualify her use of humour. She only uses it when she thinks a patient has a sense of humour. Gwen mentions another caring practice. In some circumstances, she practices caring by helping the patient define him/herself beyond the identity of patient (e.g., asking people about their families and jobs). In comparison to Jan and Gwen, Tye's caring practices are still different. Tye's kneeling beside Rose appears to symbolically reduce the hierarchical relationship between nurse and patient. In addition, she seems to anticipate Dr. Holt's exam Rose's breasts, and the pain associated with this exam. So, she chooses not to do a breast exam herself (e.g., to prevent Rose from experiencing this painful exam twice). In these examples, it could be argued that Jan's, Gwen's and Tye's caring practices arise from an implicit respect and concern for their patients. Moreover, each nurses' caring practices is different, and they talk about their practices as flexible. They seem to have developed caring
practices that fit their own personalities, and the specifics of each patient's circumstances.

Although I have just highlighted a few fragments from some of the nurses' caring practices, all of the nurses agree that caring is their common philosophical position, and that it comes to life in their practices. But, caring is neither a simple nor benign philosophical position; it is riddled with paradoxes in the day to day realities of these nurses' practices.

**Problematizing Caring**

Historically, caring is construed and enacted as "women's work" (George & Larson, 1988; Melosh, 1982). It is perhaps not surprising to find that nurses' work and caring go hand in hand. Throughout history, nurses' work is seen in such terms as: "distinctly women's work" and caring is "simply" the mothering of sick adults (Chua & Clegg, 1990, p. 140). Within this natural order metaphor, caring is not a choice; rather, it is nature's prescribed function of nurses (and women) (Hubbard, 1988). This metaphor leaves very little space for nurses who would like to confess that caring has personal costs, or that caring can make them unhappy (Hughes, 1990; Reverby, 1987). In other words, it silences discussions about the personal sacrifice or altruistic component within this definition of caring (Growe, 1991). And, the absence of caring within this job description does the same thing. Without the concept of caring in this document, the nurses have no official medium or voice to either articulate their caring practices (like the ones described above), or discuss the personal costs associated with caring. In the following discussions, I have selected three excerpts from our ongoing group discussion, which problematize the notion of caring in nurses' everyday practices (Smith 1987 & 1990).
In this first example, Kara, Liz, and Ann talk in general terms about the idealized notion of caring within their post-secondary education, and how this has made it difficult for them to establish limits for their caring practices:

Kara: Not all nurses care. Some just shut off and focus on the tasks.
Liz: I think that's true, but you've got to remember that caring was drilled into most us in training. Care, care, care! And, some of us never learned how to shut it off.
Ann: That's for sure!
Liz: And sometimes its hard for us to shut it off. So, sometimes nurses just shut off completely.
Jan: It's hard. In the OR, the sterile fields (linens) we use around the operative site usually go above and beyond the patient's face. Thank God, we don't have to look at the patient's face as the surgery is going on. That would just be too much, we'd just turn into blithering idiots. We wouldn't be able to do anything.

Kara, Liz, Ann and Jan seem to be empathizing with each other about their attempts to draw boundaries around their capacities to care. Although Kara and Liz make a special point of mentioning that some nurses "shut off" their caring, there seems to be no blame attached to these nurses. To Kara and Liz, it would appear that "shutting off" is more of a protective mechanism than a deficit. In addition, Jan's abilities to establish some physical boundaries for caring is an unique circumstance within her OR specialty.

In this second example, Ann, Liz, and Tye talk about the problematic construction of caring when Ann is confronted by male patients who expose themselves:

Ann: In the past three weeks, I have had three men expose themselves in ER. The last time, I told this young guy to turn over on his stomach, and I'd be back to give him an IM (intramuscular injection) in his butt for his nausea. When I came back he was laying on his back with the bed covers down exposing himself. I just told him to get over on his stomach, and I just rammed that needle into his butt. He screeched and jumped!
Liz: Good for you!
Ann: Well you know, I feel guilty about doing it. But, I'd just had enough!

Tye: Don't feel guilty! He's got no respect for you. He deserved it. Please (stated with emphasis), come see me in action. I wouldn't have put up with that for a second. I would have told him off, but quick.

Kim: Did you report it to nursing admin.?
Ann: No, because nothing ever happens when you do. I've reported stuff like this before, and you never hear from them.

I think that this conversation amongst these nurses gives some interesting insights into how the community of nursing practice works toward debunking and resisting a historically and culturally prescribed vision of caring (Van Maanen, 1988). Even in the face of sexual harassment, Ann's account gives a personalized look at the dilemma she faces in setting boundaries for caring. This seems to be further perpetuated by an apparent unresponsiveness of the hospital to act in such cases. Although Ann's actions are supported by Liz and Tye, her guilt is not. To help Ann overcome this guilt, Tye offers help. Tye invites Ann to watch her in action or role model, how she has learned to make dividing lines within caring. I think that Tye's conversation with Ann is extremely insightful. Although she does not use the word altruism, Tye seems to be trying to help Ann remove the altruistic component within her conception of caring. I should also point out that Tye's help seems to be based upon her "caring" for Ann.

In this last example, Leah talks about the paradox between nursing "care" and medical "cure." Kara describes one of her experiences in relation to this paradox:

Leah: We try to help people have peaceful deaths, but sometimes the doctors just won't stop things. They try to cure people, and they see death as a failure.

Kara: I remember this poor old man. He was on a ventilator, with every other tube in creation. I couldn't take it anymore . . . I yelled at Dr. Jons, for God sake turn this equipment off, the man is dead! He refused. So I when to the family, to let them know what was really happening. All they wanted was to be told about their Dad's prognosis -- that's their right.

Leah: What did Dr. Jons do?
Kara: Well, the family pushed him to let their Dad go, and he did. But, he knew I talked to them. He snubbed me for a month. But, that didn't bother me.

As I mentioned at the beginning of this chapter, according to the nurses' job description, medical interventions are supposed to supersede the nurses' plan of care. However, Kara seems to resist this interpretation based upon her implicit perspectives of caring. Although Kara does articulate her views about "the right to die" to Dr. Jons, he appears not to consider her perspective. But, Kara re-strategizes and talks to the family. Within her conversations with this family, Kara seems to have found a legitimate voice for her practices of caring. Leah's general comment about medicine's emphasis on "cure" and nursing's emphasis on "care," seems to reaffirm Kara's actions. In addition, the equipment that Kara asks to be removed is specific to the ICU setting.

I have purposefully not tried to confine this discussion by offering textbook definitions of caring. Instead, I have tried to represent aspects of caring within some of the nurses' lived experiences. Given that the nurses' job description does not mention caring, I have emphasized caring in this opening section, not to artificially separate it from the nurses' theories of practice, but to underscore its importance as a philosophical belief that drives and constrains the ways nurses practice. In the next discussion, I will look more closely at prescribed theories for, and nurses' implicit theories from, practice.

Building Theories For/From Practice

All of the nurses agreed that the following statement in their job description does not account for the realities and complexities of their practice: "(nurses) implement Henderson's model for nursing through the use of the nursing process." To trace the roots of this disparity between these "prescribed" models for nursing practice and nurses' theories from actual practice, I will focus on some aspects of: 1) what
these nurses have learned about nursing theories in their post-secondary education; and 2) how they (re)create their own implicit theories from practice.

During one of our group discussions, I asked the nurses to reminisce about their nursing education programs, focusing on how they had been taught about prescribed nursing models, and what they thought about these theories for practice. The following conversation is an excerpt from this session:

**Kim:** You made a really interesting point in your autobiography when you talked about nursing school and having to learn all these needs in these categories. But independently of each other, and then you were supposed to put it all together.

**Tye:** Oh yeah, I remember. In semester one, we started to learn about the seven needs of a person. We studied every need separately . . . You thought of the seven needs that the person had, but you didn't think of them all as one . . . This was all to come together in semester two. By semester two, . . . It was very difficult to put all these needs together.

**Liz:** I remember (in nursing school) working with cardiac patients, and not knowing what the hell I was supposed to put together. Now I say to myself oh that's what I was supposed to know, to learn, to put together.

**Leah:** These models are too cumbersome if you follow them verbatim. You really can't do a good job, as you should be doing it, as the instructors' expected you to do . . . and follow these models.

**Sue:** When I was at school trying to learn that stuff. I just said I can't do it, and my teachers would say oh yes you can. I never really did, though.

**Ann:** Yeah, its not natural.

**Kim:** So, you were taught to use these models, but you really didn't use them?

**Jan:** I don't think we did. I think that probably all of us here decided that we will go our own ways. We would do our own (models).

Within these discussions, there seems to be two general points: one is about educational practices, and the other is about educational content, nursing models.

Tye's comments about how she was taught a nursing model seems to emphasize the notion that nursing curriculum is compartmentalized into discrete topics (Bevis & Watson, 1989; Britzman, 1991). In her education program, it appears that each
need within the model is taught separately. The difficulties she speaks about -- trying to make connections between each need and trying to see this model in a holistic way -- appears to be more of a problem with the educational practices for teaching this model, than a reflection of her abilities to learn. Liz, Leah and Sue seem to have had similar educational experiences. Leah, also, suggests that the model she was learning about in the classroom setting did not seem to "fit" in with her clinical experiences. Leah's words "too cumbersome," Sue's word "stuff," and Ann's words "its not natural," appear to address the irrelevance of these prescribed models to their practice. They seem to be talking about a profound void between the prescribed or received models for practice, and their own implicit theories from practice (Britzman, 1991; Lave and Wenger, 1991). Jan's statement about resisting the prescribed models for practice and creating her own model of practice, implicitly suggests that the origins and development of such a model would be relational or based upon her own experiences. But, how might such theories take shape and be reshaped in practice?

**Theories of Lived and Shared Practice**

As I started to piece this section together, I found it increasingly unproductive, to fragment nurses' knowledge into reified types such as "declarative and procedural" (Anderson, 1990). As this discussion unfolds, it will become evident that these nurses remember certain experiences for specific reasons, and in highly contextualized ways. In their utterances, various knowledges are intricately interwoven together. Initially, I will talk about the forms and functions of these nurses' experiences, and about how these nurses (re)create theories from the experience of practice (Britzman, 1991). Although this discussion is based upon the nurses' journals, and my field notes from direct observation, most of the nurses' conversations will come from our group discussions, where we tried to collectively
analyze these theories from practice. In this regard, this discussion represents a retrospective analysis of nurses' theories.

As these theories are being discussed, I will also try to chip away at the notion of homogeneity. This assumption is basic to the nurses' job description and the prescribed theories for nursing practice (e.g., Henderson's model and the nursing process). To begin to deconstruct this assumption, I will focus on how the nurses' theories are composed of experiential differences, and contextual differences across nursing specialties (Bruner, 1986; Luria, 1979; Wertsch, 1985 & 1991; Vygotsky, 1978). Lastly, I do realize that I have not discussed the nursing process, yet, but I will interweave into the next section which addresses nurses' theories in the action of practice.

In our group discussions, I suggested that the nurses talk about some of their experiences as a way to look at the nature or structure of what they remembered, and determine why these memories are important to their practice. Both Jan and Leah talk about one of their memorable experiences, and their reflections on the importance of their experiences:

Jan: I was called in for an Open Reduction and Internal Fixation of a fractured ulna (forearm bone). The fracture was complicated because there was two different types of fractures. One clean break straight across the bone, and the other was an oblique spiral. During the surgery, the orthopedic surgeon attempted to stabilize the clean break with a multi-holed plate. This was a struggle because it was difficult to hold the shaft of the ulna steady enough to apply the plate and drill the holes for the screws. After at least an hour of struggle . . . I was unable to stop myself from saying, 'what would happen if the pieces of bone at the oblique fracture site were screwed together first?' . . . It was not too long after this discussion that the surgeon did exactly what I had suggested - stabilized the oblique fracture and then plated the clean fracture.
Jan's Reflections:

It's like putting your experience together, and coming out with something different . . . Besides, even though Dr. Jurgens didn't acknowledge it, I'd showed him a different way of doing it, and I took great pleasure in that.

Leah:

He was sitting on the edge of the bed and he had the table in front of him and he was pulling this table into him; that's how anxious he was and I had to start yelling at him to look at me and to breath with me because otherwise he was gone . . . so I'm giving him some ventolin (a drug used to improve breathing), and he is just panicking. I listen to his chest, air was going in, I mean sort of. At that point, I didn't have a oxygen saturation on him, because it was too far to go and there was just too much happening at the same time. The next thing I knew, my eyes kind of wandered down toward his feet . . . he was all mottled from his legs right up to his stomach. I knew he was in big trouble.

Leah's Reflections:

I guess it's a good reminder about what to look for. . . Mr. Klein's breathing was the obvious problem, but that mottling was more about CHF (congestive heart failure). The breathing wasn't really a lung problem. It was a cardiac problem.

Jan's and Leah's reflections seem to speak about two different ways that past experience is used to create new ways of knowing. Jan's experience seems to represent a turning point in her practice -- a point where she synthesizes her past experiences and creates a new way of dealing with this type of complex fracture (Bruner, 1986; Lather, 1991). Whereas, Leah's experience seems to be hallmarked by the notion of preventing premature closure -- going beyond the obvious symptomology related to shortness of breath and looking for alternative explanations. Tye, also, provides an interesting perspective on the experiences that she deems noteworthy to her practice:
InNisible Practice

Tye: I try to remember the unusual things. Like, usually there's certain things about the patient's history and presentation that lets you know what's going on, but you have to watch out because you can get fooled. . . About two years ago, this older guy came in (to the ER) with bad chest pain. He was diaphoretic (sweating), and just clutching his chest. I thought for sure he was having a MI (heart attack). As it turned out, he had esophagitis. Then, last year, this woman comes in with a sore chest. She was calm and only 36. So, I thought she had pleurisy or something. Her enzymes (blood tests) came back high. . . she'd infarcted (had a heart attack). So, you have to be careful about what you decide.

Tye appears to be talking about two strategies for learning from her experiences: on the one hand, she tries to find similarities across her experiences to create typical presentations of patients; on other hand, she tries to look for differences -- patient presentations that do not fit the usual ones (Britzman, 1991). Her idea about going beyond the typical and looking for the atypical is similar to Leah's idea about preventing premature closure. In these partial examples of nurses' experiences, I have tried to identify a few strategic ways that some nurses use their past experiences to guide their current practice. However, the construction of meaning from experience can be different for different nurses.

On different shifts in the ICU, Liz and Sue looked after the same patient, Mr. Larson. Mr. Larson came to the ICU immediately following a complicated and extensive abdominal surgery. Although Liz and Ann came to the same conclusion about his condition, the data that they used to form this conclusion are different:

Liz: When I came on shift there was no (urine) output from the tube (in the ureter) and the foley catheter (in the bladder). So I irrigated the tubes. Still no output was coming back. Only the same amount that I used for irrigation, and nothing more. Then I emptied the hemovac (a drainage tube inserted into the abdominal cavity), and there was a lot of drainage there . . . about 200mls. The drainage (from the hemovac) looked like the urine that should have been coming from the tube and catheter. So, I phoned Dr. Allan and told him . . .
didn't think that the drainage coming from the hemovac was urine. . . Try Lasix (a drug used to increase urine output). But, after the Lasix most of the output was coming from the hemovac. . . So, definitely the urine was draining from there . . . When he zoomed in and looked at it, he realized that the urine was draining from the hemovac.

Sue: I thought the same thing. Was this just blood in the hemovac? Because I think right from the start there must have been some urine in there. It (meaning the drainage) wasn't clotting.

Although Liz and Sue come to the same conclusion about where Mr. Larson's urine is draining from, they have emphasized different findings in the constructions of this conclusion. Liz's conclusion appears to rest on three interrelated observations: no urine output from the ureteral tube or from the catheter in the bladder; the urine-like colour of the drainage from the hemovac; and the increased output from the hemovac following Lasix. Interestingly, Sue's conclusion seems to rest on one observation: the drainage from the hemovac did not clot like it normally should. It could be argued that the differences within Liz's and Sue's analyses of this clinical situation rests upon the contextual differences within their past experiences -- how their differing experiences have shaped and influenced the current ways in which they construct knowledge (Vygotsky, 1978; Wertsch, 1985 & 1991).

Based upon the partial collection of nurses' practices presented, I would like to coordinate and interrelate some of the key points. I do realize that I will be making some generalizations about nurses' implicit theories of practice, but these generalizations are not meant to be restrictive like the ones found within the nurses' job descriptions (e.g., Henderson's model). These generalizations are meant to be fluid. They will depart from the homogeneous assumptions underlying the grand theories for nursing practice, and will stress some of the ways in which variations across nurses' implicit theories of practice can be interpreted on the basis of contextual differences (Vygotsky, 1978).
Throughout my earlier discussions on the practices of caring, and in this discussion on creating theories from practice, there seem to be recurrent elements. When nurses talk about their practice, they tell very detailed stories about patients and events in context (Britzman, 1991). As Kara said:

If I try to slow my thinking down, I would describe it as watching pictures unfold in my mind.

Hence, she narrates her stories from the pictures in her mind. Most of the nurses' stories presented, thus far, are like "... packages of situated [and interrelated] knowledge..." and appear to represent turning points or transformations within their thinking and practices (Jordon, 1989; quoted in Lave & Wenger, 1991, p. 108). The nurses talk about constantly integrating and interconnecting their stories -- constantly interweaving past and present experiences to renew and recreate their approaches to patient care (Benner, 1984; Tanner, 1992).

Within this (above) description, if I remove the word "story", and replace it with "case study," it would be possible to make analogies between the nurses' clinical story building, and ethnographers' case study methods (Goetz & LeCompte, 1984; Van Manen, 1990; Yin, 1989). Like ethnographers, these nurses focus on contextualized experiences; they analyze large bodies of qualitative data; and they are interested in developing themes (similarities) and in finding differences within these themes. However, unlike ethnographers, these nurses are engaged in researching their own lived experiences (Van Manen, 1990). In addition, unlike ethnographers who usually remove themselves from the research site for data analyses, these nurses do most of their analyses as they practice.

I have tried to build this particular analogy between nurses' stories and the research method of case study analysis for two reasons. First, the idea of nurses as "researchers of their own practice," deconstructs the following statement within the nurses' job description: "(nurses) change practices or procedures to reflect
current research findings." As researchers of their own practices, nurses are the active (re)constructors of their own implicit theories of practice (Lather, 1991; Lave & Wenger, 1991; Wertsch, 1985 & 1991). Second, the notion of nurses as researchers, also, deconstructs the hegemony of universal or grand theories for nursing practice, which is reified by nursing education and this hospital's job description (Gramsci, 1988). As active researchers and constructors of knowledge, nurses can be re-situated with/in the contextual diversities of their practice. Based upon these contextual differences, each nurse has unique experiences, which in turn, influences the ways in which she (re)constructs her theories of practice (Belensky, Clinchy, Goldberg & Tarule, 1986; Van Manen, 1990). And to extend this point further, each nursing specialty has contextual differences which, in turn, creates particular practices in particular specialties. I will expand upon this last idea.

In the last group of examples from nurses' experiences -- Jan's from the OR, Leah and Tye's from the ER, and Liz's and Sue's from the ICU -- the types of practices that they describe seem quite different. In these examples, Jan's practices seem to focus on the events around a particular surgery; Leah's and Tye's practices appear to focus on analyzing their patient's chief complaints (e.g., shortness of breath and chest pain); and Liz's and Sue's practices seem to focus on recognizing a rare post-operative complication. Within their accounts of practice, there seems to be no evidence of a generic theory for practice like Henderson's model. They do not speak about generic needs or divide their patients up into needs as this model would suggest. Rather, their experiences and practices appear to be shaped within their specific work contexts or specialty areas, and within specific patient circumstances (Britzman, 1991). In our group discussions, Kara and Jan extend this idea:
Kara: I think that whatever your specialty is, you have your own theory or model for that . . . What I really found interesting was when I started a new job and changed specialties . . . I initially started explaining everything in relation to my previous experience which was dealing with cardiac patients. And now I was working with patients with renal failure. In the beginning, I would explain their care to myself in relation to my cardiac experience, because this was where my background was.

Jan: Like, I can only explain things from an OR nurse's point of view, because that is what I know.

What Kara's and Jan's ideas seem to suggest is that there are specific contextual differences within each nursing specialty which, in turn, create different perspectives and practices. These specialties are like specific communities of practice within the broader or more general community of nursing practice (Lave & Wenger, 1991). Although I have only presented examples from nurses' practices that suggest some contextual differences across their communities of practice, each nursing specialty is not completely different from each other. There are some instances where nurses' practices from different communities can intersect (Lather, 1991). But at these points of intersection, what might be similar and different?

In our third group discussion, Ann talked about a patient, Mr. Sanchez, whom she admitted into the ER. Mr. Sanchez came to the ER, because he was experiencing extreme shortness of breath. In this following excerpt, I asked the group to talk about how they would care for Mr. Sanchez, so that we might be able to uncover some of the similarities and differences across the ER, ICU and OR communities of practice:

Ann: In the ER, we'd focus on his history --when did the SOB (shortness of breath) first start . . . is there orthopnea (unable to breath when lying flat)? . . . what meds is he taking?

Liz: We don't have to worry about those things (in the ICU), because by the time he gets to us all of that information is in the chart. We'd check his respiratory rate and listen to his lung and heart sounds right away, and do an O₂ sat. (a machine that measures the oxygen saturation level in arterial blood).
Tye: (In the ER) We'd do that, too. We'd probably give some ventolin or Lasix... then watch the urine output and recheck his lung sounds and O₂ sat.

Kara: Yeah, we'd watch for that (in ICU).

Jan: We admit patients to the OR just before their surgery... So, we look out for things like SOB, but we really just have to recognize it... watching for a fast respiratory rate and looking at the colour... Then, we'd just tell the anesthetist and he'll deal with it.

It would appear from these conversations that all of the nurses have prior experiences in caring for people who are experiencing shortness of breath, and that they have developed some strategies for examining and caring for this patient situation. However, Ann's emphasis on focusing on a person's history appears to speak to a unique situation in the ER setting. When patients come into the ER from home, they do not bring a chart containing all of their previous medical history, doctor's summaries and diagnostic test results with them. So, the ER nurses must build a clinical history and picture of the patient. These circumstances are unique in comparison to the ones encountered by ICU or OR nurses. By the time a patient is admitted to one of these specialty areas, the patient has a comprehensive history in his/her chart. Thus, thanks to the ER nurses (and ER doctors), the ICU and OR nurses have a comprehensive background on the patient.

Within this (above) conversation, the ICU nurses (Liz and Kara) and ER nurses (Ann and Tye) share some similar practices (e.g., listening to lung and heart sounds, analyzing oxygen saturation levels, etc.). But, Jan's examination practices, within the OR setting, are less extensive. I am not using the word "less" here to suggest that Jan's examination is not as important as the others. Rather, I am trying to indicate that across their specific communities of practice, these nurses have similar and varying degrees of participation in the care of this patient. Lastly, it is interesting to note that what is considered "medical practice" in the OR setting (e.g., the anesthetist would look after the management of the patient's shortness of breath) is considered "nursing practice" in the ICU and ER settings.
In this section, I have tried to piece together some of the components of nurses' implicit theories, and argue that these theories bear no resemblance to the prescribed model for nursing practice within the nurses' job description. I have emphasized that the nurses remember certain experiences for specific reasons, and in very detailed and contextualized ways. Each nurse seems to use an ever growing repertoire of experiences like an ethnographer would use case studies -- to analyze the similarities and differences within and across specific events, and to guide and create new ways of knowing. I have also talked about these case studies as stories. The stories each nurse tells herself about her practices, and the stories she tells other nurses about her practice. I will further explore the role of story-telling within the community of nursing practice.

**Story-Telling Within the Community of Nursing Practice**

Within the excerpts from our group discussions that I have presented and my own observations as I watched nurses in practice, I noticed that nurses are constantly telling stories about their practice. This heritage of story-telling can be traced throughout nursing history. In Chapter One, I talked about how the "lay" nurses handed down their "tried and true remedies" of practice through story-telling practices (Ehrenreich & English, 1973). However, many of the nurses from the past were illiterate, so this was the only way that the legacy of nurses' practices could be passed on and, thus, (re)produced (Lave & Wenger, 1991). In current times, the circumstances are different; clearly, nurses can read and write. However, the oral tradition of story-telling still lives on. Why? I will work through two examples of nurses' story-telling practices and, then, look at one possible reason for this lasting tradition.

One day, while I was directly observing nurses' practices in the OR setting, May asked me to look at Rose's inventive tubing set up for the Phaco machine. This
machine is used during cataract surgery for applying ultrasound in the eye's capsule to "break up" the cataract; for applying suction to remove the cataract pieces; and then irrigating or cleansing the eye's capsule. As this conversation opens May is about to escort me down to the OR theatre, where a cataract surgery is in progress:

May: (Kim) Have you seen Rose's excellent set up for the Phaco machine.
Kim: No, but I'll come down and take a look.
May: (Rose) I brought Kim in to see what you've done with the tubing on the Phaco.
Rose: Come over, here (smiling) . . . Well, when we got this new machine, it came with instructions for setting an IV bag and tubing for irrigation . . . one day while I was assisting with an abdominal peritoneal resection, I noticed that the patient was getting two units of packed cells (blood) through "Y" tubing (this tubing is called "Y" because it has two ports at the top, where two IV bags can be attached. So, the tubing is shaped like a "Y"). Then, it hit me. I could use the same thing for the Phaco.

Kim: What do you mean?
Rose: Well, when one bag is finished, I can just turn on the second bag. It's much saver for the patient, because you don't have to worry about running out of irrigating solution, and running around to get a new bag. So, when the fluid starts to get low I just quickly turn on the second bag.

Kim: Your brilliant!

In this remarkable conversation, I am witnessing Rose's creativity-in-practice. Rose appears to have taken a practice from one situation and transformed it into a new practice in another situation. She has shown the other OR nurses how to set up this tubing, and through these story-telling practices, the other OR nurses are able to reproduce her creation, and in this way her legacy lives on (Lave & Wenger, 1991; Wertsch, 1991). However, her creation is not written down in the hospital's official procedure manuals or in any of the textbooks and journals that we looked through (and we did look through numerous reference texts and journals).
The next example is along the same vein only it is situated across the ER and ICU settings.

In the ER and ICU setting, it is very important to be able to distinguish angina from myocardial infarction (heart attack) pain. Oftentimes, it is difficult to know which is which, because the chest pain associated with these conditions can be very similar. However, angina does not cause heart damage, but myocardial infarction does. With the administration of thrombolytic agents (drugs that dissolve clots in the heart's arteries), frequently, the extent of the infarct (heart damage) can be reduced as long as these drugs are administered within six hours of the onset of the chest pain. For the ER and ICU nurses, this means that the faster they can differentiate between angina and myocardial infarction (MI), the faster the patient with a MI can receive these drugs. The following excerpt from our group discussion opens as Tye starts to talk about how she examines people who are experiencing chest pain:

Tye: Well, usually there's that typical pain: mid sternal with radiation to the arm or jaw. And then there's a cardiac history, that's good to know.
Kim: Say none of the test results were back. How can you tell angina from MI?
Ann: Oxygen usually eases up the angina, but not MI pain.
Leah: Yeah.
Ann: Just something tells you. It's all these things together, they usually have a (cardiac) history, usually this pain just started on its own while they were at rest, not doing anything; that's usually a good indication of MI.
Kara: They're usually diaphoretic (sweating). They look kind of ashy yellow.
Sue: But, there's something about their color that kind of pale ashen look.
Leah: Yeah, that kind of gray chalky look.
Ann: Yeah, oh my god, you know, that chalky look.
Tye: I think that colour is a very important thing.
Kara: And then, there's that fear, that anxiety.
Tye: They'll just kind of lay on the bed, still.
Ann: They're quietly hyperventilating. They're not saying anything too much.
Leah: That's part of the anxiety.
Ann: Yeah, that's right they usually express their anxiety that way.

In this collective effort, the nurses appear to be trying to piece together parts of their experiences that represent similarities and differences in the clinical presentation of people who are experiencing angina and MI. Although they mention a number of observations that are similar to both of these conditions, their ideas about differentiating these conditions based upon the "person's colour," and "expression of anxiety" are fascinating. We have combed through many texts and journals trying to find the emphasis that these nurses place upon skin colour and the expression of anxiety. We have not found it. It is something that the nurses have learned within their practices, and shared through story-telling, but it seems to be something that the official authors of nursing texts have ignored.

In both of these glimpses of clinical practice, I have tried to show how nurses' practices move beyond the "minds" of individuals, and become situated along the intermental plane within and across specific communities of nursing practice (Bruner, 1986; Lave & Wenger, 1991; Luria, 1979; Vygotsky, 1978; Wertsch, 1985 &1991). Through story-telling, the nurses share and enact each other's practices.

Interestingly, in both of the (above) examples, there seems to be a disparity between how the "official" authors of texts represent nursing practice, and how nurses actually practice. Some of the specifics and intricacies of practice may not be well represented in nursing textbooks, and may not be written down anywhere. So, like their historical counterparts, these nurses appear to use story-telling as a means for sharing and learning about actual and situated practices within their community of practice. For the community of nursing practice, story-telling becomes a significant social mechanism for praxis -- sharing, uniting, enacting and
(re)creating nurses' theories in practice (Britzman, 1991; Lather, 1991; Lave & Wenger, 1991).

By its very nature, this discussion about nurses' implicit theories of practice and the importance of story-telling within the community of nursing practice is fragmentary and tentative (Aronowitz & Giroux, 1991; Lather, 1991). I have used specific, but partial examples that indicate some of the different ways nurses' practices can be represented. In this discussion, I see my main task as trying to represent aspects of nurses' implicit theories of practice in similar, different and contextualized ways (Britzman, 1991; Lather, 1991). Within this discussion, there is a profound disparity between how these nurses represent their practices, and how their job description represents their practices. This disparity speaks to the creativity within each nurse's practice, and to nurses' collective resistance of the prescribed ways for constructing nursing practice within their educational programs, and within this hospital's job description. The next discussion will look at how nurses' theories of practice come alive in actual practice.

Theories With/in Actual Practices

I do not have data that specifically relates to how nurses were taught about clinical decision-making models in their post-secondary education. But during our second group discussion, the nurses did critique such models. In the following conversations, the nurses discuss the applicability of the "nursing process model" to their actual practice:

Kim: What about the nursing process?
Liz: I don't use it either. I think most of the times I've got about 5 or 6 things going on in my head about a patient. I think that the nursing process doesn't really allow for that.
Kara: It's vertical. We work on the horizontal. Everything.
Sue: Yeah, integrating everything at the same time.
Kim: Like, there's a number of things happening and you're looking at how they affect each other.
Kara: Yeah, but it comes automatically without even thinking about it.
Sue: Just even an eye ball. You can just look at a patient. Like I just can look at a patient. I can go up to the patient and know... Oh, shit this patient is going down the tubes. And it happens.
Leah: It's like multi-sensory. It's a kind of multi-sensory type thing, you know... you walk in to take a look at somebody, and you take a real good look at the way their body is; what's their physical demeanor; what they look like in general; kind of how they smell. And a whole bunch of different sensory things going on, and I think that's how you kind of get those impressions.
Jan: Yea, like you're splitting your consciousness in different directions; we do that.
Tye: Sometimes you don't even have to see the patient. You just look at the chart and know this patient's in big trouble!
Jan: I guess we can throw it (the nursing process) out the window, too. Nobody uses it here.

Like Jan's last statement implies, it can be concluded that the nursing process does not adequately represent the ways in which these nurses' make clinical decisions.

In contrast to the nursing process which emphasizes the linearity of nurses' thinking, all of these nurses mention the simultaneous nature of their thinking. Liz's statement, "I've got about 5 or 6 things going on;" Kara's idea, "We work on the horizontal (as opposed to vertical or linear);" Leah's comment, "It's a kind of multi-sensory type thing;" and Jan's notion, "splitting your consciousness in different directions;" all tend to merge on the simultaneous nature of their thinking. But, how might this form of thinking take shape in actual clinical situations?

**Simultaneous Thinking-in-Practice Related to One Patient**

Given that we had arrived at the idea of simultaneous thinking as a way of representing clinical decision making early on in the course of this research project (e.g., during our second group discussion), I tried to keep this idea in mind as I directly observed each nurse in her clinical specialty. So, whenever it was possible -- when I was not disrupting the nurse's care of her patients -- I would ask her to help me piece together her thinking with the observations that I had made in my field notes. The following representation of thinking-in-practice is a result of these
collaborative efforts. In this glance at Kara's thinking-in-practice, I have constructed a table with three categories: conversations between Kara and her patient, John; her actions; and her reflections on what she was thinking at the time. And for the sake of brevity, I have only included the initial part of her examination of John. John is middle aged, and came to the ER experiencing severe chest pain. After Kara helps John onto a stretcher, she begins her examination (refer to Table 3, on the next page).

I think it is important to mention that Kara is an experienced ER nurse. This experience seems quite obvious in the way she has used specific interview questions, performed definitive examinations, anticipated future difficulties and redesigned her care around the specifics of John's circumstances. It could be argued that she has designed her care of John based upon past experiences -- her own case studies about similar patients in similar circumstances. When I interviewed Kara immediately following her care of John, we tried to piece together my notes, with her interpretations of her thinking-in-practice. During this time, she said:

. . . so much of this comes automatically to me. . . I can tell you about some of the things that were going in my head. . . but, some of it, I'm not really conscious of. . . it just comes naturally.

Kara has made a very interesting point not only about herself but also about me. First, my field notes are constrained by my own conceptual lens, which allow me to see some things and not others (Mishler, 1986). Second, based upon Kara's experience, it would seem that she has developed highly automatized strategies for examining people with chest pain (Anderson, 1990). So in relation to this example, there may be other ideas and events happening, and what we have captured, here, is only what she and I are conscious of. However, what is captured is important, and needs further explanation.
Table 3: A Representation of Kara's Thinking-in-Practice.

<table>
<thead>
<tr>
<th>Conversations:</th>
<th>Actions:</th>
<th>Kara's Reflections:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kara: Where is the pain?</td>
<td>-puts John on oxygen.</td>
<td>-if this is heart pain, the oxygen will help; if it's not, the oxygen won't hurt him.</td>
</tr>
<tr>
<td>John: It's in my chest (points to the middle of his chest).</td>
<td>-helps the patient off with his shirt and attaches him to the bedside electrocardiogram (ECG) monitor, and looks at the ECG monitor to see the patient's heart rhythm. -takes a printout of the ECG rhythm. -puts her stethoscope on her chest and listens to his heart and lung sounds.</td>
<td>-it looks like pretty intense pain. He's grimacing. -he looks a little ashen, and he's so thin. -he looks like a hippie with those clothes and that long beard. -looks like normal sinus rhythm with ST segment elevation (the latter is an indication of reduced blood flow to the heart; it can indicate angina or MI). -no heart murmurs, so the valves are okay, and his lungs are clear so no heart failure, yet. -better find out if its angina or MI.</td>
</tr>
<tr>
<td>Kara: Wendy, will you make out the reqs. for cardiac enzymes and a 12 lead. Wendy: In just a sec. Kara: Does your pain move anywhere? John: Down my (left) arm. It feels numb.</td>
<td>-looks at the arm.</td>
<td>-typical pattern of radiation. -he's moving his arm okay. I'll check his motor strength later.</td>
</tr>
</tbody>
</table>
Table 3: A Representation of Kara's Thinking-in-Practice (continued).

<table>
<thead>
<tr>
<th>Conversations:</th>
<th>Actions:</th>
<th>Kara's Reflections:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Kara:</strong> (Kim) Would you get me an 18 gauge and tubing? Kim: Sure.</td>
<td>-takes John's blood pressure (B/P) and looks at his arm veins.</td>
<td>-better find out if its angina or MI.</td>
</tr>
<tr>
<td></td>
<td>-Kim returns with the IV catheter and tubing.</td>
<td>-B/P is okay.</td>
</tr>
<tr>
<td><strong>Kara:</strong> I'm just going to put in an intravenous in your arm. Then I'll give you something for the pain. Are you allergic to anything? John: Yes, pork insulin. Kara: Oh, so you're diabetic.</td>
<td>-Kara starts priming the IV tubing.</td>
<td>-I'd better get an IV into him, because I'm going to give him some nitro (drug) for the pain and I can't have his B/P drop after the nitro within an IV line to compensate by giving fluids.</td>
</tr>
<tr>
<td><strong>John:</strong> Yes.</td>
<td></td>
<td>-he's got veins like garden hoses, I'll put in a big one, an 18 gauge.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-he's really sick so I can't leave him alone.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- I always make sure about allergies, before I give any drugs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-he's quite alert so his blood sugar is probably okay.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-diabetes is a big cardiac risk factor.</td>
</tr>
</tbody>
</table>
In this representation of simultaneous thinking-in-practice, Kara appears to have: 1) developed two fairly specific, but tentative diagnoses (angina or heart attack); 2) ruled out three possible diagnoses (low blood sugar, heart valve disease and heart failure -- however, she still thinks the later may occur); and 3) filed away the arm numbness for future diagnosis. This latter point speaks to her priorities. She seems to think that the time it would take to investigate this numbness should not take precedence over dealing with John's chest pain. At the same time, she has: 1) started an interview with John; 2) put him on an ECG monitor; 3) taken his blood pressure; 4) assessed his heart and lung status; and 5) set up IV tubing. Also, she appears to be anticipating and preparing for future problems such as: a low blood pressure, which is related to the administration of nitroglycerin; a low blood sugar level which is related to the patient's diabetes; and a cardiac arrest which is related to the John's cardiac status. With regard to the last point, she does not leave John's bedside, and delegates the laboratory requisitions to Wendy, and the obtaining of IV equipment to me. This is not a usual practice. Based upon the critical nature of John's condition, she has apparently redesigned her practice. If John does have a cardiac arrest, she seems to want to be at his bedside so that she can spring into immediate action. In addition, she appears to have made some judgments about John's identities beyond that of patient. She seems to think he may be a "hippie." If her practice has not made you dizziness, yet, you should know that all of what appears in this table took place within a 20 to 30 second time frame. Also, I should point out that all of what Kara has done, thus far, is without the direction or supervision of the ER doctor.

Although nurses' simultaneous thinking-in-practice is evident across the three clinical specialties, the specifics within this thinking process is different in the OR setting. Jan explains how the OR context shapes her thinking:
In/Visible Practice

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We do the same sort of thing, but its different. When your working as the scrub nurse, you're like the surgeon's assistant . . . you're always splitting your consciousness . . . making sure about the integrity of the sterile fields . . . looking into the operative site to see what's going on . . . where's the surgeon's hands? . . . where should you put your hands? . . . what does the surgeon need next? . . . what other instruments are needed . . . should some sponges be added?

In her care of one patient, Jan's simultaneous thinking appears to be actualized somewhat differently than Kara's. Beyond focusing on the immediacy of the instruments, sterile fields and other equipment, it would seem that monitoring and anticipating the surgeon's practices becomes an extension of her multifocused patient care.

Simultaneous Thinking-in-Practice Across a Group of Patients

Up to this point, I have looked at thinking-in-practice from the standpoint of a nurse's care of one patient. However, in the ICU and ER, nurses care for a number of patients at the same time. As a result, the nurses are usually in constant motion, repriorizing and redesigning their practices in concert with the multiple necessities of all their patients' care. For these nurses, this type of work context not only calls for thinking-in-practice for a specific patient, it also requires thinking-in-practice for a group of patients. Tye aptly sums up this form of thinking-in-practice by saying:

It's like having your brain everywhere!

In the next ICU clinical example, Liz and I have pieced together some observations from my field notes with her reflections on her practice. In this representation of Liz's practice, a two column table is constructed: the first column depicts some of the conversations and actions that Liz engages in; and the second one identifies some of her reflections on these events. This situation opens as Liz and Rita start "day" shift, and decide which patients they will care for (refer to Table 4, on the next page).
Table 4: A Representation of Liz’s Thinking-in-Practice.

<table>
<thead>
<tr>
<th>Time:</th>
<th>Conversations &amp; Actions:</th>
<th>Liz’s Reflections</th>
</tr>
</thead>
</table>
| 0730   | Liz: "Do you want to have the same patients as yesterday?"  
Rita: "Sure that’s fine."  
Liz: "I can take Mrs. Mayo (a new patient), too."  
Rita: "Good, okay."  
Liz and Rita sit down at the nursing station and listen the audio taped "end of shift report" that the night nurses, Paula and Sarah, have prepared.  
While sitting at the nursing station (or desk) and listening to report, Liz:  
   a) -jots down a few notes.  
   b) -on several occasions, Liz gazes at the screens on the central ECG monitoring system at the desk.  
   c) -takes printouts of her patient’s ECG rhythms, then, measures the waveforms and analyzes them.  
|        | We listen to each patient’s report . . . We have to know a little about all of the patients, and a lot about our own patients. |
| 0731   |                                                                 | You can't remember everything, so I write down some important points about each patient.  
At the same as you listen to report you have to make sure that everyone’s okay. So you're always looking at the monitor.  
These ECGs are like baselines. They need to be compared with the patient’s previous ones and to any changes that might occur later on today.  
My plan was to see Mrs. Mayo first because she's new . . . she's had a head injury so it's really important that I get a sense of her mental status, and motor function early . . . so I'll recognize even the slightest change later on . . . I already know Mr. Jacob from yesterday . . . he's pretty stable so I just |
| 0744   | -goes up to Mr. Jacob’s doorway and says: "I'll be in to see you in about 10 minutes or so." |                                                                                                                                                |
### Table 4: A Representation of Liz's Thinking-in-Practice (continued).

<table>
<thead>
<tr>
<th>Time</th>
<th>Conversations &amp; Actions</th>
<th>Liz's Reflections</th>
</tr>
</thead>
<tbody>
<tr>
<td>0747</td>
<td>- walks into Mrs. Mayo’s room, chats with her, and starts to examine her.</td>
<td>stopped in to make sure. He looks fine -- his ECG is normal, his colour's good, and he's breathing fine.</td>
</tr>
<tr>
<td></td>
<td>- the phone rings, and Liz runs to answer it.</td>
<td>I knew Rita wouldn't have time to answer it, because she's in with Mrs. Logan and she's really sick. That was Mrs. Logan's daughter on the phone, so I told her about how her mother was doing.</td>
</tr>
<tr>
<td></td>
<td>- at the same time, she is talking on the phone one of the ECG alarms goes off, and she de-activates it as she is looking at the rhythm on the screen.</td>
<td>That's nothing -- just (patient) movement on the monitor.</td>
</tr>
<tr>
<td></td>
<td>- returns to Mrs. Mayo's room and finishes her examination.</td>
<td>She is oriented, and her hand grasps, and leg movements are all equal and strong. So, she's doing pretty good right now. Her right pupil is a little larger than the left, but that's nothing new . . . she came in with that . . . but it needs to be watched closely.</td>
</tr>
<tr>
<td>0749</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0753</td>
<td>- starts walking towards Mr. Jacob's room, then Dr. Reist appears in the hallway.</td>
<td>That was something that Sarah mentioned during report . . . We are always organizing what the doctors need to order and reorder.</td>
</tr>
<tr>
<td></td>
<td>- Liz says to Dr. Reist: &quot;We need to draw some lytes (abbreviation for the blood test electrolytes) from Mr. Jacob.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Mrs. Fresen's call bell sounds, and Liz walks into her room.</td>
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</tr>
</tbody>
</table>
Before I begin to comment on certain aspects of Liz's practices, I think it is important to mention the central functions of "end of shift report" within the ICU (and ER) communities of practice. In essence, these "reports" are another example of nurses' story-telling practices, that I described earlier. These reports are the stories that one shift of nurses tells the next shift of nurses about their patients. In these stories, the nurses usually include a detailed discussion about: 1) their ongoing examinations of each patient (e.g., Is the patient's condition the same or has it changed? What are the specific examination practices that the oncoming nurses should focus on?); 2) each patient's special considerations (e.g., Who are the people that make up the patient's social support system and have they been in to visit the patient? What approaches seem to be helpful in caring for the patient?); and 3) any treatments or drugs that the doctor has ordered (e.g., Why the doctor prescribed a new drug and how the patient is responding to this drug). In these respects, report facilitates the continuity and (re)production of nursing practices across shifts (Lave & Wenger, 1991).

In this glimpse of Liz's practice, the notion of simultaneous thinking across patients becomes evident while she is listening to report. During this time, she appears to be performing at least three different thinking tasks at the same time: 1) determining and writing down some key points about all patients; 2) scanning and making judgments about all patients' ECG rhythms on the central monitor; and 3) formally analyzing her own patients ECG rhythms on the printouts. Also, it could be argued that, while listening to report, Liz is developing some tentative plans about the care of her own patients. By the end of report, Liz has apparently decided to focus on performing an extensive examination of Mrs. Mayo, prior to doing the same for Mr. Jacob. Thus, on the basis of report, Liz appears to have made some initial judgments about the acuity of her patients, and opts to examine the more acute patient, Mrs. Mayo, first. Interestingly, while en route to Mrs.
Mayo's room, she evidently verifies this plan by stopping at Mr. Jacob's doorway and performing a cursory examination of him (e.g., He looks fine -- his ECG is normal, his colour's good, and he's breathing fine). In addition to making some initial plans for her patients' care, she appears to have made some preliminary judgments about the acuity and workload requirements of Rita's patients.

Given her conclusion that Rita "... wouldn't have time ... because she's in with Mrs. Logan and she's really sick," Liz seems to anticipate and compensate for Rita's workload by answering Mrs. Fresen's call bell, and the telephone call. In these ways, Liz is simultaneously and peripherally participating in the care of Rita's patients (Lave & Wenger, 1991). Interestingly, Liz and Rita did not talk about how they would deal with call bells and telephone calls. Liz's collaborative practices across Rita's patients appears to demonstrate how these nurses have learned to rely on each other, "without having to ask." Moreover, Liz's plans for her patient care possess an inherent flexibility. She appears to be constantly redesigning her care around the specifics of her own and Rita's patients; and around the contextual constraints of a(n) telephone call, patient call bell, ECG monitor alarm and doctor's visit. In this partial rendering of Liz's practice, we (Liz and myself) have tried to identify some of the ways in which her thinking-in-practice extends beyond the immediacy and boundaries of caring for one patient, and moves into the collective care of all ICU patients. Although aspects of thinking-in-practice for a group of patients is evident across the ICU and ER nurses' everyday practices, the contextual differences in the OR creates interesting variations within this form of thinking.

In our group discussions, the nurses used the field notes (that I had written) as a basis for sharing their clinical practices with the group, and for analyzing the simultaneous nature of their thinking-in-practice. Within these conversations, Jan
analyzed the ways in which her simultaneous thinking in the OR setting differs from that of the ICU and ER nurses:

In the OR there is two nurses in each OR. We work as partners. We flip our roles around . . . but for each (surgical) case, one of us is the scrub nurse, and the other is the circulating nurse. The scrub nurse works with the patient and alongside the surgeon . . . the circulating nurse looks at everything that's going on . . . the total picture . . . keeping an eye on how the patient is doing, how the anesthetist is doing, how the surgeon is doing, how the scrub nurse is doing . . . Your constantly looking around to get a sense of what's going on, and who needs or might need what.

In Jan's account, she seemingly emphasizes how the contextual realities of the OR setting influence the ways in which she simultaneously thinks-in-practice. In comparison to the ICU and ER setting, where each nurse appears to interweave simultaneously thinking for a specific patient with simultaneous thinking across patients, the OR scrub and circulating nurses appear to share these forms of thinking across the intermental plane (Vygotsky, 1978). The scrub nurse's role seems to be primarily focused on simultaneous thinking in relation to one patient; whereas, the circulating nurse's role seems to be primarily focused on simultaneously thinking across the activities in the OR theatre. As Jan has mentioned, the OR nurses are like "partners" who share these two forms of simultaneous thinking-in-practice. Another variation, in the OR setting, lies within Jan's simultaneously thinking across the activities in the environment. In contrast to ER and ICU nurses' thinking across patients, Jan's analysis suggests that the circulating nurse's simultaneous thinking is not related to a group of patients, but to a group of professionals. She seems to relate the circulating nurses' thinking to the simultaneous observations of, and judgments, about the anesthetist's, surgeon's and scrub nurse's practices.

Be it in the OR, ICU or ER setting, the concept of nurses' simultaneous thinking beyond the immediacy of one patient can take on subtle, yet, significant forms. In
the next clinical examples, I will draw from my field notes and interviews with Jan and Leah to identify some subtle observations inherent to their simultaneous thinking. In this first example, Jan is working as the circulating nurse, and has just finished helping the anesthetist, Dr. Forg, intubate Joanne, who is about to undergo surgery. At the same time, the scrub nurse, Marty, has finished setting up her sterile fields and laying out her instruments:

Dr. Forg: We're ready to start. Where's Dr. Toberth (the surgeon).

Jan: ^

(Looking at Jan) Would you call for him (over the intercom).

Jan: I'll wait a second, because I think he's on his way in.

A short time after this conversation between Dr. Forg and Jan, Dr. Toberth walked into the OR theatre. I, then, asked Jan how she knew that Dr. Toberth was on his way in:

Well, I heard the water running in the sink outside the room, and I thought that it was probably Dr. Toberth doing his surgical scrub . . . You know, its interesting you asked me about this because I'm always splitting my concentration . . . You tend to observe things without noticing. And you might have to think back on the sequence of events, but you can say, yes, I did hear that . . . that's how I knew, it was the water running.

In the next example, Leah is finishing her initial examination of Julia who has come into the ER seeking treatment for severe nausea and vomiting. As this conversation opens, Leah is about to leave Julia's bedside and go to Bob's, bedside:

Leah: I'm going to let Dr. Orson (the ER doctor) know how you're doing and I'll come back with an injection of gravol for you.

Julia: Okay. (walks away from Julia's bedside and walks to Bob's bedside).

Leah: (Bob) Your ventolin treatment (a liquid drug nebulized through compressed air) is finished . . . I'll just put you back on the oxygen and listen to your chest.
In relation to the geographics of this situation, Julia and Bob were situated at opposite ends of the ER. After we left Bob's bedside, I asked Leah how she knew that his ventolin treatment was finished:

You know, when the air goes through the ventolin it makes that kind of a gurgling noise . . . and after all the ventolin is gone the gurgling noise is gone, and you get that kind of high pitched flow noise from the compressed air.

In these clinical fragments, Jan and Leah have evidently earmarked certain sounds in their environments as important and deserving of their attention. Although these sounds may serve the same "attention gaining" function as the ones identified in Liz's example of simultaneous thinking (e.g., patient call bells, ECG monitor alarms and telephones ringing), there are inherent differences in the origins of these two types of sounds. The ones described in Liz's example have been designed by others to gain the attention of the nurses; whereas, the ones described in Jan's and Leah's clinical practice apparently arise from, and are deemed important by their experiences in practice. Beyond the reasons mentioned by Jan and Leah for earmarking some sounds, Sue explains how a certain sound helps her recognize a potential emergency situation:

Sometimes its just in how the patient coughs. There's the usual coughs, and then there are those kind of strange coughs that are like a cough, cry and gasp all in one. You investigate that one, because it's a noise that patients can make as they are having a cardiac arrest.

It could be argued that the nurses' earmarking of certain sounds is one of the strategies that they use to facilitate their simultaneous thinking beyond the immediacy of one patient. These sounds appear to help them divert their attention away from their immediate practices, and help them make judgments about what is going on around them. However, to understand why nurses have developed such a strategy, it is important to underscore the complex mental demands placed upon
their memory and attention, as they simultaneously think and act in practice. To make this point clearer, I will interconnect a few points that I have made earlier.

In the earlier discussions of Kara’s examination of John’s chest pain, and in Liz’s examinations of her own patients and care of Rita’s patients, I think that it is important to notice that these nurses have not "charted" or written down anything about these patients. This is not an omission on my part, but rather a reflection of the nurses’ actual practices. Thus, all of the information that the nurses have collected about their patients, and all of the judgments that they have made about their patients are committed to memory. During one of our group discussions, Sue, Ann, Liz, Tye and Kara extend this point:

Sue: Charting is something we do when we get time.
Ann: Yeah, you have to deal with what's going on first . . . sometimes there's so much going on, that you don't get around to charting till much later . . . sometimes not until the end of the shift.
Liz: But, it (meaning charting) is always very detailed.
Tye: Well, sometimes we ad lib a bit.
Kara: Yeah, we can't remember everything . . . Our jobs are about caring for the patients . . . we chart to cover ourselves legally.

In this discussion, these nurses seem to be talking about how the contextual circumstances of their practice creates a lag time between: when they perform their patient examinations; and when they write down their findings in the chart. This lag time means that the nurses must remember the details of their patient examinations for extended periods of time -- until they find time to chart. The mental efforts necessary for remembering, coupled with mental efforts necessary for simultaneously thinking-in-practice, creates another layer of complexity within nurses' thinking (Anderson, 1990). While thinking about and carrying out the actions of patient care, the nurses are, also, trying to remember the details of each patient's initial and ongoing examinations. Given the mental energies devoted to remembering the details of each patient's examination, and to simultaneous
thinking-in-practice, it is plausible to suggest that the nurses might develop compensatory strategies like earmarking certain sounds to help them attend to specific and important events in their environments (Anderson, 1990). In addition, the notion that nurses learn to remember detailed accounts of their patients (in practice) can be interconnected to my earlier discussion on story-telling practices. What I am suggesting, here, is that the nurses have learned to remember detailed accounts of their patients as a commonplace practice, and that this may be one of the explanations for their abilities to reproduce stories of practice with such precision and detail.

In these discussions, I see my main purpose as presenting aspects of nurses' simultaneous thinking-in-practice in similar, different and contextualized ways. Within these fragmented examples of nurses' thinking-in-practice, there seems to be a profound gap between how these nurses actually practice, and how their practice is constructed by the nursing process. The nursing process represents nurses' clinical decision making in behavioral and linear ways; however, there appears to be no evidence of this form of thinking within the nurses' everyday practices. It could be argued that the nursing process has undervalued the complexity, nonlinearity and contextualized nature of nurses' thinking-in-practice (Benner, 1984 & 1992; Bevis & Watson, 1989; Britzman, 1991; Smith, 1987 & 1990; Tanner, 1986 & 1992). Given that this model only focuses on clinical decision making for one patient, the notion of simultaneous thinking across a group of patients interweaves another layer of complexity into nurses' thinking-in-practice. It would appear that nurses' thinking-in-practice is shaped by the contextual realities of their experiences, and by their resistance to prescribed models like the nursing process (Vygotsky, 1978; Lather, 1991). In the next and last section, I will interconnect aspects of prior discussions, with some of the strategic ways nurses learn to learn with/in practice.
Learning With/in Practice

Throughout this analysis of nurses' in/visible practice, I have been implicitly and explicitly articulating how nurses learn in practice. Given that their theories of/in practice appear to be different from the ones taught in their post-secondary education programs, and the ones identified in their job description, it is plausible that their ideas about learning with/in practice might be different. As I mentioned earlier, nursing education is structured around behaviorist interpretations of learning which tend to promote and legitimate: 1) the establishment of hierarchical relationships between educator and student; 2) the student's learning process as passive and based upon their abilities to recant prescribed knowledge as outlined in the curriculum; 3) the evaluation of student's learning on the basis of decontextualized behavioral acts; and 4) the separation of theory from practice (Aronowitz & Giroux, 1991; Bevis & Watson, 1989; Freire & Faundez, 1989).

These prescriptions for education/learning are reified in the nurses' job description by the following statements: "(nurses) maintain clinical competence by regularly attending continuing education programs;" and "(nurses) change practices or procedures to reflect current research findings." In this segment from our group discussions, the nurses describe how their ideas about learning with/in practice resist, and depart from the traditions established in their post-secondary education programs and their job description:

Sue: When I was in nursing school I just said where's the reality here? We'd be in the classroom most of the time . . . I just think it was the school of unreality, nonsense!

Liz: I know what you mean . . . I went back to do my BSN . . . It was worse than my original training . . . You ended up having to live in a head space that says do I prostitute myself, prostitute my values and beliefs in order to get marks? That's what happened to most of us who went back. And the profs weren't happy with us because we couldn't be cloned. We already had a sense of reality.
Leah: Yeah it's like learning is based upon the number of degrees you have or the number of courses that you've taken.

Ann: It's like, as long as you've paid money and shown up for a course, then, that's okay, that's learning. But, it could have been terrible.

Tye: The last course I went to was terrible. It was so stilted. It was obvious that the women teaching had no clinical experience. She was trying to do it right, but not getting it right . . . she couldn't do it the natural way, she had no hands on experience.

Kim: The academic community says that we must justify ourselves as a profession based upon the number of degrees and courses we have, but this is so short sighted, because what they haven't done is give credit to the expert nurses who practice.

Leah: Right, you don't take 16 million courses and all these degrees to become an expert nurse. The best way is experience, hands on experience.

Ann: Yeah, and we learn from each other.

Liz: We do that all the time. Somebody says to me what do you think about this patient. And I say well it looks like bla, bla, bla. And then somebody else comes along and says something a little different. And you learn two different opinions and we both have the same basic knowledge. But each one has a little different edge.

Ann: Yeah, it's like asking another nurse to help me care for a type of patient that I have never cared for. That's continuing education.

Kara: Your right. The first ventilator patient that I looked after was a little girl . . . You had the ventilator; you just had to learn. So, when I came on (shift), I said, how does this work . . . she (another nurse) showed me . . . when I ran into problems she was my back up.

Sue: I remember when I started in ICU . . . I heard about this particular nurse -- how good she was . . . so I'd kind of go in and watch her . . . to pick up her expertise . . . I'd watch her very carefully . . . I'd ask about the decisions she'd made. What she was thinking and why she was thinking that?

Jan: Students come up to the OR. And I remember how terrified I felt when I had my first OR experience. I figure that if I make it seem fun, and make it enjoyable they'll learn. The students enjoy coming up, because we have got the time to explain things to them, and their not stuck in the corner while we dash around in a mad circle . . . We let them get scrubbed up with us, and let them belly up to the bar.

Tye: You know, in every shift we work, we are always learning from each other . . . finding out what works, what's the best, what to do next time . . . that's learning.
Kara: And when things don't work out right, that's not necessarily bad. We still learned something new.

The apparent sarcasm in Sue's comment, "the school of unreality;" and Leah's comment, "You don't take 16 million courses . . . to become an expert nurse;" tend to merge on the notion that their post-secondary education failed to teach them about the actualities of practice and, thus, failed to teach them about how to practice nursing. Interestingly, Tye's recent experience at a continuing education course seems reiterate similar sentiments. Tye appears to have judged this course as "stilted" and "terrible" based upon her perception that the instructor "had no hands on experience." In addition, Liz's emphasis on "we couldn't be cloned" seems to relate to some of the authoritative and inculcating teaching practices that she has encountered, and to her resistance of those practices.

In this group discussion, the nurses continually refer to learning with/in the experience of practice. In some respects, their ideas about learning-in-practice appear to be similar to Lave's and Wenger's (1991) notion of "legitimate peripheral participation (p. 29)." They speak about contextualized learning; learning with the help of more experienced nurses; and learning about practice by first participating on the periphery, and then moving toward the centre of patient care (Lave & Wenger, 1991). In relation to this last point, Sue's comments about closely watching a nurse "to pick up her expertise," and Jan's comments about helping student nurses learn by having them "get scrubbed up with us," seem to address the peripheral participation of neophyte nurses. However, in Kara's discussion about caring for her first ventilated patient, she mentions a learning strategy called "back up." In this situation, Kara evidently participates at centre of this patient's care until she runs "into problems," and needs the "back up" of a more experienced nurse. Ann seems to intimate this back up strategy when she talks about "asking another nurse to help me care for a type of patient that I have never cared for."
This back up strategy appears to coincide with Kara's and Ann's participation at the centre of patient care and, thus, it could be argued that, within the community of nursing practice, this strategy is shared across experienced nurses. Kara and Ann seem to fully participate in their patients' care until they encounter a novel or new situation. Interestingly, there seems to be an implicit respect and trust underlying this strategy. The decision to consult a more experienced is apparently left up to Kara and Ann. They seem to fully participate in their patients' care until they deem it necessary to consult a more experienced nurse. However, given the notion of simultaneous thinking across patients, it could also be argued that a more experienced nurse would have an awareness of, and would be making judgments about, how Kara and Ann are coping with their patient care.

Beyond the notions of contextualized learning and degrees of participation in practice, it would appear that these nurses establish nonhierarchical learning relationships (Belensky, Clinchy, Goldberg & Tarule, 1986; Lave & Wenger, 1991). Jan's ideas about making learning "fun" and enjoyable," Liz's comment, "we both have the same basic knowledge . . . But each one has a little different edge," and the frequently repeated idea that "we learn from each other," seem to imply a respect, kindness, and support for each other, which is possible when learning is constructed as a nonhierarchical and collaborative effort. Within these nurses' conversations, the concept of helping each other learn seems to be the "social responsibility" of "all" nurses within the community of nursing practice. The notion of nurses' nonhierarchical, contextualized and participatory learning relationships appears to dramatically depart from the educational practices employed in their post-secondary education, and reified in their job descriptions. As the active constructors of their own educational/learning experiences, the nurses appear to, once again, defy external prescriptions for their practice.
As I look back on this preliminary and fragmented analysis of nurses' in/visible practice, I am fascinated by the breath, complexity and scope of these nurses' practices. And at the same time, I am astounded by how this hospital's job description has undervalued the sheer brilliance of their practices. I think that Liz's comment aptly sums up the nurses' sentiments and thus, the central proposition with/in this analysis of nurses' in/visible practice:

"We are more intelligent than the hospital says."
Chapter 4: Discussion

The assumption that nursing practice can be "prescribed" by others (than those directly involved in patient care), and written about in "decontextualized" terms, is not a contemporary development but, rather, a social norm that can be traced throughout history, and that is reified in this nurses' job description. However, what seems to be unquestioned is: 1) how the writing of "others" has established particular world views of nursing practice that are not necessarily authentic or in nurses' best interests; and 2) how these views continue to subtly permeate and influence contemporary ideas about nurses' practices in ways that obscure the breath and intricacies of their everyday practices. This multivoiced analysis of nurses' in/visible practice is a particular testimony to a contrary conceptualization of nursing practice; one that considers nurses to be the expert "authors" and "researchers" of their practices, and one that contextualizes nurses' thinking-in-practice. From this perspective, it would seem that nurses have rejected this hospital's simplistic and decontextualized versions of practice, as represented in their job description, and have (re)invented "complex" and "contextualized" versions of practice with/in their community of nursing practice. Thus, with/in the confines of this necessarily incomplete analysis, there appears to be no support for the hegemony of: 1) externally prescribed authorships of nurses' practices; 2) de-intellectualized accounts of nurses' practice; or 3) universal or grand theories for nurses' practices. Based upon these propositions, I will explore some educational implications and, then, address some methodological considerations for this, and future research.

Educational Implications

Since the Nightingale days, nursing education has revolved around a prescriptive orthodoxy. Nurse educators define the curriculum, specify behavioral
objectives for the curriculum, and define/confine learning to the mastery of these objectives. However, it would appear that the nurses in this study have rejected this form of orthodoxy, and have invented a "learning with/in practice curriculum," which is connoted here as contextually (re)defined, (re)negotiated and (re)interpreted by the collaborative efforts of nurses in their community of nursing practice (Lave & Wenger, 1991). As represented earlier, nurses' theories of/in practice are highly contextualized and elaborate. Operative in these theory constructions is nurses' learning with/in practice. I do realize that this study is a preliminary representation of nurses' learning with/in practice; however, their notions of learning seem to dramatically differ from those represented in nursing education. Thus, I will tentatively discuss how one could redesign aspects of nursing education to accommodate some of the intricate forms of nurses' learning represented here.

Within their community of practice, nurses have evidently developed collaborative learning strategies that are simultaneously interactional, experiential, and nonhierarchical. The interactional or social emphasis on learning is, of course, an extreme departure from their experiences in post-secondary education, which emphasized non-participatory forms of learning like classroom lectures (Bevis & Watson, 1989). From the nurses' perspectives, practice is apparently socially constructed and distributed. As such, one aspect of learning with/in practice is enacted by actively conversing or consulting with other nurses, rather than passively listening to instruction. Thus, instead of defining/confining nursing education to received and passive forms of learning, it could be reconceptualized as "interactional practices" among nurse educators, graduate nurses and students with the intent of learning the "sociocultural practices" of the community of nursing practice (Lave & Wenger, 1991). As a social construct, nursing education would, also, have to be contextualized and localized with/in students' experiences.
The notion of "hands on experience" is a pivotal theme in this work, and it has equally important implications for nursing education. It suggests that nurse educators will have to abandon their "grand theories" of practice, and learn to help students build theories of practice from their experiences in practice. Currently, many nurse educators do not actually practice nursing. However, in order to help students (re)create theories from practice, nurse educators must intimately understand nursing from the vantage point of participating in "actual" practice. Thus, I propose that a nurse who positions her/himself as an "educator of nursing practice" should, indeed, maintain an "active" clinical practice. Without a participating knowledge in practice, nurse educators are limited to decontextualized knowledge and grand theories of practice, which in turn limits students' learning with/in practice.

A de-emphasis on classroom learning and a re-emphasized access to clinical practice is an imperative. Currently, students spend more time in classrooms rather than in clinical settings (Bevis & Watson, 1989). As a consequence, when students come to a clinical unit they seem be like "visitors" rather than "beginning and participating members" of the community of nursing practice. In my own observations, this "visitor" concept is frequently reified by the educator/student relationships, and the lack of a student/practicing nurse relationships. Oftentimes, students' clinical learning is limited, directed and interpreted by nurse educators. Thus, practicing nurses on a given unit have little input into students' learning with/in practice. However, in this study, nurses seem to have developed a wide range of practices that are (re)created with/in the specifics of everyday practice, and that are not officially recognized in nursing curriculum or textbooks. Hence, to provide interpretive support for students' understandings of actual practice, their learning experiences need to be guided by practicing nurses and practicing educators. From this perspective, students' learning becomes a collective
responsibility, which is shared across the intermental plane, amongst students, practicing nurses and practicing educators (Vygotsky, 1978). As thus construed, students' learning is structured with/in nonhierarchical relationships, and is socialized and localized with/in experiences of practice. Such learning strategies as case study building, story-telling and apprenticeship would seem to be critical elements of a learning with/in practice curriculum. The strategies of case study building and story-telling not only emphasize what students can learn from practicing nurses and educators, but also emphasize what students can learn from each other.

In addition, this notion of a learning with/in practice curriculum is not conceived within, or predetermined by, stagnant and individualistic forms of objectified knowledge. As a situated and fluid curriculum, it arises from and is improvised within, the variety and unpredictability of everyday nursing practice (Lave & Wenger, 1991). Thus, the traditional notions of: 1) measuring learning on the basis of the presence or absence of behavioral traits; and 2) quantifying learning in the form of grades, do not belong in this curriculum. Learning with/in practice, does not reside in the mind of an individual student and, thus, cannot be objectified or graded; rather, it is a social effort, wherein experienced others help students (re)create and interconnect understandings at local levels of practice (Vygotsky, 1978). This curriculum is about learning to become a member of the community of nursing practice through degrees of guided and supported participation in the sociocultural practices of this community (Lave & Wenger, 1991).

These proposed transformations to nursing education are, of course, tentative and based upon aspects of nurses' learning, which are represented in this study. Certainly, more research needs to be devoted to identifying other forms of thinking/learning-in-practice by selecting participants who have varying degrees of experience, and by extending this investigation into other hospital settings, and
other clinical nursing specialties. However, what has been proposed, as educational reforms, seems to be directly related to the emphasis this research placed upon nurses' commitment to transformative resistance at their local levels of practice.

**Emphasizing Transformative Resistance With/in Nurses' Practices and the Research Group**

In emphasizing nurses' commitment to transformative resistance in their everyday practices, this research has extended some of the traditionally construed boundaries with/in "critical" and "feminist" research (Campbell & Bunting, 1991; Stevens, 1989). Instead of articulating the oppressive circumstances inherent to nurses' position in the hospital, this research has emphasized nurses' degrees of agency in their everyday practices. Like most of society's institutions, hospitals are structured in a way that promotes power/labour divisions in a hierarchical system, and in this system nurses live at the bottom of the hierarchy. However, this emphasis on nurses' degrees of agency with/in such a power structure is a departure from some traditional forms of research. Oftentimes, in a traditional critical analysis of unequal power relationships in institutions, there is a strong emphasis placed upon the dualistic notions of "oppressors" (e.g., nurse administrators and doctors), and "oppressed" (e.g., nurses). This form of analysis is problematic for several reasons. Frequently, the researcher forefronts and speaks about the oppressive circumstances created by people in positions of authority and, then, describes the disparaging ways this oppression comes to life in the world of the oppressed (Van Maanen, 1988). In such an analysis, the researcher continues to speak through the voices of the oppressor. Emphasis is primarily placed on the people in positions of authority, and the means by which they oppress the people who live at lower levels of the power structure. Thus, the
oppressed people become secondary; they become the objects of this oppression and are presented as the "passive" recipients of the controls placed upon them. In other words, they are represented as sharing and "ventriloquating" the "prescribed" power structure or presumed natural order (Wertsch, 1991). Such an analysis is counterproductive, because it creates a deficit model of the people who are being researched (e.g., they lack the ability to see and/or do anything about their oppressive circumstances) (Lather, 1991). Moreover, this analysis creates a simplistic and circular argument. By showing the ways in which people are oppressed, the basic assumption that oppressed people are controlled by their oppressors is reified. However, as this research suggests, nurses as an oppressed group, do have opportunities for agency in their everyday world -- that is to say, nurses can and do circumvent the hospital's natural order. Thus, instead of focusing on stories of despair and passivity as would be the case in a traditional analysis, I have emphasized stories of hope and creativity. I have presented stories that demonstrate how nurses resist the hospital's power relations and prescriptions for practice as stated in their job description, and (re)invent new ways of knowing. Given the proposed changes in the health care system, the notion that nurses are the legitimate "authors" and "researchers" of their own practice is of central importance.

In B.C., the health care system is currently undergoing significant changes. The British Columbia Royal Commission on Health Care and Costs (Seaton, Evans, Ford, Fyke Sinclair & Webber, 1991) has mandated a radial change in the direction of health care, moving it out of hospitals and into communities. This represents an important opportunity for nurses as it will return them to the place that, historically, has brought them autonomy, satisfaction and respect (Growe, 1991). Thus, it becomes crucially important to displace the myth that nurses "need" hospital administrators to create and monitor their practice, and replace it with the
notion that the community of nursing practice possesses its own forms of knowledge creation and regulation. Although further research is required to supplement and extend the nature/scope of this community's knowledge creation and regulation, it would appear, in this preliminary research, that nurses collaboratively (re)produce their own practice within practice (Britzman, 1991). Thus, there seems to be no support for the assumption that nurses' practices must be created and monitored by people like nurse administrators, who are removed from, and thus external to, the actualities of everyday nursing practice. Furthermore, with additional research, it may be possible to argue that, given nurses' own knowledge creation and regulation, the community of nursing practice is well prepared for its move into an autonomous form of community-based practice.

In addition to focusing on nurses' commitment to transformative resistance within nursing practice, I have pointed to some of the ways in which nurses debunk the historical myth that there is a "clear" dividing line between nurses' and doctors' practices. Jan's practice related to inventing a new surgical procedure; Kara's tentative diagnoses of John's chest pain; and Liz's request of Dr. Reist to order specific laboratory tests for her patient, all appear to be examples of how nurses' invisible practices intersect with doctors' practices. Jan's, Kara's and Liz's practices seem to suggest that nurses "can and do," facilitate, critique and create medical practices, and that nurses have "legitimate" knowledge of doctors' practices (Griffith, Thomas & Griffith, 1991). One possible explanation for this phenomenon is that, in the hospital setting, nurses learn about medical practices through their exposure to a variety of doctors, and a variety of ways in which doctors diagnose and treat particular patients. In the OR, for example, nurses may assist many doctors who are all performing the same type of surgery (e.g., appendectomy). However, in one way or another, each surgeon's technique will
vary. From these different examples of surgical techniques, OR nurses learn about what has worked or not worked in specific cases. The same argument could be posed for the ER and ICU nurses. From the variety of doctors that they deal with, ER and ICU nurses learn about what information doctors use to make particular diagnoses, and what treatments they use for them. From these experiences, nurses learn about what works and what does not. In other words, through their everyday interactions with doctors, nurses can learn to create and critique medical practices. However, the notion that nurses can become adept at doctors' practices could be construed as threatening to the medical profession (Cockburn, 1985).

Based upon the claim that they possess a unique and specialized body of knowledge and practices, doctors have justified their elitist position in the hospital and health care system (Flexner, 1910 & 1915). According to this claim, only doctors are educated to perform medicine. But, when nurses are enacting doctors' practices, they are eroding doctors' primary claim to power. Nurses can learn doctors' practices "on the job" and, thus, are debunking the myth that "only" doctors have the capabilities to practice medicine (Ferraro & Southerland, 1989). It is perhaps not surprising, then, that the nurses' job description renders nurses' medical practices in/visible, so that this natural order is maintained (Ashley, 1976).

However, this research suggests that there are no clear divisions, but only "blurred" lines between nurses' and doctors' practices.

Thus far, I have addressed some of the power relations established within the nurses' job description and argued that the following implicit and explicit assertions seem to be questionable: 1) the presumption that nurse administrator positions are justified upon the notion that nurses' practices must be monitored; and 2) the presumption that doctors' elitist positions are justified upon the notion that they are the only ones who possess medical knowledge. However, I do not think that questions about these power relations could have been raised without this
research's focus on nurses' commitment to transformative resistance with/in practice.

Transformative resistance is, of course, an integral concept in some feminist research traditions (Lather, 1991). However, I think that it is first important to underscore the lack of feminist research in the nursing profession and, then, identify where I have extended the boundaries of this tradition. For various historical reasons mentioned earlier, feminists and nurses have had at best a tenuous relationships. As a consequence, it has only been in recent years that nursing research has incorporated aspects of feminist methodologies. This study is an attempt to add to this small collection of research, and, in particular, to demonstrate how some of the philosophical tenets with/in a feminist methodology can be operationalized into participatory and nonhierarchical relationships between the researcher and the researched. In so doing, this research has aimed towards demonstrating the importance of, and continued need for, collaborative and participatory forms of research in nursing practice. I do not think that the details and complexities inherent to this analysis of nurses' in/visible would have been possible without the joint construction of knowledge between myself and the nurses.

Beyond the emphasis placed upon nurses' resistance to prescribed renderings of practice (e.g., the nurses' job description), this study is also interested in the transformative nature of the research project (itself), and thus, departs from the feminist tradition of "the appropriation/give back paradigm." Oftentimes, this research paradigm of appropriating data from the participants and, then, giving them something back is applied to help participants in relation to some of their oppressive circumstances. Although this notion of "giving something back" to participants seems benevolent, it de-emphasizes what participants have learned
while being a part of the research process, and makes in/visible what they are capable of doing on their own. As Benmayor (1991) argues:

Rather than being a final stage in an "appropriation/give back" paradigm, we have discovered that "return" is an ongoing and organic part of the entire program. Participants do not depend on the research(er) to get something back (p. 165).

Benmayor's notion of focusing on the transformative nature of the research process is similar Lather's (1991) conception of "catalytic validity," as follows: "... the degree to which the research process re-orientates, focuses and energizes participants toward knowing the reality in order to transform it ... " (p. 68). Thus, my interest here is in the transformative nature of the research process, itself.

During our last group discussion, the nurses discussed their ideas about the nature and meaning of the research process:

Sue: I've really enjoyed these meetings. Even with all the different people, it's been so nice.
Kim: Honestly, at first I thought it was going to be a nightmare trying to get us together for these meetings. I've been amazed about how we all have been able to work around everybody's commitments and shifts. I can't thank you enough . . . But more than that, I think our commitment to meet goes beyond just research.
Ann: Yeah, there's a lot of support, here.
Kara: Yeah, my son calls them our group therapy sessions.
Ann: We seem to have a connectiveness and camaraderie and it's nice.
Jan: I even noticed when I come to ICU or when I come to ER, now, the nurses say hello, how are you, and ask me different things . . . . I'm person, now, rather than a nurse just dressed up in OR greens.
Tye: I think that's neat . . . we should be doing more of that . . . starting personal relationships with nurses in other areas.
Liz: Yeah, we've learned about each other's specialty, each other's perspectives . . . some quite good ideas about how you can handle certain things that you probably haven't even thought of before.
Jan: It's interesting, too, because in the group we've all kind of worked together. There hasn't been any cliques that have formed. We have all stayed together.
Kara: We should stay together, have pot luck dinners once a month, and just talk.

Ann: Yeah, and we don't just have to talk about nursing. We can talk about raising our kids, talk about anything we want.

Tye: Yeah, I think so, too.

Liz: With all of us together, we can speak out with more power, too. Sometimes when you are vocal, the other nurses only support you so far.

Ann: Yes, until that scary stage, and then you better have your parachute on.

Liz: So, we can be each other's parachute.

Kim: What do you think about adding some more nurses to the group?

Tye: Yeah, we should do that. Put together a group of real fighters.

Kara: Yeah, the higher ups are going to make some changes soon. And we've got to fight them. And the more nurses we pool together the stronger we will be.

Jan: Especially from the OR and Critical Care, we are pretty outspoken groups, and the hospital can't function without us.

In this discussion, the nurses seem to be: 1) developing a retrospective analysis of the importance of relationships formed within the group; and 2) developing a prospective agenda for the continuation of the group. In relation to the former, the often repeated words "support" and "nice," Ann's statement about, "connectiveness and camaraderie," and Sue's and Liz's emphasis on entertaining and learning from difference perspectives, seem to speak about the nurses' respect and commitment to each. In particular, Jan's statement about: "There hasn't been any cliques that have formed" suggests that the social group structure is nonhierarchical. This horizontal structure, also, appears within, and seems to be pivotal to, the discussions about nurses' learning with/in practice. Given these shared values in the group, it appears that the nurses have become interconnected to one another in meaningful ways, and that they would like to continue meeting. Interestingly, Jan's experience of, "when I come to ICU or when I come to ER, now, the nurses say hello, how are you, and ask me different things," apparently identifies one of the ways in which being a member of this group has been helpful in personalizing her presence in other clinical specialty areas in this hospital.
As far as future endeavors, the nurses are evidently committed to continuing and extending the group's purposes. In relation to transformative resistance, Tye's comment about putting "together a group of real fighters," and Kara's statement about "The higher ups are going to make some changes soon . . . And we've got to fight them," seem to address future intentions of the group. However, Sue's suggestion that, "we don't just have to talk about nursing. We can talk about raising our kids, talk about anything we want," implies that being a nurse is only one of these women's identities, and that a future goal of the group needs to more "holistic"—meaning that the group's commitment to, and support of, each other should extend into each other's interwoven and multiple identities. It would appear that this research project has been meaningful to the group, and the catalytic nature of this project seems to rest upon the nurses' commitment to continue.

As I close these preliminary chapters on a representation of nurses' in/visible practice, I thought it appropriate to leave this work with the (above) voices of the nurses who apparently have been, and will continue to be, forging out personal and professional practices that are simultaneously in/visible, inventive and resistive.

Like any research project, this one has a particular research question, which in turn creates a particular emphasis; an emphasis on nurses' in/visible practice. Given this emphasis, I think it is critically important to mention that the practices of other hospital personnel like dietary aides, housekeeping staff, doctors and social workers have been rendered in/visible by this research project.
Bibliography


Hutchinson, S. (1990), Responsible subversion: A study of rule-bending among nurses. Scholarly Inquiry For Nursing Practice. 4, 3-17.


Tanner, C. (1992, Feb.). *Teaching clinical judgment*. Paper presented for the Department of Nursing Education and Research, St. Paul's Hospital, Vancouver, B.C.


