UNTying Our Hands: The Social Context of Nursing in Relation to Violence Against Women

by

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ABSTRACT

Violence against women and children is acknowledged to be a health problem of epidemic proportions, yet the health care response has been inadequate at best. This ethnographic study examined the relationship between the social context of practice and the way in which nurses recognize and respond to women who have been abused. Data collected over two years in two hospital Emergency units and communities included about 200 hours of field work, as well as interviews with 30 health care providers and five women who had been abused.

These data support other research showing that violence against women is neglected within health care. Abuse was largely unrecognized, with "blatantly obvious" consequences of physical violence being most recognized. Importantly, violence was often anticipated predominantly among poor and "non-white" people. When abuse was recognized, intervention focused on the physical results of violence, and the social and emotional consequences were often ignored. When abuse was addressed, such efforts were often attempts to influence the woman toward choices that she may not want or actually have, or worse, choices that may endanger her further. However, health care providers also intervened by offering and respecting choices in a manner that was congruent with the needs of the women interviewed.

Data analysis suggested that the predominant pattern of routine practice in Emergency, in which patients are efficiently processed in accordance with an ideology of scarcity, fosters the neglect of violence. It is argued that violence and abuse are neglected because the power of dominant interests is exercised through ideologies which are
congruent with neglect. As individuals work within a social context in which dominant interests shape their everyday worlds and provide the lenses through which they interpret their world and personal experiences, practices are mostly congruent within dominant interests.

In order to attend to violence against women in a meaningful manner, it is argued that individuals at all levels of decision-making in society, from the corporate elite, to health care policy-makers, to nurses at the bedside, must develop a critical consciousness regarding domination, and the ways certain interests in society are served.
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For my mom, Marion Varcoe
in loving memory of her son, my brother
Vance Emmett Varcoe
(1956-1974)
CHAPTER ONE - THE PROBLEM

Violence against women is a problem of epidemic proportions, a global epidemic that spans all "races"\textsuperscript{1}, all classes and most countries (Heise, 1994; Heise, Pitanguy & Germain, 1994). The most recent survey of the incidence of violence against women in Canada estimates that one in every two women over the age of 16 has experienced physical or sexual abuse (Rodgers, 1994). Most assaults against women occur within the context of intimate relationships (Dobash & Dobash 1988; Heise, 1994; Koss, 1994; Rodgers, 1994). Although all estimates of violence in intimate relationships "underestimate reality" (British Columbia Institute on Family Violence, 1994, p. 1), in 1993, 29% of Canadian women who had ever been married or lived in a common-law relationship reported being physically or sexually assaulted by a marital partner at least once during the relationship (Johnson, 1996; Rodgers, 1994). Dobash and Dobash (1988) found that in Great Britain, 25% of all violent crimes are wife assaults, and conclude that "it is through taking on the position of wife that women are most likely to become the victims of systematic and severe violence" (p. 57).

Violence against women incurs enormous health consequences, although it is rarely seen as a public health issue (Heise, 1994; Heise et al., 1994). At a global level, the health burden from rape and domestic violence is comparable to that posed by cancer, human immunodeficiency virus (HIV), and cardiovascular disease (Heise et al., 1994). In the United States, violence against women is the leading cause of female trauma (Campbell & Sheridan, 1989). In Canada, the women who responded to the Violence Against Women Survey (VAWS) said that they had been physically injured in 45% of all cases of wife assault and in 22% of violent sexual assaults (Johnson, 1996). The conditions attributable to gender-based victimization include sexually

\textsuperscript{1}I have put "race" in scare quotes throughout this thesis in order to stress that race is a social construction. I considered this important because the idea of race as I encountered it throughout this study was more likely than other concepts (such as "class" and "culture") to be treated as "natural facts".
transmitted diseases (STD), HIV, abortion, depression, alcohol and drug dependence, post-traumatic stress disorder (PTSD) and death from suicide or homicide (Heise et al., 1994). The long term physical consequences of violence and abuse include chronic pain, irritable bowel syndrome, arthritis, neurological damage, chronic pelvic pain, and pelvic inflammatory disease (Campbell, 1993). The psychological consequences of abuse include intrusive symptoms such as nightmares, hyperarousal, and disconnectedness from others (Herman, 1992). The consequences of victimization have been shown to extend long beyond the assault and are reflected in the significantly greater use of health services in comparison to non-victimized people (Koss, 1993).

The consequences of violence against women also extend to children exposed to violence, who experience problems such as difficulty in problem solving, adjustment problems, and learning to use violence (Jaffé, Wolfe & Wilson, 1990). Twenty one percent of Canadian women who said they were abused by a marital partner were abused during pregnancy and 40% of these women said that the abuse began during pregnancy (Johnson, 1996; Rodgers, 1994).

Despite the size of the problem, and the associated health consequences, violence against women is neglected in health care. Violence and abuse are largely not recognized in health care settings, and when recognized, are not dealt with effectively. The rates of recognition of violence against women by health care professionals are extremely poor (Heise, 1994; Kurz & Stark, 1988; McLeer & Anwar, 1989; Stark, Flitcraft & Frazier, 1979; Warshaw, 1993). Studies of Emergency units suggest that without specific domestic violence screening protocols the recognition is less than 2% of all cases of abuse (Kurz & Stark, 1988; Stark et al., 1979; Warshaw, 1993). Similarly, without specific domestic violence screening protocols abuse is recognized in 5-7% of female trauma cases (McFarlane, Christoffel, Bateman, Miller & Bullock, 1991; McLeer & Anwar, 1989), despite estimates that 20-30% of all female trauma victims
(Stark, et al.; McLeer & Anwar), and 22% of all trauma victims (Goldberg & Tomlanovich, 1984) have been abused.

In addition to failing to identify women who are abused, health care professionals tend to blame women for this lack of recognition, and often respond in ways that make women responsible for the abuse and leave them even more isolated (Heise, 1994; Warshaw, 1993; Kurz & Stark, 1988; McLeer & Anwar, 1989; Stark et al., 1979). Ratner (1995) used LISREL® to analyze the VAWS data and concluded that “when abused women come into contact with physicians, nurses, the clergy, or counselors, as a result of the abuse they have experienced, they are likely to receive no gain or incur further losses to their health status” (p. iv).

It is especially critical to address the shortcomings of the health care system and nursing in dealing with violence and abuse. The health care system is particularly well placed to allow providers to intervene with women who have been battered because it is the single system with which every woman is likely to interact at some point in her life (Heise, 1994) and nursing’s holistic approach, health orientation and clinical concern presage a unique contribution (Campbell, 1992). Because nurses are in contact with women on a regular basis they have the potential to make a significant contribution to the health care of women who are battered and to the prevention of further violence.

Racism, classism and negative attitudes toward women by health professionals contribute to the detrimental responses (Campbell, Pliska, Taylor, & Sheridan, 1994; Dobash & Dobash, 1992; Hampton & Newberger, 1988). However, the reasons for the neglect of violence and abuse have not been fully explicated. Analyzing the reasons for the lack of an appropriate and sensitive health care response, Kurz and Stark (1988) conclude that a lack of information and sexism alone are insufficient explanations. They suggest that the response of those within the health care
system has been inadequate because, as in the larger society, violence has been conceptualized as
an individual problem, and as extensions of the state, health care institutions are not mandated to
intervene in “private matters” and health care providers have not developed a mechanism of
response. Stark, et al. (1979) further suggest that the political and economic constraints within
which the health care system operates are part of an extended patriarchy that is reconstituted by
medicine in dealing with women who have been abused.

The role of nursing in responding to women who have been battered has not been described
separately from the role of other health care professionals, so it is not clear what the differences
and similarities are between nurses and other health care professionals in dealing with violence.
It is also not clear how nurses influence and interact with others in the health care system and the
larger community with regard to violence. Warshaw (1993) has speculated that nurses' condi-
tions of work and relative powerlessness within the health care system may limit their
effectiveness with women who have been battered, but the influence of these factors and the fact
that nurses are predominantly women has not been studied.

In summary, violence against women is known to be an epidemic globally and in Canada,
with most assaults against women occurring within the context of intimate relationships. Abuse
of women is also known to be a significant health problem with immediate and long term
physical and psychosocial sequelae. Although women frequently seek assistance from the
formal health care system, it has been shown that professionals fail to identify women who are
battered, tend to blame women for this lack of recognition, often respond in ways that make
women responsible for the abuse and feel more isolated, and may make health outcomes worse.

The lack of an appropriate and sensitive health care response has been suggested to arise
from the fact that the health care system, as an extension of the state, is not mandated to
intervene in "private matters", and has not developed a mechanism of response to violence. It has been suggested that, as in the larger society, health care professionals conceptualize violence as an individual problem, a view which colludes with the political and economic constraints of an extended patriarchy within which the health care system operates.

As nurses are regularly in contact with women, they may be able to contribute significantly to the health of women who are abused and to preventing violence. Nursing has begun to contribute to knowledge regarding violence against women. However, to date the actual practice of nurses in relation to violence has not been studied. Despite growing awareness that violence is a problem of power relations that is deeply gendered, nursing research has not analyzed power relations or oppression in relation to violence. Further, the ways the social context influences and is influenced by nurses' practice in relation to violence has not been studied.

The Research Questions

The following three research questions were used to guide this study: 1) How does the social context in which health care is provided, and the power relations within that context, shape and constrain nurses' care for women who have been battered? 2) How do nurses affect the structures and relationships within the social context in relation to their practice with women who have been battered? and 3) What are nurses' experiences in providing care for women who have been battered and how do they understand the context in relation to their practice with women who have been battered?

Conceptual Issues and Definition of Terms

Terminology within the area of violence against women is problematic and highly contested. Despite careful consideration of the conceptual meanings and terminology used in this study, I found that over the course of the study, some of the terms I had drawn upon from the
literature became problematic in the field. Within the context of the everyday world of nurses and women who have been abused, I found that the participants ascribed quite different meanings to certain terms than the theoretical meanings I had ascribed. Thus, I have replace several terms used initially so that this work might more accurately reflect the terminology I actually used with participants, and so that it might be more accurately read by participants.

Most importantly, the research questions concerned women who have been battered, as I understood battering to be distinguished from abuse on the basis of health risk, and had defined battering as the physical and psychosocial sequelae of abuse (Stark & Flitcraft, 1991). Although this term is used occasionally throughout the study, it has been replaced where possible with the term women who have been abused, for two reasons. First, the women interviewed who had experienced abuse objected to the term “battered” as to them the term connoted physical violence and they insisted that the significance of mental, emotional and economic abuse be recognized. Second, the term also connoted physical violence to nurses in this study, and using the term “battered” colluded with their tendency to focus on physical violence.

The other central concepts in the study are the social context of nursing, violence, violence against women and wife abuse. The Social Context of Nursing refers to the entire context of nursing practice, and encompasses the immediate units in which nurses practice (such as the emergency department), health care settings (such as the hospital), the communities in which health care settings are located, the health care system, and society. The larger society also encompasses specific social influences which are particularly relevant to this study, such as the state, the public media, and profession of nursing. Although this study occurred within the context of Canadian society, it is understood that because of globalization, the influences of society are not limited by political boundaries. For example, American media is highly
influential in Canada, including both the popular media (with a particularly influential example being the O.J. Simpson trials), and professional literature. As the phrase “social context” was not immediately comprehensible to many participants, I often had to augment this definition by also referring to the “practice environment”, the “social environment”, and the “community”.

*Violence* is defined as an abuse of power (BC Institute on Family Violence, 1994). “Violence” encompasses a vast array of abuses in a wide range of contexts. Violence can be thought of as including all forms of abuse: emotional abuse, psychological abuse, financial exploitation, physical assault and sexual assault. Violence can include stranger violence, violence in intimate relationships, and more broadly, social violence. I am using the term "violence" to encompass all forms of violence in all contexts. However, in this study I was especially, but not exclusively concerned with the unique problems of violence within intimate relationships, and more specifically the unique problems inherent in the role of wife. While I brought this focus to the study, participants often saw other ideas as central, and when asked about “violence” tended to talk more about violence against children, “stranger” violence or sexual assault.

Again, despite my meanings, participants brought their own meanings to this study. Despite defining violence in the above manner, it seemed that participants often understood violence as meaning physical abuse. I attempted to clarify my meanings when possible, but often used the term “abuse” instead of violence, as “abuse” seemed to more clearly communicate the abuse of power to which I referred, and thus in this study the terms “violence” and “abuse” are used together and interchangeably.

*Violence Against Women* clearly refers to violence that is directed toward females, and is a subset of gender-based violence directed toward females throughout the life cycle. Women are
commonly the victims of violence, but violence is by no means confined to women. Violence against women cannot be separated from violence against children, because the children of women who are battered witness violence and may also be targets of violence. Mothers of children who are abused may also be violated by the abuse of their children. Men are clearly victims of stranger violence and social violence, and to some extent are victims of violence in at least gay intimate relationships. I am choosing to focus on women with recognition that violence affects all members of our society, with the least powerful being the most violated.

As noted earlier, the term *battering* was initially used and was defined as the physical and psychosocial sequelae of abuse. However, *women who have been abused* is the phrase that is used throughout this study to refer to women who have experienced the physical and psychological sequelae of violence, which is an abuse of power. This phrase was used in an attempt to avoid using labels such as “battered woman” and “abused woman” which define women only as victims. As noted, the term “abused” was used in preference to the term “battered” as the latter term implied physical violence to the participants.

The shift in terminology occurred only as I became aware that despite how I had defined the term “battered”, connotations that were made by participants were quite different and were shaping the study. Thus, the research questions, consent forms and so on, use the term “battered”, and the term is often used by participants, at least partly in consequence of my use of the term, but in the analysis and discussion I have used the term “abused” whenever possible. This is critical because the most important audience for this work are the participants of the study; thus their meanings are the most significant.

*Wife Abuse* refers to the use of violence against a woman by a male intimate. Following feminist scholars such as Dobash and Dobash (1988), Kurz (1993), and Bograd (1988), this term
is used explicitly to draw attention to the vulnerability that accompanies the role of wife, but is not intended to imply that women only experience abuse within the context of a legal marriage. While violence against women pervades all facets of western society, abuse of a women by a male partner within the context of an intimate relationship is one of the most insidious and challenging forms of violence. Use of this term is not, however, intended to mask the fact that women experience violence in many contexts in addition to intimate relationships with men.

*The State* in this study refers to all institutions which serve to order and organize society and define what is appropriate behavior in our relations with each other (Barnsley, 1985). Given this definition, health care institutions are considered part of the state.

**Summary**

The reasons for the less than effective response of the health care system to the problem of violence against women have not been fully explored, although suggested explanations have focused attention on the social context. Further, the role of nursing in relation to violence against women has not been examined. Thus, the basis for improving nursing’s contribution to care in relation to violence against women in unknown. In light of this problem, this study was undertaken to examine the relationships between the social context and nurses in relation to violence against women. In the next chapter a more comprehensive review of the literature is presented concerning the scope of the problem of violence against women, with particular attention to wife abuse, the health consequence of violence against women, and the health care response to violence against women, with emphasis on nursing and Emergency settings.
CHAPTER TWO - THE LITERATURE

In the three decades in which violence against women has been openly discussed and researched as a social and health problem, an understanding of the scope of the problem and the nature of abuse has begun to develop. However, many controversies remain, and the social response to violence against women has not had an appreciable effect on the problem. In North America, Great Britain, and around the world, organized efforts to protect women from violent men and to assist women to protect themselves have come largely from women themselves (Dobash & Dobash, 1988; Heise, 1994). Although women frequently seek assistance from health care institutions and practitioners, professionals within the formal health care system have been largely unresponsive, and perhaps detrimental, to the welfare of women who have been violated (Goldberg & Tomlanovich, 1984, Lempert, 1997; McLeer & Anwar, 1989; Rodgers, 1994; Ratner, 1995; Stark, Flitcraft & Frazier, 1979; Warshaw, 1993).

In this chapter, the literature is reviewed to provide an overview of what is known about violence against women, the relationship between nursing and violence against women, and the social context of this relationship. First, in order to establish the importance of the problem of violence against women, the scope of the problem will be reviewed. Particular attention will be paid to wife abuse to emphasize the prevalence of this particular form of violence. Second, the health consequences of violence against women will be reviewed in order to establish that violence is a social problem of grave concern to nurses and other health providers. Third, the response of society to violence against women will be described in order to provide background for discussion of the response of those within the health care system. The reasons for the inadequate social response will be discussed with specific attention to the ways in which violence has been conceptualized. The response to violence against women by those within the health
care system is seen as a specific case of the more general social response and, in the fourth
section of this review, will be detailed in order to identify the gaps in knowledge and deficiencies
in practice. This section will focus on the lack of recognition of abuse and the detrimental
responses to abuse within the health care system. In the fifth and final section of this review,
particular attention will be paid to the response of nurses to violence against women in order to
identify the gaps in knowledge and deficiencies in practice specific to nursing. In the description
of the response of nurses and other health care providers, specific attention will be paid to
Emergency settings, primarily because Emergency has been identified as one of the primary
points of contact between nurses, other health care providers, and women who have been abused.

The Scope of the Problem of Violence Against Women

Estimates of the prevalence of violence against women are hampered by under-reporting,
lack of data, definitional problems, and methodological issues. Despite these challenges,
violece against women, and more broadly, gender-based violence, is acknowledged to be a
global epidemic. Violence against women occurs in the work place, the home and in society at
large, and encompasses rape, sexual harassment, forced prostitution, physical assault,
psychological abuse and wife abuse (Hiese, 1994; Hiese, Pitanguy & Germain, 1994).

Of all forms of violence against women, wife abuse, or abuse by a male intimate is the most
common. Reviewing 35 well designed studies from around the world, Hiese et al. (1994)
concluded that despite differences in the studies, in many countries one quarter to one half of
women report having been physically abused by a partner or former partner. An even greater
proportion of women reported being subjected to ongoing psychological and emotional abuse.

In Canada, Statistics Canada conducted a national population survey in 1993, the Violence
Against Women Survey (VAWS). In this survey, researchers interviewed a randomly selected
national sample of 12,300 women by telephone. The data from this study have been analyzed by various researchers, including Rodgers (1994), Ratner (1995), Johnson (1996), and Kerr and McLean (1996), providing the most comprehensive picture of the problem in Canada to date.

The VAWS reported that half of Canadian women over the age of 16 had experienced at least one incident of sexual or physical assault, and that 10% had been the victims of assault in the year preceding the survey (Johnson, 1996; Rodgers, 1994). In congruence with global statistics on wife abuse, 29% of women who had ever been married or lived in a common-law relationship reported being physically or sexually assaulted by a marital partner at least once during the relationship (Johnson, 1996; Rodgers, 1994). Johnson extrapolated these figures to the population, estimating that over 2.6 million Canadian women have experienced physical or sexual assault, and that of the 6.69 million women currently in a marital relationship, 1.02 million (15%) have been assaulted. In particular, British Columbia has the highest reported incidence of violence against women in Canada (Kerr & McLean, 1996).

In addition to this appalling level of prevalence, the VAWS (Johnson, 1996; Rodgers, 1994) also provided estimates of the frequency and severity of violence in the context of intimate relationships. In 63% of all cases of wife assault violence occurred more than once, and 32% of all cases of wife assault involved more than 10 episodes of violence. In almost half of all relationships with violence, a weapon was used at some point, and almost half of those assaults resulted in injury to the woman. In 43% of the situations in which the woman was injured, the woman sought medical attention. In 34% of all cases of assault the woman feared for her life.

The prevalence, frequency and severity of wife abuse in Canada is similar to that in other countries around the globe. Thus it can be anticipated that the health burden attributable to wife abuse is similar to that of other developed countries.
The Health Consequences of Violence Against Women

The impact of violence on health is not fully understood, and as analyzed by Ratner (1995), this understanding has been limited by the lack of studies designed to yield generalizable results, and the lack of longitudinal studies to examine associations between exposure to abuse and health outcomes. The impact has been suggested to include general effects on health, immediate consequences, and long range consequences.

One of the estimates of the general impact of violence on the health of women was made by the World Bank through a modeling exercise in which estimates of the healthy years of life lost due to various conditions were made (Hiese, Pitanguy & Germain, 1994). Counting each year lost due to premature death, and each year spent sick or incapacitated as a fraction of a year, it was estimated that rape and domestic violence accounted for nearly 20% of the health burden for women ages 15-44 in developed countries (the percent of the total health burden was lower in developing countries due to the greater overall burden of disease). Globally, the proportion of health burden estimated to be due to rape and domestic violence was comparable to the burden estimated as incurred by cancer, cardiovascular disease, HIV and tuberculosis, which were only outweighed by maternal conditions and STD’s.

Women’s estimates of their general health have been shown to be proportionally poorer in relation to the violence they have experienced (Gelles & Straus, 1988). Based on a national sample in the United States (US), Gelles and Straus found that the greater the violence a woman experienced, the less likely she was to report excellent health, and the more likely she was to report fair or poor health. They found that women who had been abused stayed in bed due to illness twice as often as women who had not experienced abuse. However, analyzing more recent national Canadian data, Ratner (1995) concluded that exposure to wife abuse accounted
for very little of the variance in women's perceptions of their health status, perhaps because of the way in which the general public defines health.

The specific consequences of violence against women include both the immediate effects of abuse and the long term consequences of having previously been abused or currently living under the chronic stress of violence. The consequences have been described as including physical injury, psychological consequences, alcoholism and drug use.

Physical injury is the most fully explored outcome of violence. Physical injury was initially used to define abuse, to the point of overshadowing non-physical consequences of abuse (Gelles & Straus, 1988). Patterns of injury have been used in various studies to identify the incidence of abuse (e.g. Kurz & Stark, 1988) and physical injuries continue to be used to estimate the incidence and severity of abuse, with national crime surveys in both the US and Canada typically reporting numbers and types of injuries (see Campbell, Harris & Lee, 1995; Johnson, 1996). Recently attention has turned to specific injuries that tend to be unrecognized as abuse, such as head, neck and facial injuries (Ochs, Neuenschwander & Dodson, 1996), ocular injuries (e.g. Beck, Freitag & Singer, 1996) and orthopedic injuries (e.g. Varvarao & Lasko, 1993).

In the VAWS, more than 40% of women who had been abused by their partner said "yes" to each of having been beaten up, kicked, hit or bit, slapped, pushed, grabbed or shoved, any of which could cause physical injury. In addition, 24% reported being hit with something, 30% reported being choked, and 35% reported being sexually assaulted by their partner. As noted earlier, women were physically injured in 45% of all cases of wife assault and in 22% of violent sexual assaults, and sought medical assistance in 20% of cases of wife assault. In an average year in Canada, 78 women are killed by their partners, and in 1993, about 200,000 women were
threatened, slapped, kicked, punched, choked, beaten, or sexually assaulted (Johnson, 1996). Not surprisingly, the severity of injuries varies with the severity of the abuse (Ratner, 1995).

The psychological sequelae of abuse have been variously described, and include a range of emotional effects, intrusive symptoms encompassed by Post Traumatic Stress Disorder (PTSD), suicidal ideation and suicide. The emotional consequences of wife abuse, not surprisingly, include anger, loss of trust, fear, and lowered self esteem (Gelles & Straus, 1988; Johnson, 1996; for a detailed discussion of the dynamics of these consequences, see Ratner, 1995). Among women who seek help in relation to abuse, PTSD, which includes nightmares, intrusive memories and hyperarousal, is common (Herman, 1992; Saunders, 1994). Saunders found that in previous research the mean rate of PTSD among women who had been abused was 56%, and in his study of 192 women the prevalence was over 60%. Gelles and Straus (1988) found that women who have been abused are much more likely than non-abused women to contemplate and attempt suicide, a finding subsequently supported by other studies (e.g. Abbott, Johnson, Kozool-McLain & Lowenstein, 1995). In general, the psychological consequences of abuse explored in the studies cited above tend to be worse with the severity and frequency of abuse.

Alcohol and the use of prescription drugs have been proposed as coping mechanisms for dealing with abuse (Ratner, 1993, 1995; Stark et al., 1979) and in the VAWS, one quarter of women turned to alcohol, prescription or other drugs to help deal with their situations (Rodgers, 1994). The use of prescription drugs to sleep and relieve anxiety has been suggested as much higher among women who have been battered than those who have not (Groenveld & Shain, 1989). Interestingly, Ratner’s (1995) analysis of the VAWS revealed that the strongest determinant of whether a woman took drugs or medications to deal with the abuse was contact
with physicians or nurses, a finding congruent with earlier criticisms of health care responses (e.g. Stark et al., 1979; Warshaw, 1993).

The impact of wife abuse extends beyond women to their children. Children who witness violence are traumatized by the violence indirectly, and are likely to also be abused. Gelles and Straus (1988) found that children in homes where there was violence were much more likely to have a variety of problems, including having troubles in school, being aggressive and using drugs and/or alcohol. In Bennett’s (1991) phenomenological study of adolescents who witnessed abuse, the girls were traumatized by witnessing violence and were also likely to be direct victims of abuse. In their study of 1000 women who had been battered, Bowker, Arbitell and McFerron (1988) found that in 70% of the families where children were present, the men also abused the children. Berman (1996) found that children from families in which there was violence were similar to children of war in terms of the PTSD that they experienced.

Violence against women causes tremendous suffering, and social, economic and health costs, which can only be partially quantified in economic terms. The costs of the health consequences of violence against women can only be estimated, and are assessed to be staggering (Day, 1996; Hankivsky & Graves, 1995; Kerr & McLean, 1996). What then has been the response to this epidemic?

The Social Response to Violence Against Women

The health care response to violence against women is a subset of the larger social response to the problem. The social response to the epidemic of violence against women, especially within the context of intimate relationships, has been inadequate if not destructive. As current studies of the prevalence of abuse illustrate, violence against women continues unabated. Until recently, abuse in intimate relationships has been treated as a private matter, and there has been
limited intervention by the state. In the past decade, however, such abuse has been “criminalized” in many countries, with the police and justice systems directed by policy to treat violence against intimate partners as a crime. Such strategies are not intended as primary prevention strategies, and have had limited success in preventing further abuse. The limited social response has been influenced by the way in which violence is conceptualized, by the role of the state in intervening against violence and the division between private and public realms.

**How Violence is Conceptualized**

Society's response to violence has been at least partially determined by the way in which violence against women has been conceptualized. At present there appear to be two central problems in conceptualizing violence. First, three distinct views have been used and given rise to contradictory explanations of violence and directions for practice. Second, within those three views, power and oppression have been under-theorized. Under-theorizing power and oppression has limited each of the perspectives and, I believe, created barriers to integration.

Theorists from across disciplines have attempted to understand violence by focusing attention on and seeking causal explanation for violence within individuals, within couples or dyads, and within society. Thus three models have developed to explain abuse: the interpersonal model, the family violence model, and the gender-politics model (Stark and Flitcraft, 1991). Bograd (1988) and Gelles and Loseke (1993) label these three predominant "lenses" as the psychological lens, the sociological lens and the feminist lens, referring not to specific disciplines, but rather to the focus of inquiry and presumed causality of violence.

Initial attempts to make sense of violence against women tried to explain violence by focusing on the individual. These views emphasized the psychology of the victim, and more

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1 Some of the discussion appearing here has been published along with the implications for nursing research (Varcoe, 1996).
recently, the psychology of the perpetrator. The initial focus on the characteristics of victims led to victim blaming theories of violence such as the theory of learned helplessness which "merely labels as a peculiarity...what is in fact a reasonable response to an unreasonable situation", thus diverting attention from the situation to the victim (Wardell, Gillespie & Leffler, 1983, p. 76). More recent attention to the psychology of the perpetrator has shifted the locus of causes of violence to the psycho-pathology of the perpetrator, but leaves power and gender relations unexamined. The focus on the individual has been popularized by the media which, Dobash and Dobash (1992) argue, perpetuates "unsubstantiated yet damaging theories about the problem, its victims, perpetrators and solutions [notions that] implicitly assume that this is strictly an individual problem suffered by deviants needing psychiatric care rather than a social problem in need of wider remedies" (p. 32). Bograd (1988) criticizes the focus on the psychology of individuals, because it suggests that violence is an aberrancy of a few husbands (rather than the normal patterns of most men), excuses men, implicates women and concludes that the differences between abused and non-abused women are the causes rather than the consequences of abuse. Causal explanations of violence related to the psychology of the individual leave power and gender relations unexamined and consider violence in isolation from the social and historical contexts in which it occurs.

The second set of perspectives on violence focuses on dyads or families, and seeks explanations of the causes of violence in social relations within couples and families. These perspectives, which are used in most research on violence (Silva, 1994) tend to be gender-neutral, to treat power inequities as only one factor among many, and to explain violence as resulting from external stresses and breakdown of the family, rather than as a part of most normally functioning families (Bograd, 1988; Stanko, 1988). Straus and Gelles have done
perhaps the most influential work on relations within dyads. Straus and Gelles (1986) conceptualized violence as a conflict between parties and, using the Conflict Tactics Scale (CTS), found equivalent violent behavior among men and women. Yllö (1993), Dobash and Dobash (1988), Silva (1994) and others have critiqued the perspective underlying the CTS because it does not critique power or gender relations. As with the focus on individuals, focus on dyads or families limits analysis of the influence of the social context.

The third set of perspectives, labeled "feminist", tend to explain violence as arising from the social context and contribute an analysis of the influence of gender and power to theorizing violence (Yllö, 1993). Gelles (1993) and others (e.g. Dutton, 1994; Letellier, 1994) argue that feminism is limited to using a single variable (patriarchy) to explain the existence of wife abuse, and use evidence of men who are not violent and violence in same sex relationships to argue that patriarchal ideology does not account for male violence. However, this is a narrow view of feminism and, as countered by Yllö, reflects a narrow conception of patriarchy. As Renzetti (1994) and others note, many feminists are not exclusively concerned with gender.

Tensions and conflicts between these various perspectives have led to very different explanations of violence, and therefore to very different approaches to decreasing violence. The battle between these perspectives continues to be waged, and violence theorists are calling for integrated models (e.g. Dutton, 1994; Miller, 1994, Tolman & Bennett, 1990; Renzetti, 1994). However, the approaches to integration are contentious, and I believe are seriously constrained by the limited ways in which power and oppression have been theorized in relation to violence.

Power, Oppression, Resistance, and Perspectives on Violence

Analyses of power are generally absent in work from perspectives that focus on the psychology of individuals, leaving an implicit assumption of equality between individuals.
Within perspectives that examine violence within dyads or families, power is viewed as one of many factors influencing violence and the view of power is one in which there are two equally opposing forces. From feminist perspectives, power inequalities are assumed and occupy a central position in the way that violence is theorized. However, power may not be explicitly theorized or may be theorized in a variety of ways within each of these perspectives.

Three conceptualizations of power initially proposed by Lukes (1974), and applied and refined by Gaventa (1980) highlight the limitations of the various ways in which violence has been conceptualized. The first dimension is a traditional view of power as a contest between two opposing forces in which the "winner" usually has the greatest resources (intellectual, material, personal, experiential). This view is based on the assumption that all individuals and groups have equal opportunity to express dissent. Viewing power in this manner assumes that non-participation is the fault of the non-participant and a consequence of apathy or a lack of experience or skill. Powerlessness is explained as a lack of knowledge, communication skill, political expertise or clout (Dykema, 1985), in other words, a deficit on the part of those who are least powerful. This conceptualization of power is congruent with, and supports views that focus on the individual in which the differences between abused and non-abused women can be viewed as the causes of violence. This view of power is also compatible with dyadic perspectives, as exemplified by the work of Straus and Gelles (Gelles & Straus, 1988; Straus & Gelles, 1986), in which violence is viewed as a conflict between two equal and opposing parties. Using this view of power, issues of oppression and resistance do not arise as the parties are equal, women are assumed to be autonomous agents, and questions such as “why does she stay?” are justifiable.

The second view of power suggests that some people are excluded from contesting their positions. Dominant beliefs, attitudes, values, institutional rituals and practices operate to benefit
certain people or groups. Those who benefit are supported in defense of their position; those who do not benefit are simply excluded from decision making or suffocated before being heard. This view of power is implicit in most feminist conceptions of violence, which regard the power inequalities which are fundamental to wife abuse as deeply gendered, arising from multiple sources of oppression, and fostered by the state (see for example, L. Hoff, 1992; Kjervik, 1992; MacKinnon, 1993). Devaluing and oppression of women in society are seen as fundamental to violence against women. Because women are excluded from contesting their positions, resistance is limited and women's agency is constrained. From this view of power, the question becomes "what keeps her here?" and is directed toward the structures of society and the state.

In the third dimension, power relationships are maintained because the very wants and needs of the dominated are shaped by more powerful others. Gaventa (1980) thinks that this phenomenon occurs 1) as a psychological adaptation to powerlessness, 2) from a lack of opportunity to develop political consciousness, and 3) from inconsistent belief patterns among the dominated. This view of power also underlies many feminist understandings of violence, leading to much more complex analyses of the experiences of women who are abused (e.g. L. Hoff, 1990; Wuest & Merritt-Gray, 1994). Unlike views of power which give rise to theories such as learned helplessness, this view of power explains women's behaviors as adaptations to powerlessness and domination rather than as psychological deficiencies, and sees domination arising not only from the person inflicting abuse, but from an entire system that tolerates, accepts, and perpetuates abuse. It follows that feminists argue that research on violence must be more concerned with oppression than victimization (e.g. Kjervik, 1992; McBride 1992; Yllö, 1993). However, at the basis of criticisms of the narrow concern with gender offered by
feminism (e.g. Dutton, 1994; Gelles, 1993; Letellier, 1994), is a very real problem with the ways in which oppression has been theorized by some feminists.

Feminist theorizing shifted the discourse on oppression from class as the central source of oppression (which arose from Marxism), to a concern with gender as the central source (e.g. Acker, Barry & Esseveld, 1983; Eistenstein, 1977; Harding, 1987). This shift, born of white middle class western feminism, was important in drawing attention to gender-based oppression. However, placing gender at the center of feminist theorizing erroneously implies that gender is the central defining feature of a woman and "reflect(s) the dominant tendency in western patriarchal minds to mystify a woman's reality by insisting that gender is the sole determinant of woman's fate." (hooks, 1984, p. 14). This focus on gender rests on essentialized notions of "woman" and "patriarchy" (Walby, 1992); that is to say, woman is conceived of as a biologically or socially defined "essence", and patriarchy as a monolithic entity (Alcoff, 1988; Collins, 1989).

In treating gender as a category distinct from "race", and class, these too are essentialized.

Feminists such as Brewer (1993), Collins (1986), Mohanty (1992), Ng (1993) and Smith (1990) contest the centrality of gender oppression, essentialist conceptions of gender, and the subordination of experiences of "race" and class. Following these critiques, feminists have theorized oppression as arising from multiple sites, most expressly including "race", class and gender. Critiques of uni-causal models of oppression have stimulated pleas for radical pluralism. However, accounting for endless sources of oppression presents crucial challenges to meaningful analysis (Bordo, 1994; Phillips, 1992). At the same time post-structuralists have questioned the utility of analytic categories such as "race", class and gender, declaring such categories to be too internally diverse to be useful (Walby, 1992). These two different challenges have destabilized feminist theory and threatened the very categories by which oppression can be understood and
contested (Bordo; J. Hoff, 1994; Phillips; Smith). Alternatively, Brewer proposes a focus on “the simultaneity of oppression” (p 16) which arises from multiple interacting sites, without abandoning the analytic categories of oppression such as “race”, class and gender.

The way oppression is conceived is critical to theories about violence used to guide research and practice. If gender is the sole source of oppression, then wife-abuse is seen to arise from relations between men and women, and theories locating the causes of violence within the individual and family are sufficient. However, viewing oppression as simultaneity demands a view of violence as arising from the social context. This position is congruent with the feminist focus on the context of violence (Bograd, 1988; Dobash & Dobash, 1988; L. Hoff, 1992; Yllo, 1993). Further, this view of violence as arising from multiple sites of oppression permits and requires analyses of racism, classism, heterosexism, ageism and other experiences of oppression. Wife abuse no longer can be seen as a woman's (or women's) problem, but rather becomes a problem of social dimensions requiring intervention not only with individuals who experience and perpetrate violence, but with other social relations that permit and sustain violence.

While the social response to violence against women has been limited by the way violence has been conceptualized, it may be that these theories of violence are functions of social forces that produce and maintain violence, and serve the state by reproducing and maintaining violence.

The Role of the State

Dobash and Dobash (1992) contend that there are two arguments against state intervention with wife abuse: the private sphere must be maintained (which means that whoever is most powerful is not interfered with) and, the state will support the traditional. Heise (1994) notes that

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2 Although I value the importance of these arguments, using Foucault’s view of power (as being enacted in all relationships “bottom up”, (see Methods chapter) the role of “state” did not become a focus in this study. Rather, individuals were conceptualized as creating the organization (see McCormick, 1997) and sustaining “the state” through their enactments of power.
it has taken years of struggle by feminist activists for violence to be regarded as a socio-political issue rather than as a private matter or as a problem of individual psychopathology. Dobash and Dobash ask if the battered women's movement is "seeking a form of intervention in the private to which the state has traditionally had no commitment, and thus for which the state has developed no mechanism for response?" (p. 103). Conceiving violence as a product of multiple sources of oppression, including gender, hooks (1984) argues that violence in the family is preferred by the state rather than violence against the state, thus explaining why the state has not acted significantly to end violence against women in their homes.

MacKinnon (1993) concurs, but goes further, arguing that the state deals with violence in ways which support and consolidate male power. MacKinnon asserts that the state is male in the feminist sense. She argues that male is the implicit reference for human and that objectivity is the norm of the state, reflecting a view of society as it exists and calling that view practical rationality. “If rationality is measured by point-of-viewlessness, what counts as reason will be that which corresponds to the way things are, and practical will mean that which can be done with out changing anything” (p. 208). She argues that violence is dealt with by the state, partially through law, not just from a male perspective, but in order to institutionalize male power. As the lack of state intervention is predicated on the protection of the private realm, the public/private dichotomy is an important construct to understanding the social response to abuse.

Public versus Private Violence

The notion that the home is a private domain has limited the social response to violence against women, and thus sustains such violence. Historically, the ideas of public and private have been essential for understanding gender (Schneider, 1994). The dichotomy between the
private sphere of women and the public sphere of men has been basic to the distinction between men and women, and these ideas have functioned to limit the social response to wife abuse.

As Johnson (1996) points out, the mythology of the privacy and sanctity of the home and family has “allowed husbands the necessary privacy to beat their wives without the fear of legal interference or other types of social sanctions” (p. xxi). Marcus (1994) argues that the use of modifiers such as “date” and “marital” used with rape, and “domestic” used with violence serve to locate the act or activity in the private sphere. These designations minimize the importance of such violence. And she argues, the attribution of “domestic” serves to remove any issue, including violence, from the civil rights agenda. Marcus proposes that in order to disrupt this silencing, violence against women ought to be reframed as “terrorism in the home”.

The idea that wife abuse is a private matter limits reporting of abuse by women, and limits the social response when abuse is reported, which in turn limits the usefulness of reporting. Stanko (1988) postulated that criminal events are not reported to the police because of how private individuals think their problem is, how seriously they think it will be treated, and their feelings that nothing can be done. The idea that nothing can or will be done in relation to wife abuse is well founded and inaction is also supported by the public/private schism. Schneider (1994) argues that within the criminal justice system the public/private dichotomy has been selectively applied to violence against women “in order to protect male domination” (p. 39). Arguing that the social failure to intervene with wife abuse on the grounds of privacy is not separate from, but actually part of violence, Schneider proposes that the public/private dichotomy ought to be broken down, and the notion of privacy reconstructed in ways that make wife abuse a public problem requiring collective action.
The social response to violence against women in general, and wife abuse specifically has been limited, and seems largely ineffectual. The way in which violence has been theorized, the limited role of the state, and ideas that wife abuse is a private matter have contributed to the nature of the social response. The health care response has occurred with the larger social context, and is subject to the same influences.

The Health Care Response to Violence Against Women

Regrettably, despite the fact that women come to the formal health care system for assistance, the health care response has also been limited and largely ineffectual. The response to wife abuse within the health care system has been characterized by non-recognition of abuse, and by interventions which are often less than helpful.

Women who are abused frequently seek assistance from the formal health care system. Studies of hospital emergency units have found that a high percentage of women who come to an emergency unit of a hospital do so because of injuries inflicted by their abuser or because of health care problems that result from living under the chronic stress of violence (Goldberg & Tomlanovich, 1984, McLeer & Anwar, 1989; Stark et al., 1979; Warshaw, 1993). The VAWS found that about one-fifth of women who are assaulted seek medical attention because of the severity of injury (Rodgers, 1994), and Ratner (1995) found that women seek help from health care professionals primarily because of physical injuries.

In addition to actively seeking help from the health care system, women who are abused are in contact with the health care system for problems related to the consequences of abuse and other health issues. While estimates of prevalence vary, there is consensus that many pregnant women are abused (Campbell, Oliver & Bullock, 1993; Campbell, Poland, Waller & Auger, 1992; McFarlane, 1993), with up to 23% of obstetrical patients estimated to be abused.
(Warshaw, 1993). Recent Canadian statistics show that 21% of women abused by a marital partner were abused during pregnancy and 40% of these women said that the abuse began during pregnancy (Rodgers, 1994). Herman (1992) cites a variety of studies and concludes that 50-60% of psychiatric in-patients, and 40-60% of psychiatric out-patients report childhood histories of physical or sexual abuse or both.

Violence against women has a significant impact on the health of women, and the health care system is one source of assistance to which women turn. The response, however, has been at best woefully inadequate, and at worst, a contributing factor to the perpetuation of violence. Health care professionals do not identify abuse despite being presented with obvious indicators, and when abuse is identified, the response is often detrimental. Not surprisingly, health care institutions and professionals are not usually counted as among the helpful responders by women who are battered or by service providers in the community.

It is important to note that most research on health care responses to violence against women does not distinguish between the practice of nurses and the practice of other health care professionals. Despite increasing attention in nursing to violence against women, the practice of nurses has not yet been described. Therefore, the health care response will be discussed in general and then some possible similarities and differences in nursing practice will be discussed.

Rates of Identification of Women Who Have Been Battered

The rates of recognition of violence against women by health care professionals have been consistently found to be extremely low. Most of the research on rates of identification has been done in Emergency units, although as noted, there has been considerable research in obstetrical areas, and some in other areas such as primary care (e.g. Bullock, McFarlane, Bateman & Miller, 1988; McFarlane et al., 1991; McCauley et al., 1995).
Although it is commonly reported that 22-35% of women coming to Emergency have been abused, this summary is somewhat of an oversimplification. Comparison of the various studies is hampered by differences in samples and data collection methods. Table 2-1 summarizes a number of studies that have examined prevalence and recognition rates in the Emergency. All studies are from the United States, with the exception of Grunfeld, Ritmiller, MacKay, Cowan and Hotch (1994) from Canada, and Roberts, O'Toole, Lawrence, & Raphael (1993) and Roberts, O'Toole, Raphael, Lawrence & Ashby (1996) from Australia. As can be seen, five of these studies were conducted on samples of adult female trauma patients; three on all adult patients, two on all trauma patients, and one each on all women with vaginal bleeding and all women positively identified as physically abused. One of the critical differences between the studies that makes comparison difficult is that some identify women through research protocols, some through clinical protocols, some through clinical identification without protocols, and some through a combination of these. Another critical difference is that some studies include any event during a life time as abuse, whereas others only include current or recent abuse events.

One of the earliest studies to identify the discrepancy between the number of women presenting to Emergency who are abused and the number of women identified as abused was by Stark et al., (1979) who estimated that the actual prevalence of abuse among female trauma patients was about 10 times higher than was recognized by physicians. Of the 481 charts of female trauma patients reviewed, they found that 9.6% were “positive” for abuse (injury stated as inflicted by male intimate or family member), and 15.2% were “probable” (person was kicked, beaten, hit, etc., by an unidentified but not unknown assailant) or “suggestive” (at least one injury inadequately explained by the medical history).
<table>
<thead>
<tr>
<th>Date</th>
<th>Author</th>
<th>Sample</th>
<th>Method</th>
<th>Women Identified by Research as Abused</th>
<th>Women Identified Clinically as Abused</th>
</tr>
</thead>
<tbody>
<tr>
<td>1979</td>
<td>Stark et al</td>
<td>all female trauma patients during one month (n=481)</td>
<td>retrospective chart review</td>
<td>25% (9.6% positive; 15.2% probable or suggestive)</td>
<td>2.8% of female trauma patients</td>
</tr>
<tr>
<td>1984</td>
<td>Kurz, Olsen, Flaherty &amp; Wilcove</td>
<td>adult female trauma patients (n=445)</td>
<td>participant observation &amp; chart review</td>
<td>14% (7% positive, 9% probable)</td>
<td></td>
</tr>
<tr>
<td>1987</td>
<td>Tilden &amp; Shepard</td>
<td>all adult female trauma patients (n=447 &amp; 445)</td>
<td>chart review pre and post intervention</td>
<td>9.72% pre intervention</td>
<td>22.97 post intervention</td>
</tr>
<tr>
<td>1988</td>
<td>Kurz &amp; Stark</td>
<td>randomly selected charts of female trauma patients (n=3,676)</td>
<td>chart review</td>
<td>19%</td>
<td>1.8% of female trauma patients</td>
</tr>
<tr>
<td>1989</td>
<td>McLeod &amp; Anwar</td>
<td>4th adult female trauma patient (n=359/412)</td>
<td>chart review</td>
<td>5.6% pre intervention; 30% post intervention</td>
<td>7.7% of female trauma patients (8 years later)</td>
</tr>
<tr>
<td>1993</td>
<td>Roberts, O'Toole, Lawrence, et al</td>
<td>all trauma patients during randomly selected shifts (n=656(M) &amp; 557(F)</td>
<td>questionnaire</td>
<td>7.0% of men; 23.0% of women</td>
<td></td>
</tr>
<tr>
<td>1993</td>
<td>Warshaw</td>
<td>52 women deliberately injured by another person</td>
<td>chart review</td>
<td></td>
<td>1 case (2%)</td>
</tr>
<tr>
<td>1994</td>
<td>Grunfeld et al.</td>
<td>all women during one week (n=252)</td>
<td>review of triage</td>
<td>6% of all women</td>
<td></td>
</tr>
<tr>
<td>1995</td>
<td>McFarlane, et al.</td>
<td>women with vaginal bleeding (n=416)</td>
<td>clinical screening</td>
<td>38% of women with vaginal bleeding</td>
<td></td>
</tr>
<tr>
<td>1995</td>
<td>Abbott et al.</td>
<td>women presenting during randomly selected time blocks (n=648)</td>
<td>written survey</td>
<td>11.7% of women with current male partner; 54.2% of all women (lifetime experience)</td>
<td>1.4% of women with current male partner</td>
</tr>
<tr>
<td>1996</td>
<td>Olson et al.</td>
<td>all adult females during 3 months</td>
<td>prospective survey</td>
<td>3.6% of all women during education month</td>
<td></td>
</tr>
<tr>
<td>1996</td>
<td>Roberts, O'Toole, Raphael et al</td>
<td>all trauma patients during randomly selected shifts (n=670(M) &amp; 553(F)</td>
<td>questionnaire</td>
<td>8.5% of men; 23.9% of women</td>
<td></td>
</tr>
</tbody>
</table>
In the largest study to date Kurz and Stark (1988) also examined the discrepancy between clinical recognition and the prevalence of abuse determined through chart review. Using 3,676 randomly selected charts of women who presented to emergency with trauma, they identified 642 (19% of all female trauma patients) as abused because of evidence that was either "positive" or "probable". They also found that 40% of all injuries presented in abusive relationships (many charts contained multiple trauma episodes). Medical personnel identified only 15% of the "positive" group as "abuse" or "battering", and associated only 4.5% of abusive injuries with violence, and only 1.8% of the total 3,717 trauma episodes presented by abused women with "abuse" or "battering". Similarly, Warshaw (1993) found that of 52 "positive" cases of physical abuse, only one case was dealt with directly as abuse.

Only two replicated studies were located. First, McLeer, Anwar, Herman and Maquiling (1989) replicated McLeer and Anwar's (1989) earlier study to examine the extent to which the effect of training health care personnel had persisted. Disappointingly, although the recognition rate rose from 5.6% to 30% of female trauma patients during the initial study, eight years later, the rate had dropped to 7.7%. The only other replication (Roberts, O'Toole & Raphael, et al., 1996) did not deal with clinical recognition rates, but obtained consistent prevalence rates among all trauma patients of 7% and 8.5% of men, and 23% and 23.9% of women identified as abused.

Despite the limitations, and differences between studies, it is reasonable to conclude that up to 30% of female trauma patients have been abused, and that rates of clinical identification, both with and without protocols, are much lower than the number of women abused.

Reasons for Non-identification

The reasons for non-identification of violence are complex and are not well understood as they have not been specifically studied. Some explanations tend to blame the woman, focusing
on women’s reluctance to disclose rather than the conditions under which disclosure may be made, and emphasizing the characteristics of women who are abused as influential. However, the factors which influence a woman’s decision to disclose abuse and the factors that enable a health care professional to recognize abuse appear to be intertwined.

The response a woman anticipates is likely to influence her decision to confide in a health care provider. Herman (1992) argues that people who have been traumatized, including survivors of abuse and war, assume, until proven otherwise, that a person in a therapeutic role cannot bear to hear the truth about the trauma. Stanko (1988) argues that reporting of abuse is impeded by women’s belief that police are reluctant to intervene in domestic affairs, and women’s fear of reprisal. Stanko also concludes that “part of women's silence around physical and sexual abuse in the home... can be attributed to the barriers preventing women from speaking of their homes as anything but sanctuaries” (p. 88). Women’s reluctance to disclose abuse to health care providers may be influenced by the same factors; women may think health care providers do not want to hear, and may think that abuse is a private matter and that nothing can or will be done.

Studies illustrating the impact of training on recognition rates further support the idea that the perceived reluctance of women to disclose abuse may be due to the behavior of the health care professionals. McLeer and Anwar (1989) found that with protocols and training of health care personnel, the percentage of female trauma patients recognized as abused rose from 5.6% - 30%. Similarly, McFarlane, Christoffel, Bateman, Miller and Bullock (1991) found that by conducting personal interviews, recognition of abused women increased from 7.3% to 29.3% of women coming to a planned parenthood clinic.

The similarities and differences between social identities of health care professionals and abused women may be a significant factor in determining whether or not abuse will be
recognized. Hampton and Newberger (1988) found that with regard to child abuse, "class and race are the important factors defining the gradient between reported and unreported cases" (p. 217). Such biases may also influence recognition of wife abuse. Campbell, Pliska, Taylor, and Sheridan (1994) described battered women's perceptions of racism, classism and negative attitudes toward drug and alcohol problems by hospital Emergency personnel, and Greif and Elliot (1994) found that Emergency nurses expressed similar attitudes when surveyed.

Racism may be a particularly critical factor in a woman's decision to disclose abuse. Dobash and Dobash (1992) note that seeking assistance from authorities by women of color is seen as unacceptable because the response by authorities (e.g., arrest) is seen as "a further act of racial oppression against men of color"(p. 52). They further analyze the double bind saying that "women of color are in fact being expected to bear the brunt of gender violence within a racial or ethnic group in order that the group itself or its violent members not be exposed to further racial oppression" (p. 53).

Acknowledging low levels of recognition, nurses have called for universal screening in which every woman seen by a health care professional is asked questions regarding whether violence is a problem in her life (Bullock, et al., 1989; Furniss, 1993; Grunfeld, et al. 1994; Humphreys, 1993; King, 1993; Lazzaro & McFarlane, 1991; McFarlane, Greenberg, Weltage & Watson, 1995). The studies to date suggest that training and protocols can improve recognition rates, but the experience of McLeer, Anwar, Herman et al. (1989) suggest that the effects are not lasting. Further, the rates of clinical identification tend to be low in all studies, ranging from 1.8% of female trauma patients, to 6% of all women, with the exception of McFarlane, et al. (1995) who identified abuse in 38% of women presenting with vaginal bleeding.
The literature on identification suggests that the problem of identification is complex, but is at least in part due to the behavior of health care professionals. The reasons for non-
identification have been suggested to be related to the attitudes of health providers and the messages they convey, as well as to the willingness of women to disclose abuse. If the problem of identification is conceived as partly a problem of recognition by health care professionals, rather than only as a problem of disclosure on the part of the woman, then the responsibility for recognition might be partially shifted from the woman who has been battered to health care providers and institutions, and the behavior of the latter becomes a target for study and change.

**Detrimental Responses to Women Who Have Been Battered**

Even when women are identified as having been abused, the response by health care professionals and institutions is less than helpful. Kurz and Stark (1988) found that while 4% of women identified as “positive” for abuse were hospitalized (twice the rate for “non-abuse” injuries), 47% were simply returned home and only 12% were referred to appropriate social services. Remarkably, 8% of the women identified as “positive” for abuse were referred to psychiatry (which the authors note is a rare referral for other types of injuries) and were twice as likely to be referred to psychiatry as to social services, reflecting the focus on the individual and suggesting that some believe that a solution to abuse can be found in a woman's mind. Conversely, whereas non-battered suicide attempts resulted in 96% referral to mental health services, only 22% of suicide attempts by women who had been battered resulted in such referral.

A second study reported by Kurz and Stark (1988) involved interactions between 98 battered women and emergency staff in each of four hospitals, and interviews with the staff. The majority of the staff (90%) thought they should identify battered women. However, only 11% responded in what the authors called a positive manner (e.g., taking the abuse seriously). Staff
responded positively to women they saw as deserving, "true victims", especially if they thought the women are taking some action on their own. A partial response was made by 49%, but the woman was a lower priority than other cases. Forty percent of the staff did not respond at all because 1) they saw the women as evasive, unwilling to talk and hiding something, and/or 2) they saw the women as undeserving (she had alcohol on her breath, etc.). These attitudes allowed the staff to blame the woman for the lack of an effective outcome, make battering a problem that the woman is, and tended to deny the strengths and agency of the woman herself.

Stark et al., (1979) argued that battering is socially constructed and described the process of that construction by medical personnel. In their study, the woman was initially medicated symptomatically, but following failure of the treatment, incongruity between available medical explanations and the woman's problems, and the woman's continued insistence that there was a problem, the woman would be labeled. In this process, secondary problems such as depression, drug abuse and suicide attempts, arose as much from the intervention as they did from the physical assault itself. This process appears to persist, as Kurz and Stark (1988) found in their review of medical records that 86% of women who were “labeled” (designating behaviors, complaints, groups in ways that are devoid of therapeutic value and are unsupported by evidence) were women who were battered.

There is disagreement in the literature regarding whether or not women should be treated as autonomous decision makers by health care providers. Hart (1988) claims that the woman is almost always the best judge of what should be done, while nursing authors Limandri and Tilden (1993) justify a paternalistic stance with the view that “post-traumatic stress disorders erode judgment, depress affect and impair decision making” (p. 498). Herman (1992) notes that while the need to restore control to the traumatized person is widely recognized, “those schooled in the
medical model of treatment often have difficulty grasping this fundamental principle and putting it into practice” (p.134).

Kurz and Stark (1988) characterize the response of health care professionals to violence against women as "alternating between a narrow clinical focus on physical injuries outside of the social context that makes them intelligible, and an approach that stigmatizes abused women so that they appear responsible for the abuse" (p. 249). Like other extensions of the state, the health care system not only fails to support women who are abused. Rather, the actions taken often fail to provide assistance and may even exacerbate a woman's predicament, deflect blame on to her, and increase her sense of isolation (Dobash & Dobash, 1988). The response of those in the health care system appears to go beyond negligence to harm.

Importantly, Ratner’s (1995) analysis of the VAWS concluded that contact with health care providers did not improve health outcomes, and was in fact, slightly negative. Women who do not contact health care providers in relation to their injuries may have better health outcomes than those who do, irrespective of severity of abuse. Ratner suggests that this maybe due to health care professionals focus on physical injuries and disregard for the woman’s experience. This explanation concurs with the contentions made by Warshaw (1993), and the experiences of being in an Emergency described by women who had been abused (McMurray & Moore, 1994).

Not surprisingly, health care professionals and institutions have not been widely perceived as part of the solution to violence. Brendtro & Bowker (1989) interviewed or surveyed 1000 women who had been battered, and found that the women rated health care professionals as less effective than any other formal source of help. In community based reports, health care professionals and institutions are conspicuous by their absence. For example, in a community report on wife assault (Wahamaa, 1992), the hospital is listed as the last resource and public
health and nurses are not even mentioned. While recommendations focus (predictably) on the need for community services, changes in the justice system, changes in the education system, and so on, the health care system is not addressed.

When abuse is recognized, the response of the health care system has not been helpful, and in fact may be detrimental. It may be that non-disclosure of abuse is a reasonable strategy in response to assessment of the potential risks and benefits for a woman who has been abused, and may function to protect her from the detrimental effects of the health care system.

**Why is the Health Care Response Inadequate?**

While the reasons for the inadequate health care response have not been specifically studied, various researchers have proposed explanations for their less than flattering findings. The reasons, not unexpectedly, are similar to those suggested for the inadequate social response. As noted, Kurz and Stark (1988) contend that a lack of information and sexism are insufficient to explain the response to violence in health care. Stark et al. (1979) claim that the health care system is part of an extended patriarchy and that the political and economic priorities of medicine are reflective of that patriarchy in dealing with women who experience violence. Kurz and Stark argue that, as in the larger society, health care providers see violence as an individual problem, and that, as health care institutions are not charged with intervening in “private matters” providers have not developed responses. It appears that mainstream conceptions of violence facilitate the patriarchal priorities of the health care system in relation to violence.

Seeing violence as an individual problem has been suggested as especially contrary to meaningful health care responses, but individuals within the health care system have accepted and furthered this view. Hurowitz (1993) argues that there are two factors which explain why people view health related issues as problems for individuals rather than looking at the social and
economic determinants of health: governments do not want to point to social factors because doing so only calls attention to the structural inadequacies of government policies, and health care providers benefit from having resources put into their programs, which are aimed at individuals. Rachlis and Kuschner (1994) further argue that social and economic determinants of health do not have the same appeal to politicians as “sexy” health care issues, such as high technology interventions. I would add that quick solutions have greater political appeal than insidious problems, and that there would be little popularity to be gained in calling most men violent. Rachlis and Kuschner also note that because there is no public debate about how health-care priorities are established, priorities are set by governments and influential health care institutions, in other words, by the state.

It might be argued that health care professionals have sufficient autonomy to practice in the best interests of their clients rather than in the interests of the state. However, the strong emphasis on illness and on the individual in health care has yielded practice models (particularly the “medical” or physiological model) that perpetuate this focus. Thus the unique ways of thinking in health care work with theories of violence that are counter to a collective response.

Both nurses and physicians view abuse in terms of the medical model and “medicalize” violence, thus intervention focuses on physical injuries, and the psychosocial aspects of abuse are defined as outside the framework of intervention for both nurses and physicians (Warshaw, 1993). Warshaw argues that the medical model reduces things to categories that it can handle and control, and severely limits what can happen between health care providers and women who are battered. Further she argues that the issues that women who are battered bring to the medical setting seriously challenge the medical model of care and the power dynamics of at least the doctor-patient relationship. Kurz and Stark (1988) contend that health care professionals learn to
categorize abuse along with other diseases that require treatment, and to categorize women as victims that require rescue, and thus, they reproduce and extend dependence.

The language of the medical model pervades medical records and health care policy documents. In hospital charts, medical language reduces the beating of a woman by her partner to "beaten to head and face with fist", disembodifying the woman and assailant (Kurz & Stark, 1988; Warshaw, 1994). Institutional and policy documents also reflect medicalized language. For example, an evaluation of the Domestic Violence Program at Vancouver General Hospital (Scriven & Kramer, 1993) is fraught with medicalization of the problem of violence. The report introduces the program by saying that "the approach is to improve: (i) diagnosis, (ii) the provision of appropriate and immediate treatment; and (iii) the follow-up support by mobilizing an integrated effort by the professional staff..." (italics added). It is therefore not surprising that the evaluators recommended increasing the physician's involvement from 25% to 33%, while recommending cuts to non-medical staff (social work and nursing).

The focus on physical manifestations of abuse are pervasive even in nursing. For example, the "model policy and procedure for battered women" offered by Campbell, Pliska, Taylor, & Sheridan (1994) suggested that trauma was the criteria for identification even though "battered woman" was defined as any woman who has been physically, emotionally or sexually abused, and the literature cited included Goldberg & Tomlanovich (1984) who found that most women who had been battered did not present because of trauma.

Physicians have a traditional emphasis on the physical aspects of a person and on the cure of physical disease and injury, and may be partially understood on this basis. However, in spite of the hegemonic dominance of the medical model in health care institutions, nursing rhetoric has
espoused concern with the experience of the individual and the whole person. What then has
been nursing’s response to violence against women?

The Nursing Response to Violence Against Women

Nursing authors have suggested that nurses might have an unique contribution to the care of
women who have been battered (e.g. Campbell, 1992), and specific nursing interventions have
been suggested. However, the care provided by nurses has not generally been distinguished from
the care provided by others within the health care system in studies of health care in relation to
violence. Warshaw (1993) found that like physicians, nurses “medicalized” violence, defined the
psychosocial aspects of abuse as beyond their scope of intervention, and were unwilling or
unable to directly address the abuse issues that women brought to the emergency unit. The ways
nurses care for women who have been battered have not been studied sufficiently to make claims
about the unique contribution that nurses make. However, some distinguishing features of
nursing have been suggested as influential on practice in relation to abuse.

The position of nurses within the health care system may influence the ways in which
nurses care for women who have been battered. Nurses practice largely within health care
institutions and in close proximity to physicians, situations characterized by unequal power
relations based on gender, class, and differential in professional privilege. Stevens (1983) argues
that nurses lack power because 1) women do not traditionally possess power, 2) nurses accept
traditional sex-roles, and 3) nursing has evolved in a male-dominated system where male
administrators and physicians are concerned with control over others, profits and male privileges.
Doering (1992) states that nurses lack power in comparison to physicians because nurses
typically come from lower socioeconomic classes and that the economic gap is widening. She
further argues that the disparity between educational levels, the identification of nursing as
“women’s work”, and social expectations for nurses to reflect female qualities of deference, submissiveness and conformity, maintain existing power relations in nursing. These forces limit nurses’ control over their own practice and may make it challenging for nurses to identify with women who have been abused.

Warshaw (1993) suggests that nurses may be limited in their care in comparison with physicians because of their less autonomous roles, less training for detachment, and greater conflict between nurturing and technical roles. In her study of the charts of 52 women who had “obviously” been battered, Warshaw found that triage nurses were unwilling to initiate the Emergency unit protocol that would require nurses to make referrals, insure safety and follow up, and found that the nurses preferred to shift the problem to another institution such as the police, “rather than to another overburdened nurse” (p. 138). Warshaw adds that over worked and understaffed conditions may be limiting factors to nurses’ responses, and that multiple roles and extra work for nurses may prevent identification of women who have been battered and the initiation of protocols. Similarly, the maternity nurses in Basso’s (1995) study perceived, and often felt frustrated by, a lack of institutional resources and support for their patients, and lack of support for the nurses’ own emotions.

Laden with stigma, violence against women is an area in which the care provided is influenced by the context of care and by the attitudes of care providers. Given the evidence of the influence of the inadequate health care response and the negative attitudes encountered by women who have been abused, study of health care provider’s responses is important. In particular, there are some unique features of the nursing profession which may influence nursing practice in relation to violence. First, the majority of nurses are women. Gender has been shown to play a more significant role than professional category in attitudes toward women who have
been battered, with women having more positive attitudes (Rose & Saunders, 1986). This may mean that, as women, nurses have different attitudes than male professionals. As the majority of nurses are women and there is no reason to assume that nurses are different from other women with regard to their experiences of violence, a high percentage of nurses will have been abused and such experiences may be presumed to influence practice. However, the ways in which nurses' own experiences of abuse influence their practice has received only limited attention (e.g. Basso, 1995; Hartman, 1989). Second, the way in which nurses are constructed and perceived in society may influence the ways in which nurses perceive themselves, and the ways in which women who have been battered perceive nurses and their potential for effectiveness. Thus, the context of practice and nurses' attitudes, values and beliefs are important focal points for study.

**Nursing Research and Violence Against Women**

Although the ways in which nurses care for women who have been battered have not been studied sufficiently to claim that nurses are currently making an unique contribution, nursing research is making a significant contribution to the understanding of violence against women. Nursing research on abuse has begun to build knowledge regarding the prevalence of abuse, identification of women who have been abused and the responses of women to abuse, but little is known about the care provided by nurses. Most nursing research has been from mainstream perspectives and has not focused on the social context, thus has not afforded critique of gender and power relations. The power relations between nurses and women who have been battered and between nurses and others within the health care system have received limited attention, mostly through a few studies which focus on the attitudes of nurses. In addition, despite evidence of the importance of racism and classism in relation to violence, nursing research has paid limited attention to these forms of oppression.
Studies of the attitudes of nurses regarding violence and women who are abused have afforded a beginning understanding of nursing practice in relation to violence and attention to power relations. Cochrane (1987) surveyed Emergency nurses in Alberta regarding their attitudes toward rape victims and found that Emergency nurses directed care toward the physical rather than the psychological trauma, attributed blame for the assault to the victim based on the woman’s appearance and perceived carelessness, and tried to avoid caring for rape victims. In addition, the woman’s age, marital status, and relationship to the perpetrator influenced nurses attitudes. In regard to attitudes toward wife abuse, Rose and Saunders (1986) studied physicians and nurses working in various areas of a hospital in the midwestern United States. They found that although nurses were more opposed to wife beating than physicians, these differences were attributable to gender, with women being more opposed than men, regardless of profession. Similarly, Renck (1993) found that among physicians and nurses working in Emergency and health care centers in Sweden, females were more likely than males to ask questions about abuse and refuse to accept a denial. Chung, Wong and Yiu (1996) studied the attitudes toward wife battering among Emergency nurses in Hong Kong. They found that while most nurses were sympathetic to women who had been battered, an alarming 33.3% thought women were responsible for their own abuse, and concluded that traditional patriarchal views influenced the nurses’ attitudes. These four studies from different countries reveal that the attitudes of health care providers, including nurses, are problematic and likely to contribute to the less than helpful health care response, but that as women, nurses may be more empathetic.

The way in which negative attitudes may impact women was dramatically illustrated in a phenomenological study in Australia by McMurray and Moore (1994). These researchers found that the women admitted to hospital in relation to abuse experienced disengagement from
hospital staff and loss of status, disempowerment and lack of control, stigma and social isolation, and a sense of being misunderstood. These women told of being humiliated, blamed, judged, and made to feel unworthy. Two women told of being called “a bloody idiot” for having returned to their husbands.

While attitudes toward women who have experienced abuse have received some attention, attitudes toward “race” and class have received little. With few exceptions, such as Campbell, Pliska, Taylor, and Sheridan (1994) who reported battered women's perceptions of racism, and classism by hospital Emergency personnel, nurse researchers either have not considered or have not critically examined issues of “race” and class in relation to violence. For example, Trucker (1992) reported that she interviewed women who were of a certain “race”, social class and treatment experience (presumably made possible by “race” and class) but did not specify what class or “race” the women were, (or if ethnicity varied) and did not include these facts in her analysis. In another example, McFarlane (1993) attempted to understand different ethnic patterns of abuse between African-American women, Hispanic women and white women, presumably because of the limitations of previous studies. However, there was no discussion of the basis on which women were assigned to these non-parallel categories, no discussion of class differences between the women, no attention to the cultural appropriateness of the screening used, no discussion of the likelihood of affirmative answers, no discussion of the ethnicity of the researcher, and no suggestion that there would be positive consequences for those women who disclosed abuse. These shortcomings raise serious challenges to the conclusion that the "frequency and severity of abuse was appreciably worse for white women" (McFarlane, 1993, p. 357). Given that the “race” of a woman may be a particularly critical factor which influences the decision to disclose abuse (Dobash & Dobash, 1992), the difference in findings may solely be a
function of reporting decisions by the women. In a final example, Limandri and Tilden (1993)
identified the prohibitive cost of care for a battered woman whose daughter required assessment
for abuse, but did not mention the economic impact of hospitalization that they recommended for
an abusive man. While this reflected an implicit understanding of the intersection between class
and gender, Limandri and Tilden did not make this part of their ethical analysis. Clearly an
analysis of oppression which arises from “race” and class is not incorporated in these studies.

A few nurse researchers have explicitly used feminist theories of violence and have thus
attended to oppression. For example, in her ethnographic study of battered women in their
formal social networks, L. Hoff (1990; 1992) focuses primarily on the sociocultural context of
violence and explicitly considers power relations and oppression. The practical implications she
identifies include the need for public awareness, consciousness raising regarding the role of
women and redefinition of oppressive social structures, the redirection of policy and human
service providers to hold assailants rather than victims accountable for violence, and the need for
nurses to combine social action with crisis intervention strategies. Wuest and Merritt-Gray
(1994) also explicitly used a feminist approach to study the social violence done to women as
they attempted to leave abusive relationships. The implications they identify are directed toward
social policy and programs, and toward the attitudes of nurses and other service providers who
become frustrated with women who return to or cannot leave abusive relationships.

To date, recommendations for practice change from research have emphasized better
recognition strategies. While moves to increase the recognition of abuse are commendable, they
are clearly insufficient. While nursing authors recognize the importance of responding to women
who have been battered in a supportive manner (Trucker, 1992; Limandri, 1987) and of adopting
a framework of empowerment for practice (Humphreys, 1993; King, 1993; Limandri, 1987),
putting such ideas into practice will require challenging and painful work. Nurses will have to develop a deeper understanding of violence and unlearn the “blame the victim” theories which underlie most academic work and media representations, and redefine nursing success in terms of empowerment of women rather than in terms of nurses’ idealized choices for women. Nurses will have to reconceptualize violence as a socio-political problem that manifests in individual cases, rather than as a problem of the individual cases per se. Such a perspective would guide nurses to consider the social and economic context of individuals and seek change at the social as well as the individual level. Kurz and Stark (1988) argue that we have to see abuse as requiring both help and politics; action and analysis. Ethical dilemmas presented by social inequities could then be recognized and analyzed. Such endeavors would also require unlearning the sexism, racism, heterosexism, classism, and so on that pervade our society and practice.

There is growing consensus that violence is not just the problem of disturbed men and is not confined to “dysfunctional families”, but rather is a socio-political phenomenon of epidemic proportions (Bart & Moran, 1993; Dobash & Dobash, 1988; Heise, 1994; hooks, 1988; Stark et al., 1979; Warshaw, 1994). Violence is being reconceptualized as a “fundamental dimension in most normally functioning families” (Bograd, 1988, p. 19) and as a socio-political phenomena that is condoned and supported by the state (hooks, 1988; Rachlis & Kuschner, 1994). Nursing must reconceptualize violence against women as a socio-political problem and critically examine power relations, including inequities arising from gender, class and “race”. We must critically examine nursing practice and the role of sexism, racism, classism in relation to women who have been battered, and in relation to the institutions and communities in which nurses practice. We are challenged to be self-critical and participate in what Dobash and Dobash (1988) refer to as the “necessary task of confronting professionals with the evidence of their contribution to the
continuation of the problem of violence against wives” (p. 68-9). From an understanding of how violence is currently supported and maintained, resisted and countered within the context of health care and society, nurses can develop approaches that will contribute to effective care of individual women, not by attempting to change the women, but by attempting to change the structures which permit violence to permeate our society unchecked.

Summary of the State of Knowledge

The nursing response to violence against women, and wife abuse in particular, has been part of inadequate health care and social responses to the problem. Violence against women is known to be an epidemic globally and in Canada, with most assaults against women occurring within the context of intimate relationships. Abuse of women is also known to be a significant health problem with immediate and long term physical and psychosocial sequelae. Although women frequently seek assistance from the formal health care system, it has been shown that professionals fail to identify women who are battered, tend to blame women for this lack of recognition, and often respond in ways that make women responsible for the abuse and leave them even more isolated.

Abuse of women continues unabated, and through our inaction we collude. Direction is unclear regarding what strategies will improve the contribution of nursing, partly because the reasons for inadequacy seem so deeply rooted in the position of nursing within the health care system and in the nature of the nursing role, partly because the reasons for inadequacy are not well understood. The lack of an appropriate health care response has been suggested to arise from the fact that the health care system is not mandated to intervene in “private matters”, and thus health care providers have not developed meaningful responses. As in the larger society, health care providers conceptualize violence as an individual problem, a view which colludes
with the political and economic constraints of an extended patriarchy within which the health care system operates. Further, evidence suggests that racism, classism and negative attitudes toward women by health care professionals contribute to the deleterious responses. Although suggestions regarding the reasons for ineffective health care responses point to the social context of practice, it is not known how these factors influence actual nursing practice, and thus, how practice can be improved.

Violence against women demands attention. The costs of violence against women in terms of human suffering and economic impact are staggering. Nurses are particularly well positioned to contribute to ending violence, at least for individual women with whom they come in contact. However, the reasons for the lack of effective responses must be understood before the contribution of nursing can be improved. As the social context of practice appears to offer the greatest potential for understanding the reasons for and the barriers to appropriate and effective responses to violence against women, the influence of the social context of nursing in relation to violence warrants investigation. This study was undertaken with the goals of enhancing understanding of the current nature of nursing's contribution to the care of women who have been abused, and providing a basis for improving practice.
The Interview

coffee stains
sunshine pools
arborite and chrome

childhood pains
coffee cools
country kitchen home

busted dreams
broken jaws
grubby curtain lace

ragged seams
felon's laws
empty table place

refills poured
smokes relit
bolted locking door

scratches scored
bruises hit
chipping tile floor

one last cup
getting late
broken window pane

packing up
out the gate
fresh and cleansing rain
CHAPTER 3: THE METHOD

In order to address the research questions, I required a methodology that could create an account of the social context of nursing practice, the power relations within that context, and the ways in which the context and power relations influenced practice in relation to violence against women. I needed a method which would create an account of the understandings, experiences, actions, practices of nurses in relation to care of women who have been abused, and insights of nurses into the power relations and structural constraints of the social context in which they provide this care. The design that best met these requirements was critical ethnography. For the purposes of this study, the social context selected was the Emergency.

Research Design

A critical ethnography, including participant observation and interviews, was planned and conducted. Ethnography is a social research method that has extensive, although controversial, traditions (Hammersley & Atkinson, 1983; Atkinson & Hammersley, 1994), and is aimed at the study of social contexts. Ethnography typically involves both participant observation and interviews, both of which were essential to addressing the research questions in this study. Interviews provided data regarding nurses' perceptions of the influence of the social context, their influence on the context and their experiences with women who have been abused. Participant observation provided data regarding the context and the relationships between the context and practice, permitted me to do my own analysis of the influence of the context, and to compare my analysis to the analyses of the nurses.

Various forms of ethnography have evolved over the past century as philosophies of science have developed and various disciplines have adopted and adapted ethnographic techniques. During the “modern era”, ethnography was born of cultural anthropology which focused on the
study of tribal societies, and accompanied (or followed) colonialist expansion. Ethnography served colonialism by rendering "primitive societies" open to scrutiny, and exoticised tribal people. Theories that saw colonized people as "culturally deprived" and those that pathologized responses to colonialization and genocide supported such colonization and genocide. In contrast critical and feminist ethnography are distinguished from traditional ethnography by attention to power relations and to the relationship between the researcher and the researched, and by concern with the critique and transformation of oppressive conditions.

Critical ethnography, although variously defined, has grown out of discontent with earlier approaches to social research, in particular, postmodern discontent with the colonializing tendencies of "modern" ethnography. Anderson (1989) claims that critical ethnography has grown both out of
dissatisfaction with social accounts of "structures" like class, patriarchy, and racism in which real human actors never appear... and out of dissatisfaction with cultural accounts of human actors in which broad cultural constraints like class, patriarchy and racism never appear." (p. 249).

The defining features that make critical ethnography "critical" are concerned with the relationships and power inequities between social actors and the socio-political framework, the transformation of those relationships, and attention to the research process as a form of social practice imbued with power within material conditions (Anderson, 1989; Simon & Dippo, 1986; Quantz, 1992). Because I was concerned with examining the relationships and power inequities within the context of nursing practice, wished to foster transformation of those relationships, and was concerned with the research process as social practice, I considered critical ethnography to be the most suitable form of ethnography for this study.

I thought that a feminist perspective was also essential, but insufficient, for this study. Approaches to ethnographic research informed by feminisms that are concerned primarily with
gender inequities have both contributed to (Anderson, 1989), and been seen as contradictory to
critical approaches (e.g. Stacey, 1988; Strathern, 1987). One of the ways that feminist and
critical approaches have been seen as distinct from traditional ethnography, but contradictory to
one another, has been in the construction of the relationship between the “self” and “other”, in
other words, between the researcher and the researched. In traditional “modern” approaches to
ethnography, “self” is not thought of as problematic, the self is separated from other, and the
researcher seeks an objective distance from those studied, the objects of study. The researcher
does not appear in these texts, yet speaks with ethnographic authority. This stance is congruent
with colonialization, as the researcher as “self” is already distinguished from “other” on the basis
of “race”, culture, language, and so on, and the research serves to reinforce the distinctions
through objectifying and further exoticizing “other”.

In critical and feminist postmodern approaches¹ attention to the research account as
constructed (rather than “uncovered”) has demanded different conceptions of the relationship
between the researcher and the researched, and the researcher as self has been considered
problematic. In both critical and feminist approaches, analyses of power demand a rethinking of
the relationship between the researcher and the researched, rendering as problematic and
interrogating this relationship. Feminists have particularly drawn attention to the relationship
between men as researchers and women as objects of study. However, depending on what is
meant by “feminism” and “critical”, there may be differences in the construction of this
relationship. Strathern (1987) argues that feminism (and I assume that she is referring to a
feminism concerned primarily with gender based oppression) presumes an antagonistic

¹ I am not claiming that all critical and feminist methods are “postmodern”, but those that are postmodern are
characterized by “awareness of the partiality and contingency of every claim to knowledge, an eschewing of “grand
narrative” and “grand theory” in favour of smaller narratives, and an avoidance of the claim to speak for all women
(Ashe & Cahn, 1994, p. 189). By postmodern, I am not referring to post structuralism.
relationship between the self and the male “other”, whereas critical approaches point out the
"illusory nature of feminist pretensions" of the separation of women from men within a culture.

Feminist stances characterized by an assumption of antagonism between the researcher and the male “other” rests on essentialized notions of “women” and creates an a priori distinction between some social actors (women) and others (men), and deals only with certain inequities within the sociopolitical context. Stacey (1988) points out that “feminist researchers are apt to suffer a delusion of alliance more than the delusion of separateness”, meaning that, especially when research is assumed to be done “woman to woman”, an alliance between the researcher and the researched can be falsely assumed. Further, I would contend that there may be greater distance between the researcher and the researched based on other sites of oppression (such as ability, sexual orientation, “race”, class, age, and so on) than there is common ground created by gender. Critical approaches, while rendering these relations problematic, may err on the other side, that is to say, may fail to attend to gender inequities.

Thus, the disadvantages of using a solely feminist approach would be that “feminist” might imply a concern only with gender oppression, lead to the assumption of alliance between the researcher and the researched based on womanhood, reproduce essentialized notions of women, and account only for certain aspects of the social context. This was of particular concern for me. I was wary of theorizing violence as a gender-only issue. In fact, I theorized violence as deeply gendered, but as arising from social relations which are fraught with power inequities arising from multiple sources of oppression including “race”, age, ability, class, and so on (Varcoe, 1996). I was also wary of assuming an alliance with women, as I was examining the relations between nurses and women who have been abused. With which women would I ally: women as nurses or women as abused? And why would I separate women in that manner?
A critical perspective offered an approach to accounting for power relations and various sites of oppression that I theorized were relevant to examining violence against women. However, simultaneously, I did not want to lose sight of the way in which violence is deeply gendered. In this study, then, I chose to do a critical ethnography informed by a feminist perspective. I reconciled the contradiction between my self as the researcher and men as “other”, and battered women as “other” by theorizing people as simultaneously raced, classed and gendered, and so on. Thus I thought of the relationships between my self and those being researched as problematic, and attempted to continuously interrogate those relationships along multiple lines of oppression, with particular attention to gender as an important site of oppression in relation to violence against women (see following discussion of challenging assumptions).

Critical ethnography was selected as the appropriate methodology for this study for five reasons. First, critical ethnography begins with assuming that power inequalities exist, and is directly concerned with power relations. I began with the assumption that power inequalities exist in society, in health care organizations and in nursing practice and sought to understand the relationships between these power inequalities and the way in which they affect the nursing care of women who have experienced abuse.

Second, analysis of power relations and attention to the relationship between the researcher and researched gives voice to those less powerful and limits the extent to which the researcher’s voice overwhelms those of the researched, a consideration which was especially important in this study. Nurses are less powerful in the health care system than others such as physicians and administrators, due to differences in gender, class, and professional privilege (Doering, 1992; Stevens, 1983). In addition, nurses, who are predominantly women, are at least as likely to have been abused as any other women in the population. Without critical attention to power relations
and the impact of the research process, a research account could be produced that was merely faultfinding with nursing practice in relation to violence. Therefore, I considered it essential that the research process include nurses as active agents rather than producing further oppression.

Third, a critical approach attempts to decrease the power inequality between the researcher and those being researched. Researching others makes those being studied the objects of study and creates power inequalities between the researcher and the researched (Oakley, 1981). When those being researched are members of an oppressed group, the power inequalities with the researcher are compounded by the participant's relative powerlessness. By using a critical approach to understand the influence of these power inequalities I sought to decrease the objectification of those being researched and to avoid participating in further oppression.

I shared many characteristics with most of the nurses in this study, characteristics such as gender, class, being a nurse, initial education, and the appearance of being Caucasian. However, in other ways, I had considerably more privilege than the nurses with whom I conducted this research, and hence had greater potential to enact relationships in an oppressive manner. Most of the nurses in this study had diploma education and a certificate in a specialty such as Emergency Nursing. With two graduate degrees completed, and doctoral studies underway, I had considerably more education, stronger communication skills and more knowledge in some areas. In addition, I have occupied several positions of authority in nursing (manager and educator). Finally, I entered the study sites in the role of researcher, a role that carries prestige, and freedom to come and go, to spend time as I wished, to create my persona and role.

Using understanding of these power inequalities in reflexive, deconstructive analysis, I tried to "mitigate the issues of authority and ideological appropriation" (Opie, 1992, p.5). As Lather (1986) further argues that the need for reciprocity operates between the theory and the data, as
well as between researcher and researched, I also used other strategies for decreasing power inequities including collaboration on the analysis and negotiation of meaning with participants. I clarified meanings with participants, sought contradictory opinions, gave copies of transcripts to those interviewed, and drafts of the evolving analysis to members of the core sample for feedback. However, regardless of these strategies I was constantly aware of the potential for misuse of power, as I retained control of the research process and the final research account.

Fourth, a critical approach attempts to account for researcher bias through critical analysis. In non-critical qualitative research, investigators strive to bracket or suspend their own experiences to achieve objectivity (Hutchinson, 1986; Oiler, 1982; Omery, 1983). In contrast, authors such as Alcoff (1991), Harding (1991), Opie (1992) and Roman (1993) argue that "strong objectivity" is achieved by researchers acknowledging their own experiences, locating themselves in relation to the research and those being researched, and critically examining the influence of their location on the entire research process.

As the researcher in this study, I began with assumptions and biases based on my experience. Rather than merely stating categorical social locations (which I found difficult to assign to myself in any case) I sought to interrogate the biases and assumptions I brought to the research throughout the study. Preliminary interviews illustrated the importance of reflexive analysis of my own assumptions. Interviewing Lisa², a white, middle-class woman, challenged my assumptions about what constituted "choice". Lisa told me that although she had a professional career and an earning capacity of about $40,000 per year, she chose to return to her husband rather than face the relative poverty and the social violence that arose from her status as

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² All names used are fictitious, and most were chosen by participants themselves.
a "single mom" and "failed wife". Like Lisa prior to her experience of violence, I had assumed that a woman with those resources would not choose to endure a violent relationship.

I was able to examine some of my biases and assumptions before beginning data collection; others surfaced throughout the study. Some ideas that I began with included those about responsibility and choice for women living with abusive partners. For example, having experienced abuse as a child, I had to confront my own anger about not being protected as a child, and to be able to understand that women do not have unlimited choice, and accept that the needs of mothers are sometimes counter to the needs of children (see Ashe & Cahn, 1994, for a discussion of the challenges of child abuse to feminist theory). Having critically examined my own thinking and biases in this regard was beneficial in at least two ways. First, I was able to be less judgmental of women who stay in relationships where children are being abused, and second, I was better able to recognize when women I interviewed were also working through contradictions between their personal experiences and the demands of their professional roles.

I became aware of other biases and assumptions only as the research progressed. Opie (1992) cautioned that during her study of care givers of the elderly, it was easy for her to highlight the exploitive nature of the role and ignore the value care givers found in their roles. She argued that it is critical to modify textual practices to avoid appropriation of the researched in this manner. Similarly, because I began with assumptions about power relations and oppression, it was easy for me to appropriate the nurse's voices by focusing only on the oppressive and oppressing aspects of the nursing role. I did this on several occasions. First, I uncritically accepted nurses' accounts of their own failure to attend to the non-physical aspects of patients as persons. Second, I tended to see the ways in which nurses did not have control of their practice more readily than I saw the ways in which they took control. In addition, I focused
predominantly on the ways in which "race" was used by nurses to distance themselves from "others" (perhaps due to having experienced racism directly myself\(^3\)) and ignored the ways in which nurses struggled to understand patients across language and cultural differences. I dealt with (and continue to deal with) each of these "blind spots" (although I am sure others, such as my heterosexism, remain) by working collaboratively with the nurses in the study, seeking their analyses\(^4\), and working to account for my own biases through critical self-awareness and rigorous analysis (e.g. see Visweswaran, 1994).

I also attempted to challenge my own biases by examining my initial inclinations, and pursuing the opposite. For example, when nurses declined to participate because they thought that they had little or no experience with violence, I was initially inclined to agree. However, I went against my own judgment, and said that I actually wanted to interview people regardless of their experiences. This proved critical to my analysis, as examination of why certain people had little or no experience with violence was foundational to the central thesis. Similarly, I tried to take a contrary approach to making observations and recording data. Initially, if I thought some action was irrelevant, I made note of that action. Again, many observations that I initially thought would not be relevant proved critical. For example, nurses “chatting” at the desk initially did not seem relevant to studying practice in relation to violence, but later contributed to my understanding of the patterns of practice that foster neglect of violence. Finally, in reporting, I looked for contrary evidence. If I saw “oppression” (say of nurses by physicians), I looked for

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\(^3\) I wish to emphasize that having “experienced racism” does not imply that I have purged myself of all vestiges of racism. Rather, this study has been invaluable to me in unlearning racism, including “self-directed” racism, a process that will probably take a lifetime.

\(^4\) It is important to point out that accounting for researcher bias does not mean deferring to participants’ analyses. Rather, as I used participant perspectives to challenge mine, I also interrogated the biases of participants and challenged their perspectives.
the ways that nurses also used their power to influence physicians, and tried to report the complexities, rather than a one-sided analysis.

Fifth, and finally, a critical ethnographic approach offered the possibility of emancipation of the participants. The role of the researcher in critical ethnography allows the researcher to engage the participants in critical thought and in analysis, and thus can assist participants to develop new ideas about their practice, and take action on these ideas. In this study, I engaged the participants in analysis of the ways in which the context influences their practice, and the ways in which they in turn influence the context. Although the specific focus of the study was on the care of women who have been abused, this analysis extended to broad consideration of nursing practice. Throughout the study, I was rewarded by feedback from participants regarding how their thinking had evolved through participation. Some nurses said that participation in this study changed their interpretation of past personal experiences. Others thought that participation changed their thinking about nursing, and others specifically focused on changes to their thinking regarding violence and women who have been abused. For example, Susan thought that participation would help her think more critically about her approach to patients in general.

Toward the end of her first interview, she said

I know if I could listen to the tape after that I would cringe at some of the things that I have probably said and I am interested in that because maybe that will make... me look at not only this topic but other topics I maybe haven’t spent the time on. If it comes through this strongly just in a conversation with you I cringe to think how it comes through to the patient when I make a casual comment, that maybe I don’t appreciate ties into what their personal experience is. From my perspective for practice the interview is valuable, if painful. I don’t mean painful in a negative way but painful in a risk taking way because I don’t know you and you don’t know me at all and we are sharing things that are personal and we have no friendship to say that we will accept what. So to me it is a risk taking behaviour.

Bo thought the study opened a new space to talk about violence and abuse. She said “I think you opened our eyes. I think it [violence against women] is something that there is a place for and I
think if we talk about it and having people like yourself highlights it and make us think about it.”

Lulu talked about some specific ideas and questions that arose for her during our first interview.

Just in talking to you, things have come up that I haven’t thought about, which to me is great. The thought of asking somebody how their home life is, the thought of opening the door for the women so that you can, but then again, what are you going to do about the information? If we can recognize more cues, even it is by the way we question then to me that is great. And then how can we help them? What choices can we give them?

The rationale for using critical ethnography was based on a conception of critical ethnography characterized by collaboration with those being researched, reflexivity and deconstructive analysis, and goals of emancipation. This approach is consistent with what Maguire (1987) calls "alternative paradigm research [which] aims at exposing the mechanisms for producing, maintaining and legitimizing social inequities and domination" (p. 16). In keeping with the tenets of critical ethnography and alternative paradigm research, the active participation of nurses, women who have experienced abuse, and others was sought. I especially encouraged nurses to critically reflect on their experiences and explore alternatives for practice.

Clearly, this study was not fully participatory as I established the initial research questions and the research design. The extent of participation varied with the individual participants. Many of the nurses read and provided feedback on various drafts of the analysis. Several left me copies of charts and notes about particular women that came into Emergency. One participant volunteered to work in more detail with me, and I was able to hire her as a research assistant.

Theoretical Perspective on Power

As I intended to study power relations in this study, I began with explicit ideas about the nature of power. In developing my theoretical perspective on power, I drew heavily on Foucault's thinking about power (1978; 1980). Unlike many theoretical and common sense

\[\text{In order to protect confidentiality, this nurse did not work with data from her hospital, and instead worked on literature reviews and interviews with women who had experienced abuse.}\]
notions of power, Foucault does not see power as a commodity, as something which can be held or owned, given or taken. Rather, Foucault sees power as being intrinsic to all social relations throughout the social body. Foucault theorizes power as existing only in action, as being enacted in all relationships. Foucault does not view power as being centralized within formal institutions such as the state, or as descending "top-down" as domination. Rather, power comes "from the bottom up". Because power is enacted in all social relations, all relations of power always include resistance, and power is positive and productive as well as negative and repressive. Foucault sees power relations as intentional, but not in the sense of being enacted consciously as the result of a choice or decision of an individual. Rather, local tactics are connected to one another, forming comprehensive systems. "The logic is perfectly clear, the aims decipherable, and yet no one is there to have invented them, and few can be said to have formulated them" (1978, p. 95). Finally, Foucault sees power as most effective when insidious or disguised.

This thinking about power informed my approach to this study. I began, as Foucault recommends, with an "ascending analysis of power, starting, that is, from its infinitesimal mechanisms..." (1980, p. 99). I consciously examined all social relations within the practice context for the ways in which power was enacted. I anticipated that I could find evidence of resistance in each relation in which domination was enacted. This enabled me to see acts of resistance that I might have otherwise overlooked. For example, rather than simply seeing nurses as overwhelmed by the goals of medicine and pressure to process patients quickly though the Emergency, I could see ways in which they ensured that their own goals were met. Similarly, rather than only seeing the ways in which ward nurses pushed Emergency nurses to keep patients instead of sending them to the wards, I also saw ways in which Emergency nurses also pushed ward nurses to accept patients. Rather than seeing patients as being at the mercy of interrogation
by health care providers, I saw ways in which patients resisted questions and made choices about what information they would share.

I departed from Foucault's thinking in two related ways. Foucault does not attend to the ways in which power relations are deeply gendered. He frequently has been critiqued on this count by feminists (e.g. Alcoff, 1988; Bartowski, 1988) who claim, in the words of Diamond and Quinby, that "his discussions gloss over the gender configurations of power" (1988, p. xiv). This, I believe is related to Foucault's ideas regarding the relationships between power, discourse, and ideology. Foucault (1980) sees discourse as a product of the enactment of power relations, and through the production of dominant discourses, sees "that it is quite possible that the mechanisms of power have been accompanied by ideological productions" (p. 102). Thus, Rudge (1996) claims, Foucault sees discourse as preceding ideology. In his challenge to views of power as centralized and descending, I believe that Foucault glossed over the ways in which existing social structures and ideologies shape power relations and discourses. Thus, he not only fails to account for the ways in which configurations of power are gendered, but also the ways in which they are raced, classed and so on.

In contrast, I see power as being enacted in relationships within existing social structures and discursive practices embedded with ideological ideas and images that organize our everyday practices and provide lenses through which we interpret our world (D. E. Smith, 1987, 1990). I believe that ideology influences the way power relations are enacted, and agree with Fairclough (1989) that discourses (language as social practices) draw upon existing social structures and discourse types, acting ideologically when they serve to sustain existing power relations.

Using these departures from Foucault, then, I sought not only to examine how power is enacted in all social relations and creates discourse. I also sought to examine the mechanisms
through which enactments of power draw on and are shaped by existing social structures and power relations, and at the same time, shape social structures and power relations, both reproducing and contesting them. Thus I considered the ways in which nurses enacted their practice in relation to violence against women within a social context laden with existing power configurations and how they reproduced and contested them.

Theoretical Perspective on Violence

A feminist and critical perspective on violence was used as a basis for this study. As described earlier, such perspectives are characterized by analyses of power relations and are concerned more with oppression than victimization. Feminism born of white middle-class western thinking views gender as the central source of oppression (e.g. Acker, Barry & Esseveld, 1983; Eistenstein, 1977; Harding, 1987) and would thus support a view of violence as gender oppression. The view of violence I used in this study is, however, somewhat more complex. Following feminists who contest the centrality of gender oppression, arguing that such feminism subordinates the experiences of racial and class oppression (e.g. Brewer, 1993; Collins, 1986; 1989, 1993; Mohanty, 1992; Ng, 1993), I viewed oppression as arising from multiple sites (including “race”, class, gender, sexual orientation, age, and so on) simultaneously in a multiplicative manner, in what Brewer calls “the simultaneity of oppression” (p. 16). From this perspective, I viewed violence as arising from the social context and as being produced by power relations across many sites. Therefore, while I understood violence to be a problem of power relations that are deeply gendered, I also understood violence to be a problem of power relations compounded by classism, racism and other sites of oppression.

In keeping with the critique of essentialism that underlies the view of oppression I espoused, I chose to de-emphasize socially constructed categories such as "race", class and gender and
focus on personally constructed categories of experiences of racism, classism and sexism. Therefore, experiences of sexism and abuse became the categories of analysis that replaced the label "battered women". Personal experiences of racism became relevant rather than labels by skin color or other physical characteristics. Personal resources became relevant rather than labels of low, middle or upper class, or even "family" income.

I theorized violence as arising from multiple sources of oppression, and thus sought to account for these multiple sources simultaneously, and to examine the contribution to that oppression by health care professionals as gendered, classed and raced agents. I examined the relationship between the researcher and the researched and examined power and privilege, oppression and resistance along many lines simultaneously. I saw the goal of research as including countering oppression at the level of the individual, the institution and the state.

Combined with the perspective on power I was using, this view of violence as arising from multiple sites of oppression permitted and required an analysis of gender, "race", and class oppression within all social relations with regard to violence against women. Such analysis was particularly critical to this study, given the role of racism, classism and sexism in responses by health professionals to women who have been abused (Barbee, 1992; Dobash & Dobash, 1992; Hampton & Newberger, 1988). From the chosen theoretical perspective, I saw violence against women not as a woman's (or women's) problem, but rather as a problem of social proportions that requires intervention far beyond the individual. Thus violence was not viewed as arising only within the relationship between the woman and the person who is abusing her. Violence was also seen as arising from the social context that tolerates abuse, permits abuse to continue, and commits further social violence.
The Sample

The sample for this study was obtained from two hospital Emergency units. I chose to focus on Emergency units because a large number of women who come to a hospital Emergency unit do so because of injuries inflicted by their abuser or because of health care problems that result from living under the chronic stress of violence (Goldberg & Tomlanovich, 1984, McLeer & Anwar, 1989; Stark et al., 1979; Warshaw, 1993), making the Emergency one of the most common points of contact between nurses and women who have been abused. In order to protect the identity of the participants, units in two separate hospitals were used. One hospital served as the "primary site"; the other served as a secondary site for collateral data and to protect the privacy of participants.

Both hospitals were located in urban communities which are part of a large metropolitan city. The community served by the primary hospital is separated geographically from other communities, which provides distinct boundaries and creates a self-contained community. The people who come to the hospital for care are primarily from the community itself, and are often known to the staff from previous visits or from contact in the community. In addition, the hospital serves several rural and coastal communities as a primary community hospital and as a referral hospital. In contrast, the other community is geographically continuous with other urban areas. The boundaries of this community are not as distinct, and people who come to the hospital are from bordering urban areas as well as from the immediate area.

One of the hospitals serves a predominantly affluent, Caucasian population and has a sub-populations of very wealthy people and very poor people, and sub-populations of several specific cultural, religious, language, and ethnic groups. The other community is more predominantly ‘middle class’ and has greater diversity, with a wide variation in income levels, numerous
cultural, religious, language, and ethnic groups, and large populations of people who speak Chinese (33.6% in 1991), Korean, Punjabi, Hindi, and Tagalog as their first language (Statistics Canada, 1991). Both communities include large First Nations communities.

The two hospitals were chosen based on the characteristics of the communities they serve, the characteristics of the hospital itself, and the willingness of the nurses, hospital and community to be involved in the study. Because I was interested in the role of racism and classism, I targeted communities that were diverse in terms of income levels, and cultural, ethnic, religious and language groups. Because I was also interested in the influence of resources and barriers within the hospital, I chose community, "non-teaching" hospitals (a term which in common usage only refers to teaching of physicians) that were not rich in terms of practice and research resources. As most hospitals in BC (and Canada) are in this category, the findings of this study thus may be meaningful in a wide variety of settings. The willingness of nurses and hospital personnel to be involved in the study was also a factor in first selecting the sites, and then in determining which site would serve as the primary site.

The sample was comprised of a core sample of Emergency nurses and a secondary sample comprised of other Emergency nurses, non-Emergency nurses, other members of the health team, women who had experienced abuse, and patients. Participants were sought using a variety of techniques to protect the right to refuse to participate, and a variety of options for different levels of participation (as will be explained) were made available.

**Emergency Nurses**

Invitations to participate were extended to all nurses in both study units at staff meetings, through notes in the unit communication books, through e-mail, and through personalized information letters. These letters outlined different levels of participation, including no
participation, being observed, being a field guide and being interviewed (see Appendix 1).

Given the emotionally charged nature of the topic and the fact that nurses were as likely as any women to have experienced violence, it was especially critical to avoid any approach that could be construed as coercing participation. I did not directly request an interview of any of the nurses at either of the study sites. Rather, I indicated my interest in interviewing, and waited for people to volunteer. I stressed the fact that the study was aimed at examining the social context and that I was viewing violence as a social problem (rather than individual woman's problem). I believed this was important in order to clarify that "blame the victim" approaches were being avoided and to convey that nurses could participate without sharing personal histories of violence. Simultaneously, I wanted to make it clear that nurses need not assume that I cannot bear to hear about the trauma of their own personal experiences if they wished to share them.

The core sample for this study was comprised of 12 Emergency nurses from the two study sites. All of these nurses volunteered to participate, be observed and be interviewed. These nurses were considered the “core sample” because their ideas were fundamental to the analysis, and/or because they contributed to the analysis in an active and significant manner. All of these nurses were observed in practice and interviewed once, and four were interviewed at least twice. Six of these nurses served as field guides as I “buddied” with them during their shifts.

A secondary sample of nine Emergency nurses was also interviewed once. These nurses were considered part of the “secondary” sample primarily because they were less involved in the study, and because they were interviewed later in the data collection process and thus were less influential on the development of the analysis. This secondary sample of Emergency nurses included four nurses from the two study sites, all of whom were observed in practice, and five
nurses from other hospitals throughout the province. The nurses from other hospitals became involved in the study as they expressed interests during personal contacts with me.

In attempting to de-emphasize a priori social categories, demographic data were not collected at the outset. Rather, through interviews I sought data that seemed relevant to understanding the relationship between nurses and the social context in relation to violence. The experiences that nurses identified as relevant included the number of years of Emergency nursing experience each nurse had, each nurse's education, experiences of violence in her family, and gender. Experiences that I thought were relevant included the nurses' apparent "race", her role at work and her recalled experiences of violence at work.

All of the 21 nurses interviewed were female, and appeared to be Caucasian. None of these nurses discussed sexual orientation or experiences of heterosexism, and none told me that they had experienced racism. Although some nurses who agreed to be observed were male, throughout the remainder of this study all nurses will be referred to as female to protect the identity of the male nurses.

With the exception of a student in an Emergency Nursing certificate program, all 21 nurses who were interviewed had a minimum of four years of Emergency nursing experience. The number of years of Emergency Nursing experience ranged from four years to 20 years, and the average was nine years. Of the 21 nurses, two were Assistant Head Nurses, five were Head Nurses or Nurse Managers, one was a student, and the remainder were staff nurses. Throughout the rest of this study, in order to obscure identities, the positions of nurses will be mentioned only when it seems relevant, and positions will not be identified in conjunction with code names.

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6 Two of these nurses were students of mine. In order to lessen potential for coercion, I delayed their interview until after I was no longer in a student/teacher relationship with them (I left my job) and offered to have a research assistant conduct the interviews.
Eighteen of the nurses had a diploma as their initial nursing education, three of whom had also completed a baccalaureate degree; the other three nurses had a baccalaureate degree as their initial nursing education. Thirteen nurses had completed one or more certificate programs in Emergency Nursing, Critical Care Nursing or Outpost Nursing.

Of the seventeen nurses who specified their personal experiences, eleven had experiences of violence in their families. All but three of the nurses could recall some experiences of violence at work, although three others thought these experiences were very few. The relevance of each of these experiences are explored through the analysis.

Other Health Care Providers

All health care providers that I came in contact with were invited to participate by being observed. Initially I offered information letters, and requested written consent, but the number of personnel involved (I could encounter 20 different lab technicians, x-ray technicians, unit clerks, cleaners, admitting clerks, and so on in an hour), their lack of interest, and the fact that I only observed their presence rather than their actions, made written consent unreasonable. Thus, I insured verbal consent from those peripherally involved with the nurse’s work, and focused on obtaining written consent from those physicians, admitting clerks, and unit clerks whom I observed beyond noting their presence.

In order to obtain a clearer picture of the context of practice, selected health care providers including social workers, admitting clerks, physicians, clinical nurse specialists, psychiatric Emergency nurses and hospital administrators were interviewed. Although sensitivity to privacy and willingness to share experiences was extended to all participants, these health care providers were asked directly for interviews regarding the hospital and community policies and practices with regard to violence against women. From observation and initial interviews with nurses, I
identified those who seemed to influence Emergency nursing practice and sought interviews with them. Nine such interviews were conducted. Non-study site interviews were obtained through my personal contacts and through a letter (see Appendix 5).

Women Who Have Experienced Abuse

Five women who had personal experiences of abuse volunteered to be interviewed. I did not initiate requests for these interviews. Three of the women I met as patients in the Emergency during field work, and they asked how they could help. Another woman contacted me through a shelter worker, and one I met through personal contacts. Each of these women had experienced abuse in the position of wife; two had also been sexually abused as children, and another one had a small daughter who had been sexually abused by her partner. One woman was currently living with her abusive husband; the other four were living in violence-free situations (although all remained connected to their abusive partners through children, finances, the courts, and so on). These women were all Caucasian. They ranged significantly in terms of education, from one having elementary school education only, to another having many years of university education. They also ranged in work and income. Two were currently on Social Assistance and/or a Disability Pension, one earned a middle class income as a professional, one owned her own business, which seemed to be doing reasonably well, one worked as a prostitute. One woman, previously married to a wealthy high profile business man, supplemented income from her husband by cleaning houses. All had been to an Emergency while married to an abusive partner.

Data Collection

Data were collected over a period of two months during preliminary field work, and, following a break of more than a year, over a period of about 15 months during the actual study. Preliminary data were collected in what became the secondary site, and initial fieldwork was
begun in the other site and later extended to back to the secondary site. The choice of the primary site was made because approval to begin data collection was delayed in the secondary site due to political unrest in the Emergency unit. Data collection proceeded in overlapping phases and was guided largely by data analysis (see Appendix 9).

**Interviews**

Forty one formal interviews were conducted with 35 participants (see Appendix 10). All of the participants were interviewed once: five women who had experienced abuse, 21 nurses, and nine other health care providers (physicians, social workers, unit clerks, psychiatric Emergency nurses, clinical nurse specialists, and administrators). Second (and in some cases, third) formal interviews were conducted with four nurses in the core group. Additional informal interviews were also conducted with nurses in the core group, but these interviews were conversations about analysis, and thus were not taped or transcribed.

Throughout the interviews, I encouraged participants to describe in their own terms their experiences of the social context in relation to their practice with women who have been abused. I attempted to attend to the value of the research to those involved (for example, by discussing research outcomes that would be meaningful to them) and to be sensitive to the needs of those being interviewed (for example, talking about what they wanted to talk about, rather than attending to my own agenda). Interviews were conducted in a reflexive manner using strategies recommended by Alcoff (1991). These strategies included 1) analyzing and fighting against the impetus to speak, 2) interrogating the bearing of my own location (age, gender, class, ethnicity, experiences with violence, role in the research, etc.) and context on what was being said, 3) seeking responsibility and accountability in what I said, and 4) analyzing the probable and actual

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7 By "formal" I mean interviews that were taped and transcribed. By "informal" I am referring to interview which were conducted outside of field work, but were not taped or transcribed.
effects on the discursive and material context of the interview. This meant that during interviews I attempted to be thinking on many levels simultaneously: listening with empathy, listening analytically, listening reflectively.

Despite the best of intentions, I made mistakes, missed important ideas, and sometimes blundered about. I caught myself arguing with participants, trying to convince them to see things my way, and leading participants to conclusions I had already reached. Most notably, I disagreed with participants about their understandings of experiences of violence, and their ideas about people of certain “cultures”. While I wanted to understand participant’s perspectives, I felt morally obligated to confront what I saw as “victim-blaming” and racist ideas about abuse (see “intervention/non-intervention”, this chapter). Overall, however, most participants said they enjoyed their interviews, and during many I experienced moments of profound connection.

The interviews with nurses focused on the nurses’ experiences of the social context in relation to their practice in caring for women who have been battered. Interviews with other health care providers also focused on the influence of the social context on their practice, but additionally invited their perspectives on nursing practice. The focus of interviews with women who had experienced abuse was on the women’s experiences during emergency visits, and their analysis of the ways in which the social context influenced their experiences of abuse. I used participant observation as a backdrop for all interviews, and used specific practice examples as a basis for reflection. I shared my observations as appropriate as a basis for discussion. Questions evolved as analysis progressed. All formal interviews were audiotaped and transcribed verbatim and formal analysis was begun following the initial interview.

There were three phases of interviewing. Preliminary interviews were initially useful in developing the research questions, planning the research design, and anticipating challenges in
data collection. Those preliminary interviews were re-analyzed during the actual study, and became "phase 1" interviews along with others completed during this phase.

**Phase 1**

Phase 1 interviews consisted of eight initial interviews with nurses from the core sample that I completed prior to developing a formal conceptual framework, and all of interviews conducted with non-Emergency nurses and non-nursing personnel. I began these interviews by posing the first of the three research questions identified for this study. That is, I asked some variation of the question "You know that I am interested in understanding how the social context, including the unit you work in, the hospital, the health care system, and society in general, influences how women who have been battered are cared for by nurses. Can you tell me in your own words what you think about this?" This proved problematic as often participants did not understand the question, and I would have to launch in to examples, or expansions of the question. After the first several interviews, I began to ask participants to give me a description of their own background and/or experience in Emergency, and then introduced the first research question gradually by picking up on some aspect of the social context to which they referred.

Although my intention was to ask participants all three of the study questions, following the lead of participants meant that, during initial interviews, we rarely got to the third question, which asked how they thought they had influenced the context. Often these initial interviews focused on the participants' own experiences, especially when the participants had personal experiences of violence that they thought were significant and that they wanted to discuss. During this phase, the interviews were highly descriptive. I asked for examples and descriptions, and initially held back from offering my analysis. I did ask for explanations of observations I had made during field work, and invited further examples of phenomena I had observed.
Five of the eight interviews with Emergency nurses conducted during this phase formed the basis of my initial analysis, but because analysis was ongoing, the interviews during this phase were increasingly informed by the analysis and the conceptual framework that I was developing. Increasingly I would check out points in my analysis by following up cues in a particular manner, or by introducing new questions. For example, as it became apparent that nurses' ideas about why women don't leave relationships were important to how they practiced, I would clarify the ideas of participants as they introduced them. In this way, this phase of interviewing overlapped with the second phase.

Phase 2

Phase 2 interviews were marked by the extent to which they were guided by the developing analysis. This phase consisted of another eight interviews with Emergency nurses from the study sites and five interviews with Emergency nurses from non-study sites. These interviews were not repeat interviews (with one exception); they were first interviews with "new" participants, but were overtly informed by the conceptual framework I had developed. Although I continued to begin the interviews with the same questions, I added new questions (see Appendix 7), and followed up on particular hypotheses that I was pursuing. For example, as it became clear that many nurses were basing their practice largely on personal experience, I asked all nurses about the bases of their practice. I also began to give participants drafts of my analysis. I gradually invited more participation in analysis from the participants, and in this way, these interviews overlapped with the third and final phase of interviewing.

Phase 3

Phase 3 interviews were characterized by participation in the analysis by the nurses being interviewed. These interviews consisted of second and third interviews with Emergency nurses,
and were overtly driven by questions arising from analysis. At this point I ceased to use the research questions as starting points, and instead used either discussion of the various theoretical arguments I was developing, or a draft of some component of the analysis to begin the interview.

**Field Work**

Field work consisted of participant observation in the Emergency units and communities of both study sites, and was also divided into three phases: preliminary, initial, and continued field work. Preliminary field work was conducted in the secondary study site only, and, along with the preliminary interviews, these data were useful in refining the research questions and design. Preliminary field work data were analyzed along with field work data of the actual study.

Initial field work was conducted in the Emergency Units of both study sites, and in their respective communities. I spent most of my field work time in the Emergency Unit of study site one, and the community of study site two. Initial field work in each Emergency allowed me to become familiar with unit routines, norms of practice and personnel. This was accomplished through participant observation, informal interviews, and collection of relevant documents.

Gaining entry was initially difficult in both Emergency Units. In site one, initially no one volunteered to participate or returned my information letters and consent forms, despite the fact that the head nurse facilitated my entry and invited me to staff meetings. In fact, the only consent form that was returned turned out to be a prank or joke by male members of the health care team. Eventually one nurse whom I knew from previous contacts agreed to have me “buddy” with her, and during the first shift, I lined up several more nurses with whom to “buddy”. In this site I eventually developed strong working relationships with six nurses who participated in interviews and analysis, four of whom who served as my field work guides.
In the second site, entry was delayed, despite formal hospital approval, because administrative decisions were causing anger and upheaval among the staff, and the head nurse was reluctant to allow me to begin field work. However, eventually the unit began to focus on violence and abuse as issues, and, attending an in-service on the topic, I was given a few minutes to explain my study. At this meeting, four nurses volunteered to participate, two of whom became my field guides, and three of whom participated in interviews.

During initial field work in both Emergency Units, I spent considerable time and effort simply trying to obtain informed consent. I asked all nurses directly if I could observe with them during their practice, and used over 200 consent forms to obtain about 70 signed consents. As noted, I also asked all health care providers that I came in contact with for either verbal or written consent, and all patients for verbal consent. My observations focused on the culture of the unit, norms of practice and relationships among personnel and between health care personnel and patients. This phase also allowed the staff to become more familiar with me and the study, and to decide to what extent (if any) each wanted to participate. Observations of the nurses' practice provided specific practice examples that I used as a basis for discussion during interviews.

During “formal” field visits (I also dropped into the unit informally at times), I “buddied” with one of the nurses who volunteered to be field guides. I followed the nurse in her work, and observed her work and interactions. I participated by conversing with patients, and by helping as appropriate. I helped my “buddies” by getting supplies (warm blankets, telephones and urinals usually), helping to move patients, watching patients when the nurse went elsewhere and so on, and found that nurses were more protective of my researcher role than I. Discussing the extent of my involvement in care giving with approval committees and head nurses, I was directed in both hospitals to use my judgment and negotiate directly with staff. On a moment-by-moment basis I
guided my involvement with my best judgment about the harm action or inaction would cause, and seeking to balance the needs of my research role with the needs of patients (see “intervention /non-intervention”, this chapter). Only one nurse (not a “buddy” nurse) asked me to do work for her. In contrast, several physicians attempted to give me “orders”, telling me to deal with samples, convey messages, put patients on monitors, or accompany them during pelvic exams.

The process of developing relationships with the nurses was both interesting and rewarding. Understandably, people seemed wary at first. Very few of the nurses had previous involvement in research, and most did not seem to see “violence” as highly relevant to their work. Two factors seemed key to the development of what were eventually some very strong working relationships: first, being as accepting, supportive and non-judgmental as possible and second, presenting myself as a nurse as well as a researcher. At first being non-judgmental meant reassuring nurses that I was not being evaluative, and resisting any pressure to be evaluative. Later, it meant seeking analyses of data that rendered the thoughts and actions of nurses understandable, and involving nurses in the analysis. “Helping out” was important to both of these key factors, as in doing so I both acknowledged the nature of the nurses’ work and the constraints to practice, and demonstrated being a nurse. Acceptance was gradual, but rapid, and by the end of the study, six nurses read various drafts of this work, critiquing and commenting on the work, phoning or meeting with me to discuss their feedback, and in some cases, giving detailed written feedback.

I wrote rough field notes throughout each field visit. Initially I made notes about everything I observed, but later became more focused as observations became repetitive. As I found it uncomfortable to write in the unit, I would go to the staff lounge at various times to make these brief notes. These sessions in the lounge were additionally beneficial as staff would come in for
coffee and chat about my study. Respecting that their breaks were social opportunities, I did not introduce the topic of my study, but staff were usually interested and introduced the topic. These sessions offered the best opportunities for me to explain my study, obtain consents, and, once consent was obtained, they provided rich data through informal conversations.

Following each field visit, I used the rough notes to write detailed field notes on the computer. These detailed notes included analytic comments embedded in the observations. In addition, I collected any relevant documents or made notes about documents and manuals.

Initial field work extended beyond the Emergency units to include the hospital and community as the context of the Emergency unit. Field work in the hospital and communities included informal conversations and interviews with various administrators and service providers, such as directors of nursing, directors of crisis services, police, shelter workers, victim’s assistance workers and so on, and attendance at public events related to the issue of violence against women. In one community, this wider field work also included significant involvement in the community’s coordinating committee of anti-violence service providers, participation in the development of community protocols and in the organization of community workshops. This participation connected me with anti-violence activities and organizations in other communities and at other levels of social organization (e.g. government bodies). Through these activities I collected data in the form public documents such as minutes, brochures, and protocols to provide a broader description of services available outside the hospital and of the community as part of the social context.

“Continued” field work was distinguished from the initial field work in that I had gathered sufficient data to complete my analysis, but continued to return occasionally to both study sites
to remain in contact with the staff. At this point field notes were less detailed and focused only on recording data that I knew were relevant to the analysis.

Data Analysis

To say that “analysis was concurrent with data collection” is a vast understatement. Analysis stalked my every thought. Each encounter in or out of the “field” was imbued with analytic possibilities and meaning. As I drove in my car, listening to tapes or replaying interactions in my mind, I was analyzing. Writing poetry to escape the discomfort of my harsh analysis, I was analyzing. The theoretical perspectives with which I began developed and evolved with analysis, and in turn, reshaped the analysis.

All interviews were transcribed, and all detailed field notes were entered into the computer. I rejected using a qualitative data management program (I thought it too time consuming to learn and was cautious of the way such programs might channel my thinking) in favour of working in the word processing program Microsoft® Word for Windows™ (Microsoft Inc., Redmond, Wa.).

Proceeding from the theoretical perspectives that I had developed, I began analysis warily informed by directives for ethnographic analysis by the “great men” of ethnography such as Hammersley and Atkinson (1983), Clifford and Marcus (1986) and Spradley (1979). I say “warily informed” because I was concerned that these approaches did not account for the analysis of power relations and oppression sufficiently for my purposes, and were perhaps somewhat committed to “discovering truth” or “uncovering reality” rather than to creating a critical analysis of the taken-for-granted to which I was committed.

I balanced these established approaches with ideas from critical ethnography, and critical discourse analysis. In seeking an analysis of power relations, critical ethnography requires attention to multiple perspectives. Thus, in data analysis, I continually sought to find and
accommodate competing and contradictory perspectives, entertaining tensions between perspectives as points for analysis rather than as problems to be resolved or choices to be made. Rather than glossing over contradictions in the data, I endeavored to create conceptualizations to accommodate multiple and competing perspectives.

In conjunction with this attention to multiple perspectives, I assumed a particular stance in regard to the nature of "experience". As argued by Allen (1996) and Scott (1991), experience is often held as an incontestable and irreducible form of evidence. This is problematic because it precludes critical examination of how experience is produced and produces subjects, and therefore tends to reproduce rather than contest historical, socially constructed categories such as "battered woman" as though such categories are "real". Scott calls for analysis of processes that position individuals and produce their experiences, a view in which it is "not individuals who have experience, but subjects who are constituted through experience" (p. 779). Experience is no longer the evidence for what is known, but rather experience is that about which knowledge is produced. Scott calls for treating all categories of analysis as "contextual, contested and contingent", but cautions that "this does not mean that one dismisses the effects of such concepts and identities, nor that one does not explain behavior in terms of their operations" (p. 793).

Thus, I treated "experience" as constructed by and constructing those who conveyed the experiences. So, for example, I analyzed how nurses constructed stories of experiences of abuse in their families, and the ways those experiences appeared to constitute the nurses who told the stories. I analyzed stories by nurses about women who had been abused not only for the content, but also for the textual features that the nurses used in constructing those stories and for the ways in which the stories reflected the storyteller.
The principles of critical discourse analysis formed a background to the analysis (although, as I will explain, I used the principles more explicitly in document analysis). Fairclough’s (1989) ten steps of critical discourse analysis include examining the experiential, expressive, and relational value of words and grammatical features, the use of metaphors, how sentences are linked, the use of interactional conventions and the presence of large scale structures. With these ideas as background, I was aware of textual features throughout analysis. For example, I noticed the frequent use of metaphors of addiction, such as alcoholism and smoking, in reference to women and violence. I noted how agency was conveyed (an experiential value of grammatical features) in reference to women in abusive relationships. I was also able to draw on these principles to examine particular discourses more closely. For example, I noticed extensive talk about “choice” in relation to women who had been abused, and drew explicitly on the ideas of critical discourse analysis to explore the ways in which choice was discussed.

Analysis of Interview Data

Drawing predominantly on the analytic strategies described by Hammersley and Atkinson (1983), Miles and Huberman (1994) and Morse (1994), analysis of interview data proceeded in three distinct phases. First, I created a conceptual framework from initial interview data. I used further interviews to refine, modify and eventually reject this conceptual framework. Second, I developed theoretical arguments within and between conceptual categories. I used interview data to develop, test and modify each argument. In developing these theoretical arguments, I gradually developed a central thesis. Finally, I re-analyzed the data against this central thesis.

Developing a Conceptual Framework

Initially, I did line-by-line coding of interviews by hand. I identified key words or phrases that seemed to be units of meaning in each line, then identified similar meaning units within the
interview, and finally began to identify conceptual categories of meaning units. Within two
interviews however, I found this approach limited because meanings crossed many “lines”,
because there might be several “meanings” imbedded in any one phrase, because keeping track
of the relationship between categories and supporting data was cumbersome, and because
attaching a particular phrase to a particular category required decontextualizing that phrase from
other phrases or sentences. For example, consider the following interview excerpt:

My experience with them has been fairly brief, I’ve never followed a case through to find
out how the woman is doing in the community, but I have seen repeat offenders and repeat
women coming through so have seen their injuries that way. I have found Native women
very open really, about the fact, maybe because they are often under the influence of
alcohol, so that they themselves are somewhat more vocal just because they are not as
defensive, so they will speak about him hitting them and relate to it in a way that seems a
very normal part of their relationship with this man, or person, but it doesn’t necessarily
mean that they recognize it as being something they don’t -they speak about it very openly,
not in a way that they are accusing and blaming, whatever.

In this excerpt, the nurse is talking about her own experience with women who have been
abused, what she recognizes as violence, the relationship between violence and alcohol, her ideas
about “Native” women, her perception of some women’s attitudes toward violence, and so on.
She is also talking throughout the passage about “Native” women and violence. The entire
paragraph can be dissected; the entire paragraph can also be considered as a whole.

Therefore, as I moved to the computer to track the analysis, I found I was unable to copy
phrases into conceptual categories without significant loss of meaning. Instead, I gradually
began to copy much larger “meaning units”. Using the categories from the initial interviews, I
copied whole phrases, sentences and paragraphs into separate files under broad conceptual
categories. For example, I copied the entire paragraph above into a file labeled “racial context”.
I also copied different meaning units from the excerpt into various files such as “recognizing
violence”, “ideas about violence” and so on. Each meaning unit was linked back to the original
data by identifying the interview code name and the line numbers of each meaning unit. Data from each interview were collected in the broad categories and analytic notes were made as data were analyzed in this manner. With each additional interview I compared new data to data previously analyzed, and thus compared across participants and sites within each category. As new data were analyzed, I created subcategories within the broader categories, created new categories, linked categories, and gradually developed an overall conceptual framework.

The development of this conceptual framework rested primarily on about five interviews from the “core” sample, that is, five interviews of staff nurses from the primary study sites. This development was also informed by informal analysis of field work and interviews with other health care providers from the two study sites.

In developing the conceptual framework, I worked both inductively and deductively. For example, when I had decided that nurses’ talk about time and space contributed to conceptual categories labeled “temporal context” and “physical context” respectively, I created other “context” categories such as social, legal, economic, and so on, and then examined subsequent data with these categories in mind. After several renditions, I arbitrarily stabilized and retained the conceptual framework while I turned to the development of theoretical arguments, despite the fact that these arguments began to contradict the relationships proposed in the framework. The conceptual framework thus passed from being theoretically meaningful to being merely an organized way to store and retrieve data from which I was building arguments.

Developing Theoretical Arguments

From the initial conceptual framework, I began to hypothesize relationships between concepts in the data. Using the data and using the framework as a guide, I began to write arguments regarding relationships that I hypothesized within and between conceptual categories.
For example, I began to develop arguments regarding the relationship between personal experiences of violence and nursing practice. I began to develop arguments about the temporal patterns of practice, and then about these temporal patterns in relation to the recognition of violence. This process involved writing arguments using data from within and between the categories and returning to the data for supporting and contradicting evidence. This process also required the second phase of interviewing, during which I added interview questions and sought further interview data to confirm, refine and reject various aspects of the arguments that I was building. Questions in these interviews were generated from the conceptual framework, and increasingly focused on the nurses' analysis of practice and the influence of the social context.

This second phase of analysis rested on all of the initial interviews with the 12 nurses in the core sample. This phase was also informed by informal analysis of interviews with other health care providers and women who had experienced abuse. In fact, I found that detailed analysis of the interviews with other health care providers was not appropriate. Because most of these data were concerned with the health care provider's own role and experiences, only a small portion of each interview was relevant to the research questions as posed. Thus, I reviewed these interviews and selected only those data which were relevant for further analysis.

The product of this second phase of analysis was a series of arguments about the nature of Emergency Nursing practice, about the relationships between nurses' personal experiences with violence and their practice, and about the nature of Emergency Nursing practice in relation to recognizing and dealing with abuse. The conceptual framework I had used was rendered redundant, because the theoretical arguments were at a much finer level of detail than the conceptual framework. Thus the framework was replaced with a new, more detailed network of concepts and relationships outlined in the arguments.
Because analysis was informed by the theoretical perspectives that I had taken, each of these arguments shared common features. Each was concerned with the social context, each attended to power relations within the social context, and each contributed to understanding Emergency Nursing practice in relation to violence against women. However, explicit links between the arguments required the development of a central thesis.

**Developing a Central Thesis and Reconceptualizing the Data**

In the final phase of analysis, I examined the arguments that I had built within and between various conceptual categories, and developed a central thesis that ran through and united the various arguments. I then was able to reconceptualize the data, and develop a revised conceptual framework that encompassed the various arguments I had developed. I then re-examined the theoretical arguments in light of this central thesis and revised conceptual framework, modifying both the arguments and the central thesis and revised framework. Again, this final phase of analysis demanded another phase of interviewing, and I returned both to the participants and to existing data to test and refine the central thesis, conceptual framework, and revised arguments.

**Analysis of Field Note Data**

Data from field work informed the analysis throughout. Initial analysis of field notes began as I made initial notes, and continued more intensively as I wrote the field notes in detail on the computer. Each subsequent field visit was informed by my analysis of the previous visits, and each interview was informed by all preceding field visits. Sometimes, analysis of field notes would inform interviews in general way. For example, I said in an interview that I had noted that nurses often did not know when patients were discharged and that I had surmised that not knowing might cause difficulty, and invited comment. At other times, analysis of field notes would inform an interview in a more specific manner. For example, in one instance, I shared my
analysis of a particular situation in which I thought a woman had been labeled as "abused" to the exclusion of all else, and asked the nurse I was interviewing for her analysis of that situation.

During the initial development of the conceptual framework, data from field work was used as background to interview data. Later, as I began to develop theoretical arguments, I retrieved examples that supported or contradicted interview data on an ad hoc basis. Finally, when the theoretical arguments were developed, I formally analyzed all field work data, adding examples to support, extend and modify the arguments.

**Document Analysis**

Various documents (including chart forms, preprinted "doctor's orders", policy documents, communication books, triage log books) were analyzed primarily during the development of the theoretical arguments. These documents were used to support and develop arguments. For example, as I developed arguments about the focus on physiological concerns in Emergency and the patterns of presentation at triage, I examined copies of triage log books.

The principles of critical discourse analysis were particularly useful in document analysis. For example, I analyzed a draft “Domestic Violence Protocol” from one of the study sites explicitly using the steps recommended by Fairclough (1989), which allowed a detailed analysis of the way in which agency was conveyed, the way in which social relations among health care providers and between health care providers and “patients” were constructed, and so on.

**Pursuing Rigour**

The criteria for rigour in qualitative and feminist research are different from the conventional empiricist criteria used in quantitative research (Hall & Stevens, 1991; Sandelowski, 1986; Schutz, 1994). The strategies that I used to pursue the qualitative
equivalents of reliability and validity in this study included insuring auditability, using反射性和关注分析的适用性。

**Auditability**

In parallel to reliability in quantitative research, Sandelowski (1986) proposed that a visible decision trail is the criterion for judging consistency in qualitative research. In order to facilitate consistency, I focused predominantly on the nurses and the Emergency unit in the primary site, thereby limiting the number of practice contexts and personnel involved. I sought consistency in data collection approaches first by using a standard information letter to all involved in the study (See Appendix 1) and by using a standard orienting statement at the beginning of interviews (see Appendix 6). Trigger questions and some questions used to extend interviews were also standardized (See Appendix 7). I used a consistent format for field notes and analytic notes, and consistent routines for recording and reflection. I systematically collected data such as notes of meetings with community members and colleagues, notes of phone calls, rough field notes and treated all such notes as data. I tracked formal interviews and field visits in a data base.

As particular experiences became relevant to the analysis, I sought to collect data regarding these experiences from all participants. As the analysis progressed, I kept records of the various renditions of my evolving conceptual framework. Similarly, I attempted to note major turning points in my thinking as hypotheses were tested and arguments evolved. The development of the analysis is described through this chapter and the interpretations chapters.

**Reflexivity**

Issues of validity in qualitative research in general, and critical ethnography specifically, are widely discussed (e.g. Anderson, 1989; Eisenhart & Howe, 1992; Lather, 1986; Wolcott, 1990) but as yet there is no consensus, and there is no simple set of procedures to follow. However,
one of the major routes to validity in critical ethnography appears to be reflexivity. Anderson
(1989) states that in critical ethnography, reflexivity "involves a dialectic process among (a) the
researcher's constructs, (b) the informant's commonsense constructs, (c) the research data, (d) the
researcher's ideological biases, and (e) the structural and historical forces that informed the social
constructions under study" (p. 254). The practice of critical reflexivity guided this study and I
envisioned my role as researcher as that of a data collection instrument to create knowledge with
and for those being researched. Thus, I attempted to collaborate with the participants and engage
them in analysis to whatever extent they wished.

Lather (1986) argues that "catalytic validity" is achieved to the extent that participants are
reoriented, focused and energized toward understanding and transforming their reality, in other
words, encouraged toward reflexivity and a deeper understanding of their own ideas. In this
study, as noted, there was considerable evidence that participation served as a catalyst for nurse’s
thinking and action in practice. Indeed, I had to caution myself against becoming addicted to
"catalytic" validity, and the rescue fantasies that such interactions can engender.

Applicability

Sandelowski (1986) contends that the applicability of qualitative research depends not on
the generalizability of results but on a commonality of perspective. I sought applicability by
comparing data between participants at each site, across sites, and beyond the study sites from
other hospitals. The greater the commonality of perspectives, the more widely applicable the
study will be. It is important to note however, that the search for commonality should not
overwhelm oppositional voices and varied perspectives. I sought opposing and varied
perspectives and integrated these perspectives within the analysis to provide a complex
description of Emergency nursing and practice in relation to violence, and then sought feedback
from the participants and from other nurses from Emergency nursing and other specialties. The applicability of this study was attested to by this feedback. Nurses from diverse settings such as pediatrics and intensive care found the descriptions of the patterns of practice and the use of personal experience in practice relevant to their own settings. Nurses from various Emergency settings found the overall findings applicable to their particular practice sites.

Ethical Considerations

Germain (1986) argues that the application of ethical principles is influenced by the nature of ethnography, and identifies ethical considerations of particular concern in ethnography: informed consent, the protection of privacy, anonymity and confidentiality, intervention versus nonintervention in the activities of those in the study site, and the potential use of findings and power relations among various levels of the study population. These considerations are further influenced by the nature of the topic of this study.

Informed consent, protection of privacy, and the nature of power relations in this study were particularly critical. As in any research, the privacy and autonomy of the participants were essential and all participants were informed as fully as possible and confidentiality assured. Also as in any research, the data was kept confidential, and only I had access to the data. The nurses and other health care providers were all able to give their own informed consent. However, both the Emergency nurses and patients, required special consideration.

Autonomy, Privacy and Informed Consent: Nurses

Because many of the nurses might have had personal experience with violence, and because it may be difficult to discuss violence without sharing that personal history, attention to privacy, autonomy and informed consent had to be especially rigorous. Second, because the literature and preliminary field work suggested that negative attitudes by nurses may contribute to the
detrimental responses to women, there was a danger that this research could be perceived as blaming nurses. A number of strategies were employed to foster the autonomy and privacy of nurses and to avoid coercing them into participation or implying blame.

First, the nurses were approached as partners in the research process and the focus on the social context was made explicit in all interactions, such as initial meetings, information sheets and letters to participants. Because informed consent is an ongoing process (Merrell & Williams, 1994; Munhall, 1988; Williams, 1995), the nurses were offered copies of their interview transcripts and copies of drafts of the analysis (see Appendix 1). I checked with participants regarding use of their ideas in areas that I thought might be contentious, and asked those who seemed interested for input regarding analysis.

Second, the level of participation by each nurse was clearly determined by that nurse. The four possible levels of participation: non-participation, observation, buddy-observation, and interview were made explicit in an information letter (see Appendix 1). Willingness to participate was indicated by returning the consents to a locked box in the staff lounge. Those nurses who did not wish to participate were not purposefully observed, and field notes were not taken regarding their actions.

This strategy caused some problems as sometimes I was unable to distinguish between nurses who did not want to participate and those who had forgotten or misplace their letters of consent. Although I requested that those who did not want to participate return their consents unsigned, they often did so without any identifiers on the consents. I was therefore often in the position of making observations, but not being able to ascertain immediately whether or not I should make field notes. I then had to ask about consent, an act that I thought might feel like
harassment if the nurse had already decided not to participate. Indeed, one nurse was quite annoyed when I asked her, as she had already returned her unsigned consent.

There were several nurses who actively declined to participate and did not want to be observed. Others passively declined, that is they did not say ‘no’, but did not return signed consents, despite being given several copies. This was sometimes difficult to manage because those nurses were often working with and relieving for my “buddy” nurses. Also, conversation in the staff lounge was often difficult when these nurses were present, and I was unable to record what others were saying as they were interacting with nurses who declined to participate.

Most nurses were willing to be observed, although they often required several copies of the consent before they returned signed forms, and often did not understand that consent to be observed did not mean consent to be a field guide. Those nurses who were willing to "buddy" and serve as a guide to the practice setting were followed closely and detailed notes were taken in relation to that nurse's practice. Others who are willing to be observed, but did not "buddy" were observed as their practice intersected with the nurses with whom I was buddied. Individuals were not approached for interviews; rather, I made it clear that I would like to interview nurses, explained my concerns about privacy and autonomy and waited for consents to be returned or to be approached by the nurses themselves. Each nurse on both units had the opportunity to participate or to not participate and could withdraw at any point. Consent to be interviewed and consent to being observed in practice were requested separately (See Appendix 3 & 4).

Third, I attempted to respect the autonomy of the nurses involved by making participation valuable to the nurses. I tried to make each interview a positive experience in which the nurse had control and I collaboratively negotiated meaning and shared the results in an ongoing and accessible manner.
Fourth, I worked within the power relations between myself and the participants fostering a critical reflexive approach for myself and all participants. As discussed earlier, the approach to objectivity I used was one of seeking "strong objectivity" in which knowledge is understood to be created, and the biases and assumptions of those creating the knowledge are constantly interrogated for their influence on the process. As analysis and meaning were negotiated with the participating nurses, they were encouraged to reflect on their own biases and assumptions. I also continuously sought to interrogate the influence of my own perspective, to examine my power in relation to those involved, and to find oppositional voices and alternative analyses. In this way I respected the knowledge and contribution of others and held myself as fallible.

Fortunately, I was not well known personally in either of the research sites, therefore, the participants interacted with me primarily as "researcher" and some of the role confusion experienced by qualitative nurse researchers (May, 1979; Merrell & Williams, 1994; Williams, 1995) was avoided. However, in participant observation the continuous presence, interest and unconditional acceptance of the researcher may lead participants to treat the researcher as "friend", "fellow nurse", etc. and lead to sharing of information that the participant considers conversation, but the researcher considers "data" (Merrell & Williams, 1994; Ramos, 1989; Williams, 1995). This occurred to some extent, partly because I was also known as an educator with knowledge of programs in which some of the nurses were interested. In addition, a couple of nurses saw participation in the research as a way of being seen differently by fellow workers, or as an opportunity to deal with painful past experiences. In these cases, what I offered as educator and researcher was of value to the nurses involved. This challenged informed consent, and I tried to strike a balance between gaining trust, making participation valuable, and keeping
my research role evident. I made judgments regarding what to record as data, and what to consider “off the record” conversations, and when unsure, I double checked with those involved.

I was passionately concerned about behaving ethically in relation to the nurses participating in this study. I attempted to do so by continually interrogating the potential for harm in the ways in which I was obtaining participation, collecting data, analyzing data, and sharing findings.

Autonomy, Privacy and Informed Consent: Patients

During field work, I observed nurses in interaction with people who were in the Emergency unit for care. It was essential to observe nurses in interaction with patients, and especially with women. Verbal consent was sought from all patients whom I wished to observe receiving care.

Obtaining informed consent from patients presented significant challenges. Emergency units are unpredictable, nurses have many brief contacts with multiple patients, and some patients were unable to give informed consent due to their physical or emotional condition, language barriers, or communication problems. In addition, it was anticipated that some patients would be being abused, and if they were accompanied by an abusive partner obtaining consent might jeopardize the patient’s safety further, and put hospital staff and myself at risk. Informed consent for patients was discussed with personnel at both hospitals and several strategies were suggested. I tried various strategies, but rather than be guided solely by the “rules” I had established for myself, I tried to judge what ethical behaviour would be in each instance.

Initially I thought that patients with whom my “buddy” nurses had very limited contact (e.g. a patient who asks a nurse the time, asks the nurse to hand the patient something, etc.) would not be purposefully observed and therefore would not need to be asked for consent. However, this proved unworkable, as I was unable to predict which patients would require what level of contact with which nurses. Thus, I explained my study to as many patients as possible and sought verbal
consent from every patient with whom I could negotiate contact. Often this meant obtaining consent and never speaking again to the patient.

I tried to give my explanations in a manner that did not interfere with the patient's care (e.g. after the person has been greeted, reassured, and immediate discomfort attended to). This often turned out to be most convenient while the nurse took the patient's vital signs. I was careful to give my explanation to all women only when their partners were not present. If partners were present I did not attempt to obtain consent, and did not make observations until I could obtain consent in private. Initially I thought that I would be accompanied by a nurse during all patient contact, and that thus there would be a witness to verbal consent. However, nurses did not have time to listen to my explanation, and if I was unable to fit it in while the nurse was occupied with the patient, she would leave to do other work as soon as I began explaining. On one hand this meant that there was often no witness to my verbal consent. On the other hand, most disclosures of abuse by patients occurred during such instances when the nurse was not present.

Most patients were able to give informed consent freely, and these patients I observed, checking with them if I thought it necessary to obtain permission to use a particular piece of data. Others were clearly not able to give informed consent. In the case of children, for whom I had not sought ethical approval to study, I simply did not observe. In the case of some patients, such as those who were unconscious or in critical condition, I observed and made the notes about the nurse without specific reference to the patient.

Sometimes the patient's ability to give informed consent was not clear. In these cases I would make notes if I thought there was a chance of informed consent later (and destroy the notes if not), participate without making notes, or make notes only on the nurses' activities. This combination of approaches generally allowed me to capture as much data as possible without
thinking that such collection was unethical. For example, I made extensive observations during
the care of a woman who was in acute respiratory distress. She was later stabilized, could recall
the experience clearly and was able to give informed consent.

At other times, however, the ethical lines were not as clear. I also made extensive
observations of the care of a man who was seen repeatedly in the Emergency drunk. Initially he
was verbally abusive and nearly incoherent. I expected to be unable to make any field notes
regarding my observations, but several hours later, when he was much more sober, he initiated a
discussion with me regarding my research. A highly educated man who had done research
himself and had some experience working with women who had been abused, he was very
interested in my study and more than willing for me to make notes. I asked him specifically
what he thought about my noting his swearing and yelling, and he said it was fine, and went on
to be quite open about his alcohol problems. However, I remained concerned as he seemed to
really appreciate the attention, and I wondered how that influenced his “consent”. Similarly,
sometimes patients would freely give informed consent, but I wondered how their apparent
loneliness and the fact that with consent I was willing to stay and talk, might influence this
consent. In an other situation, a man gave informed consent freely, but I later discovered that he
was quite forgetful, and again I wondered about informed consent. Again, I made judgments in
each situation regarding what to record, and later, regarding what data to use, based on my
analysis of the potential for harm.

Although I planned to withdraw from observation if the patient was unwilling to be
observed or was unable to give informed consent, there were no instances in which patients were
unwilling to be observed, and in situations where the patient was unable to give informed
consent, I was able to focus only on the nurse’s actions. Patient responses to my explanation fell
into three categories. Most patients, both men and women, reassured me that violence was not a
problem for them. Many of these people remarked on either the importance of my study, or their
own lack of understanding about violence and the men often made jokes about not being
battered. Second, a few patients simply said it was fine for me to observe, but did not make
comments. Finally, a few told me that violence was an issue for them.

**Intervention Versus Non-intervention**

As anticipated, I had to decide whether and how to intervene both in relation to nursing
practice and in relation to nurse's assumptions. Minor practice issues arose regularly, as I had to
decide to what extent to participate in patient care. I tried to strike a balance between
participating without interfering with my research role. I found that I could be quite helpful to
my "buddy" nurses without detracting from my research role. Major practice issues arose rarely,
and in fact, I found that care was generally excellent, and rather than needing to intervene, I had
to resist nurse's appeals to me to act as "expert". In a couple of instances I had to participate in
care more actively than I wanted to (mixing up drugs, starting IV's) because a patient's life was
in danger. In a very few instances I felt that the behaviour of nurses toward patients was
unethical. In those cases, "intervention" was very subtle. For example, in one case, a man who
was semi-conscious following a drug overdose was treated very roughly, shouted at, and
physically restrained. Unfortunately this was such common practice that my attempt to model
speaking to the man in a respectful manner was probably seen as naive. In another instance, a
woman who was an alcoholic was treated quite disrespectfully when she was being discharged
without an explanation for the health concern with which she presented. In that case, I merely
made supportive eye contact with the woman and non-committal eye contact with the nurse.

[The nurse] is taking the woman's IV out, taking off her name band. The woman asks a
bit plaintively "what should I do?" [The nurse] replies harshly and impatiently "stop
drinking alcohol". The woman's face hardens, but she persists, and says "I am not going
to do that". She looks over at me (behind the nurse’s back), and I shrug. [The nurse] goes on to say that nothing will change if she keeps drinking, and that she should quit. The woman says "I don't think you should be telling me how to run my life". The tension is palpable, but [the nurse] catches my eye, pauses and acquiesces saying, "No, I think you're right, I shouldn't be". (Field Notes, July 1996)

In each situation, I analyzed of the degree of harm that I thought would occur if I did not intervene, tried to anticipate what action would do the most good, and acted accordingly.

Issues of intervention continuously arose in relation to nurse’s and other health care provider’s assumptions in relation to violence, poverty, “culture” and “race”. “Victim-blaming” statements about women who have been abused, and assumptions about violence among certain groups of people were often made. I tried to walk an ethical line between promoting reflection and analysis among the participants and alienating them. I tried to not position myself as beyond oppressive behavior, and tried to model critical self-reflection. However, I think I often erred on the side of “correcting” the views expressed rather than promoting critical reflection.

Potential Use of Findings

The potential use of findings and power relations among various levels of the study population were issues in various ways. First, I had to reassure participants and then model in my interactions, that I was not “evaluating” their practice. Despite knowing what my role was, many nurses asked me for feedback on their practice. I did not think it ethical to simply refuse to give any feedback, because the nurses wanted the feedback and saw it as an opportunity or value in participating. I was acutely aware, however, of the potential for misuse of power. I therefore tried to cast myself in a collegial role, and give feedback that was positive and constructive, Thus I did tell nurses (sometimes unsolicited) when I admired their practice, and told them about specific approaches that I observed that I thought were particularly effective. For example, one nurse gave excellent explanations to all her patients regarding everything that was happening to
them. I commented on how this seemed to really be helpful to most of her patients, and we had several discussions regarding her concern that she “over did it”. I also was careful not to overstep the bounds of the areas in which I could give feedback. For example, one nurse asked if I would have done anything different in the management of an elderly woman whose daughter no longer wanted to care for her. I told the nurse that she was obviously much more experienced in mobilizing resources than I, and in working with families in conflict.

The question of what information to share between levels of participants also arose. In the very process of checking out ideas I had to share my analysis between levels of participants. For example, I needed to ask physicians about the perception that the way physician’s incomes are generated seriously influence the way in which they prioritized patients. I needed to share with staff nurses administrators’ ideas that nurses operated as though “the only good stretcher is an empty stretcher”. Again, I tried to judge the potential for harm to patients and participants in sharing such analyses. Understandably, I had less concern about sharing positive data. For example, I thought it ethical to share in a general way the high regard that many staff had for others. More difficult were decisions regarding the sharing of data that were critical, and in this I did so when I gauged that the analysis would be of more value to patients than of harm to health care providers.

Finally, and most importantly, the sharing of analysis that is critical of practice, and critical of the ideas of specific nurses, caused most difficulty. The central thesis of this study concerns the ways neglect of violence is produced. The analysis relies on ideas that can be traced to the words of particular individuals. I believe this analysis must be done for the good of women who have been abused, but have attempted to attenuate the harm that such critical analysis will cause to individuals by seeking a non-reproachful analysis and tone, and engaging participants in
analysis. Specifically, I have gone back to those nurses of whose ideas I have been particularly
critical and asked them for their analysis, and to critique my analysis. Rewardingly, those nurses
have been at least as critical as I, and I have thus attempted to use their words to support my
interpretations as well as my own words.

Care for the Participants

I anticipated that research on violence against women would be draining for all involved.
As I expected, nurses shared their own histories of abuse. However, it was not these histories
that caused the most stress for myself, nor, I believe, for the participants. Rather, the participants
in this study seemed more distressed by the conditions of their work, their perceived inability to
care for patients adequately, and the lack of support they perceived from co-workers. For
myself, the stress of fieldwork was primarily related to the conditions of work with which I saw
nurses struggle and the fact that I was creating a harsh analysis of racism and classism that I saw
embedded in practice, the practice of nurses who wanted to work with me to make a difference.

Politics and Action

Through completing this research I became increasingly committed to political action as
part of my professional practice. Previously, I had seen politics as somehow separate from my
nursing practice. Working with community members and women that have experienced abuse
gave me a different perspective on my personal relationship to the community and to those with
whom I do research. Today I am an active member of a women’s action group focused on
ending violence and the chair of the community anti-violence committee in one of the study
communities. It is my intention to at least partially return the gifts I have been given in the form
of welcome, belonging, and shared knowledge and experience.
Summary

This critical ethnographic study of Emergency nursing practice in relation to violence against women was completed from a feminist perspective using particular perspectives on power and violence. Data were collected during field work in two Emergency units and their respective communities over a period of 2 years, and through interviews with over 30 participants. The study examined how the social context in which health care is provided, and the power relations within that context, shape and constrain nurses' care for women who have been abused and how nurses in turn affect structures and relationships within the social context.

Interpretations of the data in this study will be presented in five chapters. The first chapter will outline the way in which the interpretations of the data have been conceptualized. This initial chapter will outline the framework of the interpretations and will orient the reader to the chapters which follow.

The second chapter will describe the social context of Emergency nursing practice. This chapter will describe the nature of nursing practice in the Emergency unit in general terms, and will consider the relationship of the Emergency unit to the health care system, the hospital, the community, and health care workers. The ways in which the purposes of Emergency units create patterns of practice will be described, and the ways these purposes and patterns shape nursing practice and relationships with patients and others, will be examined. This chapter will provide a background for specific examination of nursing practice in relation to violence against women.

In the third chapter of interpretations, I will consider what individual nurses bring to the context of practice, with particular attention to the importance of personal experience as a basis for practice in relation to violence. I will examine how nurses interpret their world and their experiences within dominant interests, how their own interests are congruent with or counter to
those dominant interests, and thus how practice in relation to violence against women arises from personal experiences interpreted in concert with, or in opposition to, dominant interests.

In the third chapter of interpretations I will begin to consider the nature of Emergency nursing practice in relation to violence against women by focusing on the ways in which violence is recognized or ignored. In the fourth and final chapter of interpretations, I will complete my examination of the nature of Emergency Nursing practice in relation to violence against women by exploring the ways in which violence is dealt with or neglected. In these two chapters, I will analyze the ways in which various practices are congruent with and serve dominant interests, and the ways in which other practices are counter to those dominant interests.
Exhausted

She’s really exhausted.
Now I’ll tell her
she’s racist.
Tell her she’s just made it worse.

Tell her she’s part of the problem,
Describe the damage she’s done,
After she tried to help me
And given me stories she’d won.

She’s really exhausted.
How can I tell her the truth?
How can I sit down beside her?
How can I be of use?

Tell her in ways that will strengthen
Tell her and make no excuse
Tell her in words full of power
Tell her in words of no use,

She’s really exhausted.
How do I know the truth?
How can I sit down beside her?
Tell her something of use?

Tell without loosing our chances
of turning the long night around
Tell without missing our chances
of finding some sweet common ground

These walls are mossy and slickened
They offer no chance of escape
Just leave me to sit here and ponder
Words that take on no shape

I think I’ll give her a hammer,
Then I think I’ll give her some nails,
She can choose how to use them,
To crush or fashion new tales.
CHAPTER FOUR

INTERPRETATIONS: AN OVERVIEW

The purpose of this chapter is to outline the ways I have conceptualized the interpretations of the data in this study. This conceptualization is the product of the several phases of analysis used. This overview will provide a framework for reading the chapters of interpretations that follow, and will link the various chapters, and concepts within those chapters.

Reproducing and Resisting Dominant Interests

The interpretations of the data in this study are conceptualized as patterns of individuals as they reproduce and resist dominant interests (discussed below) to create local practices (see Figure 4-1). It is argued that local health care practices are enacted by individuals who work within the social context in which dominant interests shape their everyday worlds and provide the lenses through which they interpret the world (see D. E. Smith, 1987; 1990). The power of dominant interests is exercised primarily through ideology, ideas and images used to create coherent understanding of the world. Working both within the material conditions of practice, and various ideologies which serve dominant interests, health care providers allocate and ration resources, using judgments regarding deservedness to differentially allocate those resources to people seeking health care. In this study, nurses struggled within the limited resources of Emergency units and within various ideologies to provide a level of care they valued, often feeling that their “hands were tied” by forces beyond their control. This struggle created conflict and particular patterns of practice, and the predominant pattern of practice, efficient processing, obscured violence and abuse.
Figure 4-1: Conceptualization of relationships between dominant interests and individual enactment of local practices applied to the distribution of resources in health care.
Dominant Interests

The dominant interests\(^1\) in this study include the intersecting\(^2\) interests of class, gender, "race", and so on, that tend to prevail in determining health care practices. The interests of class in this case are the unseen interests of the corporate elite that dominate the political economy of Canada in general, and health care economics in particular. Berliner (1982) argued that in the medical mode of production that emerged in the late 1970's, the monopoly-capitalist mode, health care is highly integrated with the political economy. The intersection of corporate interests, political economy and health care can be seen in analyses such as those by Lexchin (1994), Northcott (1994) and Rachlis and Kushner (1994).

Among the corporate elite are those who profit from particular health care practices, such as pharmaceutical and health care technology companies, and those who profit from limiting health care expenditures, such as corporations who pay less tax when health care and social spending are cut, and corporate employers who see their "industrial competitiveness" reduced by the burden of increased payroll costs (p. 2, Policy Group on Health Reform, 1996)\(^3\). In addition, politicians and government decision-makers in Canada may benefit from "re-casting the fiscal crisis as a health care crisis", shifting the blame for government debt, and justifying austerity measures (Northcott, 1994, p. 20).

As dominant interests intersect, mirroring sites of oppression, the interests of the corporate elite intersect with interests of gender and "race". In Canadian society and corporations, both of which are dominated by white men, the interests of men, white people and particularly white

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1 Oliga (1996) defines "interest" as a comparative advantages among alternative situations, actions or events in relation to the conditions of existence of an agent, a group of agents, a social system or a particular society (p.85). Peillon (1994) says that "interest" is an "exigency of action which originates outside of social agents" (p. 167).

2 Please see Chapter 3 for discussion of intersectionality of oppression

3 The signatories to this document, who include "CEOs from hospitals and the pharmaceutical and medical device sectors, academics and government officials, management consultants with health care expertise, and representatives of provider groups" might be considered representatives of these interests (p. 1)
men, tend to coincide with the interests of the corporate elite. This study examines how these various interests intersect in the provision of health care within the context of an Emergency.

The idea of interest is fundamental to this interpretation. “Interests” are not just what social agents (individuals or groups) “want”. Rather, interest is an exigency for action which originates outside social agents, but is produced and defined by social agents (Peillon, 1994). Peillon argues that interest is one of the few concepts which can establish a link between situation and action. The situation (the context of action) itself contributes to what social agents are interested in achieving. In particular, interest may be shaped by social structure, an individual or group’s access to resources, and social relations (of domination, exploitation, etc.). The relationship between interests and action is not linear, direct or automatic, and, Peillon notes, social science has not presented realistic accounts of the relationship. This study then, is an attempt to unpack some aspects of the relationship between the interests of health care providers (as they produce their interests within specific contexts) and their actions with regard to violence against women.

The concept of ideology is also central, because it is through ideology that the exercise of power in service of dominant interests is seen to be achieved. Peillon (1994) notes that when a particular interest is presented as a general interest, we encounter ideology. Henry, Tator, Mattis, and Rees (1995) note that at one level ideology is a set of assumptions, values, beliefs, perceptions that provide members of a given group with understandings and explanations of their world, but at another level ideology functions to organize, sustain, transform and reproduce existing power relations in society. It is with this second “level” of ideology that I am particularly concerned.

Fairclough (1989) explains that ideology and power are closely linked because ideological assumptions embedded in “conventions” (common ways of thinking and doing) depend on the
power relationships which underlie those conventions. So, for example, the conventional idea that nursing is “women’s work” depends on the power relations between men and women.

Ideologies are a means of legitimating existing social relations “simply through the recurrence of ordinary, familiar ways of behaving which take these relations and power differences for granted” (Fairclough, p. 2). To follow the example, the taken for granted notion that nursing is “women’s work” not only insures that mostly women enter nursing, but also contributes to reproducing gendered power relations within nursing and between nurses and others (physicians, for example).

Fairclough claims that in modern society, power is increasingly exercised through ideology (rather than through coercion by force), and particularly through the ideological workings of language, and that the exercise of power, through the manufacture of consent or acquiescence to power, depends on ideology. In this study then, dominant interests influencing health care are seen to be exercised through the manufacture of consent or acquiescence to those interests by means of ideology. In particular, the interests and power of the corporate elite are exercised through the perception of a crisis in health care (Northcott, 1994), influencing everyone from social policy makers at the national level, to decision makers in the health care system and hospital, to those who practice at the bedside. In this study the ideas and images of austerity, cost cutting, restraint, shortages of resources are manifest in an ideology of scarcity⁴ evident in the ideas and images used by nurses in their everyday practice as they struggle to deal with and understand the influence of the material conditions of their practice.

In examining how dominant interests are exercised, analysis must account for how various interests, such as those of class, gender and “race” coincide. As argued in Chapter 3, oppression

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⁴ I am not arguing that such scarcity is not “real”, or that there is no fiscal crisis impacting health care, but rather that such ideas function ideologically to ration resources in accordance with existing power inequalities and thus sustain those inequalities.
was viewed in this study as simultaneously arising from multiple sites. So too are interests viewed and analyzed as intersecting, meaning for example as noted, the interests of the corporate elite tend to coincide with the interests of white men. The corporate elite as part of the ruling class are not conceived as an “ideologically homogenous collection of individuals standing in an identical relation to the means of production” (D. E. Smith, 1987, p. 56). Rather, following Smith, the corporate elite are part of the ruling class which is “the basis of an active process of organization, producing ideologies that serve to organize the class itself and its work of ruling, as well as to order and to legitimate its domination.” (p. 57). In this case, various interests intersect to give social form to interests within health care.

In this study of a deeply gendered social issue: violence against women, surprisingly, the interests of class and “race” intersected so profoundly with the interests of gender that they were most salient to creating new understanding. Although this study examined women (nurses) in relation to women (who have been abused), dominant interests and the interests of nurses and other health care providers were such that through the intertwining ideologies of class and “race”, women reproduced relations of gender power over other women. Thus, the interests most salient to understanding nursing and health care practice in relation to violence are class and “race”.

Individual Enactment of Practice: Reproducing and Resisting Dominant Interests

In enacting practices that are congruent with, and thus reproduce dominant interests, individuals are conceptualized as drawing on the various ideas and images that constitute pre-
existing ideologies. Individuals are conceptualized as enacting practice in congruence with and in service to dominant interests to the extent that they unquestioningly accede to these ideologies or see dominant interests as aligned with or serving their own interests. This drawing upon ideologies is not conceptualized as purposeful nor intentional. Rather, ideological ideas and images are imbedded in taken-for-granted ideas and common sense notions, and without critical examination, may, as Fairclough (1989) notes, function ideologically. He argues

Institutional practices which people draw upon without thinking often embody assumptions which directly or indirectly legitimate existing power relations. Practices that appear to be universal and commonsensical can often be shown to originate in the dominant class or in the dominant bloc, and to have become naturalized. (p. 33).

Individuals are conceptualized as not only drawing upon “extralocal” ideologies, that is, social forms of thought “made for us by others, which come to us from outside and which do not arise out of experience...” (D. E. Smith, 1990, p. 55), but also as participating in ideology production and reproduction. Nurses and other health care practitioners work within both ideological conditions and real material conditions, interpreting each within the other, creating practices and ideologies.

Health care providers are also not conceptualized as being unquestioningly aligned or blindly enslaved by ideology. Individuals in this study were often seen to strenuously disagree with policies and practices at various levels. However, individuals might disagree with the agenda of the ruling elite, but at the same time make that agenda possible. For example, nurses might disagree with policy decisions that determine staffing levels, but skip breaks and manage patient care in ways that make staffing levels appear less problematic.

Smith (1987) following Marx and Engels, connects ideology to the means of production, describing ideology as “those ideas and images through which the class that rules society by virtue of its domination of the means of production orders, organizes and sanctions the social relations that sustain its domination (p. 54). It is important to re-emphasize that these ideas of drawing on ideology or discourse types (to follow Fairclough) may be a departure from Foucault's conceptualization of the relationship between ideology and discourse (see Methods chapter).
By examining the practices of health care providers, including both language and action as social practices, the ideology and interests supporting practice can be excavated. D. E. Smith (1990) notes that “the actual practices that make ruling possible are not visible” (p. 79), but by examining the everyday practice of individuals, the ways in which dominant interests are exercised and served, in what Smith terms the “relations of ruling”, can be made visible. The ways in which individual practices draw upon, reenact and reproduce ideology, or alternately, resist dominant interests, can be explored.

**Allocation and Rationing of Resources**

Of particular interest and concern to this study are the ways in which nurses allocate and ration resources. Individuals allocate resources at the local level (especially the resource of the individual’s own time) within the material conditions of their work and within an ideology of scarcity in health care and make rationing decisions on a moment-by-moment basis.

It is argued that the primary mechanism by which resources are differentially allocated is by individuals making judgments regarding the “deservedness” of individual patients. Judgments of deservedness are mostly made on the basis of physiological acuity, however, other interests also come into play. Here then, ideologies about “race”, class, gender, ability, age and so on are combined with ideologies of shrinking health care resources and scarcity.

Because there is also resistance to dominant interests, conflict is inevitable. Individuals do not always perceive dominant interests to be in their own interests, thus there are practices of resistance as well as of congruence. And while the practices may not be theorized in these terms by those practicing them, the conflict arising from resistance is nevertheless deeply experienced.
Domination and Resistance in Emergency Practice

Using this model of relationships to interpret practices within the particular context of an Emergency Unit, individual health care providers are conceptualized as reproducing dominant interests to create Emergency health care practices that allocate resources efficiently. Within the ideology of scarcity in health care, a predominant pattern of Emergency practice is created in which patients are processed efficiently (see Figure 4-2). In this predominant pattern, the patient is stripped down to a manageable physiological problem and processed by dealing with the physiological problem, and the stretcher is emptied as quickly as possible. In this way, the hospital, health care system and society are served by the efficient use of resources to deal with physiological problems. Many patients can be processed using minimum resources.

Individual health care providers, specifically nurses, enact practice both in congruence with and resistance to this predominant pattern. This practice pattern is in nurses’ interests because it permits them to “get the job done” by defining the job in a way that can be accomplished within available resources. Practices of congruence include “going with the flow” in which nurses, working within the various ideas and images that organize their everyday world, learn to be more “efficient” and more physiologically focused. Because efficiency and a physiological focus require nurses to distance themselves from patients and non-physiological problems, nurses also learn to be “strong”, meaning that they can achieve such distance.

Adherence to the predominant pattern thus reproduces the ideology of scarcity, and contributes to ideologies of “efficiency” and emotional “strength” as images of the ideal Emergency nurse.

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8 I am using the terms “efficient” and “efficiently” in the particular way those ideas are constructed in the Emergency setting: to denote the processing of patients as physiological problems with the minimum use of resources. Thus the terms refer only to the reckoning of the costs of care in economic and temporal terms, not in terms of the human or health-related costs.
Predominant Pattern of Practice: Efficient Processing
- Stripping the patient down
- Creating a manageable problem
- Processing the patient
- Emptying the stretchers

Congruent Practices
- Going with the flow
- Being efficient and strong
- Influencing each other
- Patient as un/deserving

Resistant Practices
- Preserving the person
- Influencing the context
- Supporting each other
- Patient as agent

Social Context

Figure 4-2: Conceptualization of the individual enactment of practice in relation to the predominant pattern of practice in Emergency
This pattern of practice dictates that resources are allocated to dealing with physiological problems. However, as resources are often insufficient to meet all the physiological needs of patients, and because patients have more than physiological needs, nurses are required to ration resources by making moment-by-moment decisions regarding how to use their time, the time of others, and the resources of the unit. Rationing resources depends on judging some patients as more deserving than others. In congruence with the physiological focus, most rationing occurs on the basis of physiological acuity. More acute patients are more deserving of care than less acute patients. However, in making rationing decisions, various intersecting ideologies, particularly those regarding individual responsibility and self reliance, class, “race”, gender, and ability, are drawn upon to make further judgments regarding deservedness. For example, some nurses were quite clear that they implicitly used greater deference with certain patients (e.g. wealthy people, who tend to be white) than with others.

Nurses in this study supported practices congruent with the predominant pattern among themselves, at least in part because this pattern works in their interests of getting the job done. Nurses helped one another to become more efficient and physiologically focused by teaching each other, valuing and rewarding those attributes, and applying sanctions to promote adherence. Ideologies regarding deservedness were reproduced by nurses (and others) valuing and sharing assumptions regarding individual responsibility and self reliance, “race”, class, gender and so on. Thus congruence with the predominant practice pattern was also in individual nurses’ interests in maintaining relationships with peers.

Nurses negotiated between practices resistant to the predominant practice patterns and practices of congruence. Nurses brought values for health and holism to their practice, values

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9 I am aware that the term “sanctions” can convey approval or disapproval. I am using the term to mean measures used with a view to coercing compliance, measures which can be either disapproving or approving.
which conflicted with the efficient processing of patients as physiological problems. The conflict between values for holism and health and the dominant interests supported by the ideology of scarcity was deeply felt by most nurses, and led to practices which countered the predominant pattern of practice. Nurses attempted to preserve the patient as a whole person, usually using their time and personal resources to do so, and attempted to influence the context to allocate resources differently or to obtain more resources. Such attempts to influence the context were due partly to the difficulty nurses have “getting the job done” even when it is defined as efficient processing, and partly due to nurses’ desires to attend to more than the immediate physiological needs of patients. In both cases, influencing the context was in the nurses’ interests but counter to dominant interests.

In resisting the predominant pattern of practice, nurses counteracted their distance from patients by using strategies to preserve the person, and treating patients as active agents. Although nurses in this study influenced one another in maintaining congruence with the predominant patterns of practice, they also supported one another, albeit to a lesser extent, in practices of resistance, by valuing attention to non-physiological needs and collectively taking action to influence the context.

Conflict arose from both practicing with and against the predominant pattern of practice. Nurses held conflicting values, and individual’s values and practices often conflicted. “Efficient” processing sometimes led to conflict with patients, and practices of resistance sometimes led to conflict with co-workers, administrators and so on.

Domination and Resistance in Relation to Violence Against Women

Practice in relation to violence against women occurs in the context of these patterns of practice. In this study, the neglect of violence was unwittingly produced within the context of
the Emergency unit, as violence was **obscured by efficient processing** of patients in the routine provision of care (see Figure 4-3).

The predominant practice pattern (itself shaped by interests embedded in dominant ideology) focuses on the recognition of physiological problems, and the efficient processing of patients; non-physical abuse is easily overlooked, and physical consequences of violence tend to be reduced to a single physical problem (a fracture, laceration, abdominal pain). In accordance with the physiological focus, only blatantly obvious physical consequences of physical abuse are recognized, and **non-recognition** prevails as attention is directed elsewhere (to the "presenting complaint, which is unlikely to be "abuse"). Violence is **anticipated** and **recognized differentially** among certain groups of people in congruence with ideas about violence in relation to class, gender, and particularly "race", ideologies that function in congruence with ideas of deservedness employed in rationing resources.

When violence and abuse are recognized, routine practice patterns prescribe dealing just with physical injuries, and shifting responsibility to others, a pattern which nurses see as "doing nothing", a pattern of response which caused nurses moral distress in regard to all health problems, as well as in regard to violence. As nurses struggled with "efficient processing" in general, they struggled with efficient processing in the specific case of violence and abuse. Again, they negotiated between practices **congruent** with the masking of violence by the predominant practice pattern, and **resistant** practices which unmasked and confronted violence and abuse.

Nurses’ interests in relation to violence against women, arose from multiple sources. First, their practice in relation to violence was influenced by their interests within the context of the Emergency unit. It was in nurses’ interests to practice in congruence with the predominant
Deservedness

Efficient Processing Obscures Violence and Abuse

- non-recognition
- differential anticipation and recognition
- dealing with physical injuries and shifting responsibility

Congruent Practices

Not Wanting to Know
Doing Nothing

Resistant Practices

Asking Questions
Influencing Choices

Figure 4-3: Conceptualization of the obscuring of violence and abuse by the predominant pattern of practice (efficient processing)
practice pattern, both in order to get the job done and in order to maintain peer relationships. In addition, however, nurses’ interests also arose from understandings they derived from other sources: education, research, popular media, and most importantly, their own experiences.

Various practices within Emergency practice combine with nurses’ understandings about violence, and their interpretations of their own experiences of violence to create practices specific to violence. Practice in relation to violence against women therefore can be seen as a pattern of individuals reproducing and resisting dominant interests to create practices specific to violence.

In this study, the most important source of ideas used by nurses in discussing practice in relation to violence was personal experience of violence, especially experiences of violence within the nurse’s family. Particular personal experiences did not lead to particular practices. There was no simple linear relationship between, say for example, a nurse having witnessed her father abuse her mother and practices of vigilance in observing for indicators of wife abuse. Rather, the way in which individuals interpreted their personal experiences influenced the extent to which those experiences were understood either in congruence with or in opposition to dominant ideologies, and thus these interpretations influenced the way in which nurses practiced. As Peillon (1994) notes, interpretation is a critical component in determining interests.

Efficient processing and the obscuring of violence and abuse, which lead to non-recognition of violence, differential recognition of violence, and doing nothing, are sustained by the power of dominant interests exercised through ideology and shaping the interests of individual health care providers. While it is in the individual’s interests to practice in congruence with the predominant pattern of practice in order to get the work done and maintain peer relationships, ignoring violence may be particularly in the interests of individuals.
In a general sense, violence is not pleasant to recognize, and ignoring violence may thus be more comfortable. In a deeper way, however, recognition of violence may call into question the nature of being human. In particular, for individuals who have experienced violence in their families, ignoring abuse in patients may enable individuals to continue to ignore personal memories of abuse, thus shaping their interests toward obscuring violence. Further, dominant ideologies, particularly those manifest in discourses regarding “race”, class and violence, may function to distance individuals from violence by constructing violence as a problem of “others”. Practices of differential recognition and resource rationing are not only congruent with dominant ideologies of scarcity and deservedness, they also serve to reproduce these ideologies. For example, if nurses believe that certain groups of people (based, say, on “race” or class) are more “naturally” violent, and anticipate violence among those groups, then recognition of abuse among such people reinforces the view that they are more violent. If nurses think individuals who they see as taking responsibility for their own health are most deserving of care, then those individuals may receive more or better care, thus possibly increasing their ability to take responsibility for their health, and vice versa.

To the extent that individuals saw ignoring or neglecting violence as counter to their own interests, violence was recognized and attended to in resistance to dominant interests and refusal of the predominant practice pattern. In questioning and challenging dominant interests and ideologies, other patterns of practice and responses to violence were enacted. In the same way that nurses often refused to efficiently process patients, seeing neglect of the whole person as inadequate, they also saw neglect of violence and abuse as inadequate and sought alternatives.

Practices of resistance in relation to violence are conceptualized in this study as being continuous and overlapping with practices of congruence (see Figure 4-3). Practices extended beyond “doing nothing”, to “influencing choices”, and to “offering choices” (see Figure 4-4),
Doing Nothing
(The undeserving victim)
-deal with the physical
-shift responsibility

Inadequacy

Influencing Choices
(The deserving victim)
-disclose abuse
-call police
-leave partner

Frustration

Offering Choices
(The woman as agent)
-listening
-respecting choices
-encouraging to come back

Figure 4-4: Conceptualization of patterns of practice in relation to violence against women
the former being congruent with dominant ideology, the later two being progressively less so. In resisting dominant ideologies, the discourse of deservedness was challenged, and practices of resistance incorporated first, notions of “victims” as deserving, and more resolutely in opposition to dominant ideologies, ideas of women as active agents. Nurses attempted to influence women toward particular actions when they perceived “doing nothing” as inadequate and saw women as deserving more; they moved to offering and respecting women’s choices when they became frustrated with the limits to choice and saw women as active agents. Like practices of congruence, resistance practices arose from multiple sources of knowledge.

In summary, the central conceptualizations presented in this study are reproducing and resisting ideology to enact individual practices, and to create collective local practices. In the chapters that follow, this conceptualization will be used as a foundation for presenting the data, as the context of practice, the contribution of individuals to practice, and the practices specific to violence and abuse are considered.
CHAPTER FIVE

INTERPRETATION: NURSING PRACTICE IN EMERGENCY

The central thesis of this work is that the neglect of violence was unwittingly produced within the context of the Emergency unit because violence was obscured by the efficient processing of patients in the routine provision of care. Efficient processing is congruent with and serves dominant interests, and individuals work in congruence with this pattern because they operate within a context in which dominant interests organize their experiences and provide the lenses through which they interpret the world. The interests that are served are not, however, specific to violence. Neither is the neglect of violence purposeful or intentional. Rather, the neglect of violence is produced through enactment of local practices which serve dominant interests in the routine provision of care. Dominant interests are sustained and reproduced by individuals drawing upon discourses (which function ideologically) in their enactment of local practices. The purpose of this chapter is therefore to examine the way in which local practices operate in the routine provision of health care in the Emergency unit to serve dominant interests in society, the health care system, the hospital and the Emergency unit, and to examine the ways in which ideology is drawn upon and reproduced.

The purposes and nature of the Emergency unit shape the nature of nursing practice in Emergency, including practice in relation to violence against women. Emergency units serve a variety of functions in relation to the community, the hospital, and health care providers, and thus to the political economy of the health care system and society. These relationships all influence the nature of nursing practice. This chapter outlines the purposes that the Emergency unit serves, and the relationship of the Emergency unit to the health care system, the hospital, the community, and health care workers. This chapter examines the ways in which the interests of
society, the community, the health care system, the hospital, and individuals, including health care providers, are served by an Emergency, and how individuals in turn serve those interests, and explores how certain ideologies sustain dominant interests. The ways in which the purposes of Emergency units create patterns of practice that serve dominant interests will be described, and the ways these purposes, patterns and interests shape nursing practice and nursing relationships with patients and others, will be examined. This chapter will provide a background for specific examination of nursing practice in relation to violence against women, and the ways practice patterns obscure violence and abuse.

The Purposes of an Emergency

In relation to the community, the Emergency unit is the primary point of contact between the hospital and the community. The Emergency serves as a major conduit between the hospital and community, with about 55% of hospital admissions coming through Emergency (Hospital Statistics, 1996). The Emergency serves as a “catch-all” for the community, dealing with problems for which there are no other services and providing 24 hour services that are either not available elsewhere, or are not available outside of certain hours. To individual members of the community, those who come for service as patients and family members, the Emergency provides a wide range of services, and referral to other services. The Emergency unit provides diverse services ranging in predictability from scheduled medical treatments, such as IV (intravenous) antibiotics or blood products, to the treatment of urgent, life threatening health problems such as trauma. Approximately 65% of the patients seen at one Emergency can be classified as “non-urgent”. Services vary in focus from first aid for minor injuries, to the assessment of, and intervention for, psychiatric problems.

1 Hospital and community resources will not be referenced in order to protect the identity of study sites.
The Emergency is a major gateway into the hospital from the community. The Emergency serves as a major intake corridor, and provides flexibility to the hospital with regard to patient flow by holding patients when the wards are unable to admit them. Thus the Emergency serves also to ‘take up the slack’ with regard to staff/patient ratios throughout the hospital.

For health care providers, the Emergency serves as a place of employment. The Emergency provides steady or casual hourly employment for nurses and other health care providers. Because physicians are paid on a fee for service basis, their relationship to the Emergency is somewhat different from other health care providers; the Emergency provides an opportunity for them to make more or less money depending on patient flow. The economic differences in conditions of employment are gendered and racialized. The Emergency physicians in this study were predominantly male (approximately one female in 20 across the primary study sites), whereas the nurses were predominantly female (approximately one male in 20 across the study sites). For this reason, throughout the remainder of this work, all nurses are referred to with female pronouns, and all physicians with male pronouns. Both the physicians and nurses in both study sites were almost exclusively Caucasian, whereas in both study sites support staff such as aides, cleaning staff, and so on, reflected more closely the diversity of the underlying community. Because people of colour were identified by white speakers by terms generally meaning "not white", throughout the remainder of this work, “not-white” or “non-white” will be used when the actual words of the person cannot be used for reasons of confidentiality. In both study sites, the hospital hierarchy was Caucasian and male dominated, although the nurse managers and directors of nursing were female.

The economics of health care provide a significant context for the functions of the Emergency unit. The cudgel of cost efficiency has been extensively applied, and, in the words of
one Emergency head nurse, “everything is driven and evaluated from the perspective of cost-efficiency”. The role of the Emergency in providing flexibility to the hospital extends in some ways to providing economic flexibility. For example, on “corporate days” the hospital “shuts down”; laundry services, technician support, operating rooms, and so on, are cut back to “skeleton” staff. Although such measures are taken to accommodate the 36 hour work week negotiated by the health care unions, the impact on the Emergency nurses in this study was that they were overwhelmed with “emergency” surgeries and procedures at a time of low support from the rest of the hospital. The hospital can “shut down” because the Emergency will “pick up the slack.” Thus the Emergency serves the economic interests of the hospital, health care system, and society by providing a financial “safety valve”.

The Emergency unit also provides economic flexibility to the community and health care system by providing services that are required on a 24 hour basis, but are not available in the community. For example, as the police do not have resources suitable to monitoring people in custody who have taken drug overdoses, they bring prisoners into Emergency for surveillance. Similarly, when home care nurses, public health nurses, physicians, and other health care providers go home, the patients come to the Emergency. For example, if a person requires a dressing change outside of the hours of these other services, the patient is sent to the Emergency. Because of the flexibility and 24 hour availability, the Emergency also provides service to people who do not fit with existing services. Monica described this phenomenon.

People don’t have the support of their families or the church or whatever and a lot of the time they end up in Emergency because nobody knows what else to do with them. The Police bring them in because they don’t know what to do with them, or the Ambulance goes to the situation and they don’t really think this is a physical problem but they bring them in because they don’t know what else to do with them and therefore, it is becoming more and more frequent that we are the catchment area for people who are slipping through the hole some way or other.

All names used in this study are fictitious. Most participants chose their own code names.
Once in Emergency, patients are provided with immediate services or held in Emergency until other suitable services become available. For example, elderly patients are held if necessary until suitable home care services can be arranged; patients with psychiatric emergencies are held if necessary until suitable follow up can be arranged.

In relation to society, then, the Emergency provides the service of sorting and distributing society’s health and social problems. The Emergency unit is the nexus between most of the social and health care services available. About 85% of people seen in the Emergency are not connected to the rest of the hospital, but rather are returned home, and referred to other services as necessary. This function serves to sort problems and direct those problems to the most appropriate and cost effective service, and to protect the hospital’s resource-intensive services.

The Emergency unit is a major interface between the hospital, the community and the rest of society. The Emergency serves interests in these layers of the social context by sorting people and their problems and matching them with appropriate levels of care, providing direct services, regulating the pace of hospital patient intake, buffering the staffing requirements of both the community and hospital within specific and changing economic conditions, and providing employment which, in the case of physicians, may be lucrative. These various functions of the Emergency unit directly influence the nature of nursing practice in an Emergency setting, shaping the pace and patterns of practice and the relationships between nurses and patients, between nurses and other health care providers, and among nurses themselves, as individuals serve both their own interests and the collective interests of the hospital, community and society. The overriding interest served is that of containing the expenditure of health care resources.
An Ideology of Scarcity

A pervasive feature of the Emergency units studied was the way in which health care providers talked about resources and practice in relation to resources. The ideas and images of constraint, limited resources, cost-cutting, cutbacks, and so on pervaded conversation and influenced action. For example, on my first day of field work in one hospital a nurse talked extensively about the impact of cost constraint on care.

She said “there used to be a lot of pride in the community about the hospital”. She says that it has been very difficult as the hospital has a lot of long term employees, which she sees as one of its strengths, and that a number of people have been dismissed. She told me that the CEO has lost his job in the regionalization process and that she had difficulty understanding that, because the hospital has been within budget over the past years. She talked about the need for attention to quality as well as to cost constraint. She said that the hospital is being run like a business, but it is not a business. (Field Notes, April 1996)

Throughout field work and interviews, nurses in both study sites talked about the impact of various cutbacks, especially on their workload.

They [decision-makers] influence my practice by how effectively and efficiently the resources of the hospital are used, so if the beds are plugged up with patients who don’t need to be in the hospital, that impacts my day because the department is full and I might have less time to deal with something that I might want to spend more time on. (Susan, Emergency Nurse)

On most shifts one or more nurses were critical of the number of staff available. For example on one of my first shifts in one hospital, five different nurses made comments.

I joined Dorothy who said, “we’re short already”, looking with consternation at the white board on which staff assignments (and patient names and bed numbers) are written. Later in the shift, Lenore growled, “we don’t have time to do anything but the tasks, the workload is ridiculous”. She tells me that in the 11 years she has worked in Emergency, she has never seen it so bad (referring to the workload). She says she is very frustrated and that she writes notes daily to the Head Nurse, but the Head Nurse’s “hands are tied”. (Field Notes, April 1996)

The idea that nurses’ “hands are tied” in regard to resources and workload was commonplace, and several nurses expressed resignation to the economic conditions of scarcity.
Bo tells me that you become complacent. She says "I used to go home and think 'I didn't do this, I didn't do that', but now I just..." she shrugs. She says that she doesn't worry about obvious things, like did she take that patient off the bedpan, (she laughs at the idea) but less obvious things that might be missed. (Field Notes, April 1996)

Other nurses were acutely embarrassed about the level of care. For example, after a particularly busy shift,

Lenore is heading back to the man who had the endarterectomy to do her assessment, and so I tell her I will take my leave. She says "I'm sorry", and gestures back to the unit, which is crowded, noisy, crawling with people pushing various pieces of equipment about. I tell her not to be sorry, that this is exactly what I want to see. I see her in the chart room after I get my stuff from the lounge, and she is shaking her head and telling me she is sorry, again. I ask her why (I am truly stumped), and she says "you should see it the way it should be, not like this" (Field Notes, April 1996)

Similarly, after a shift with Dorothy during which I had to “pitch in”, she told me that she was embarrassed for herself, for the unit, for the institution.

Although the impact of scarcity was met with varying degrees of acceptance, ranging from resignation to anger, the idea of scarcity was generally accepted as fact. Nurses generally talked about constraint and cost cutting as given conditions, facts or reality, not as decisions that had been made. For example, Bo said

You’d like more staff and you’d like more participation but in reality there isn’t the money, you aren’t going to get the staff, so don’t spend the time whining and sniveling, it’s not going to be there. Just do the best you can with what you have.

Another nurse said “It’s money, it’s management, it’s things I can’t really argue with”. The idea that resources are scarce was accompanied by ideas that resources are finite and that, as Gloria Smith (1997) says, getting power means that someone else has less. One head nurse said

I think resources are tight, everyone knows that. How tight they are, who knows really, but access to them is difficult, let’s put it that way. And I think if you take resources, it is always at the cost of someone else, always. It means someone else doesn’t get something.

Messages about scarcity in health care come from multiple sources: the media, head nurses, administrators, co-workers, and so on. Awareness of the impact of resource decisions made at
the level of the state permeated the immediate context of practice. For example, in an early interview, another head nurse was discussing the possibilities for improving care in her unit. Facetiously, she said “We have 2.5% more money in health care now that the NDP [New Democratic Party] are back in government...That’s one year’s worth. They are probably going to cut us back by 10% next year, but they gave us 2.5% so they got back into government.”

Administrators and managers often promote the acceptance of scarce resources as a fact of life. For example, one Director seemed dismayed at the lack of acceptance by nurses. To do the best job with the resources that you have, that is what exemplary is. That’s I think what nurses aren’t able to do and that’s why I am really worried about where their thoughts are fiscally, like I have got a couple of them that are just wanting to quit because they can’t carry on and I am always saying to them “if this is our reality, if this is it, if we never get another nickel in the health care system, what is your plan B, what is it going to look like for you”. Some people will quit Nursing, some people will transfer to other areas of the hospital... But if you choose to stay in this environment with the resources that are here, how are you going to make it so that your practice is okay, and I can’t feel like I get the nurses to come to first base on that one.

The ideology of scarcity influences day-to-day decisions. Nurses must decide how to spend their time and how to spend other resources in the unit. The following situation illustrates some of the tensions around resource allocation.

The nurse was very concerned about her patient. He was infarcting. She called out for help. She needed someone to get morphine, some one to mix up TPA (a thrombolytic drug used for myocardial infarctions), someone to start a heparin drip... and there was only one other nurse about. I decided that the patient’s life was more important than my observations, so I offered to help. They told me to mix up the TPA, and I was in the midst of mixing up this $2000 worth of drugs (its complicated to mix) when the physician decided not to give it, because of the cost! The nurse came into the med room with the physician and we pointed out that the drug was already mixed, so that the money was spent. I took the drugs to the bedside and the drug was given. (Field Notes, April 1996)

The ideas and images of scarcity pervaded the discourse in the Emergency unit, and these ideas and images can be read in many of the interview excerpts throughout this study. Health care providers drew on these ideas and images to make decisions as they allocated their own
time, the time of others and the resources available. The patterns of practice aligned with
dominant interests through this ideology of scarcity.

The Pace and Patterns of Practice

The most striking characteristics of practice in the Emergency Units studied were
unpredictability, temporariness, and discontinuity. Despite the fact that the majority of patients
who come to the Emergency unit do so because of non-urgent problems, there was always a
sense of what could happen. Just moments away, just outside the double automatic doors is an
ambulance (or several) bearing victims of multiple trauma. Even when the unit is quiet (you
should never say the "Q" word), there is a sense of anticipation, of being prepared for anything.
The nurses are always watching; watching the doors, watching the triage area, watching the other
nurse's patients. Even when nurses are behind the curtains, they watch and listen for stretchers
going by, bringing another unknown.

As we are assessing the new patient, a stretcher wheels by. “Where did it go?” Dorothy
asks. “All the way to the end” I reply, (meaning it went to stretchers bays that she is not
responsible for). She smiles and comments that she is very attuned to that sound (stretchers
rolling by). She already has 4 other patients and has not even seen 2 of them yet. (Field
Notes, April 1996)

It is not merely the ever present possibility of cardiac arrest or a major trauma case that
creates this sense of impending chaos. The volume of work is as highly unpredictable as the
acuity and complexity of patients who may present, yet the number of staff is relatively static,
and staffing levels are adequate to manage average patient flow, not peak patient flow. One
minute there are only three patients on stretchers scattered throughout the 16 bed unit. The
nurses are quietly chatting and there are few other personnel to be seen, only the unit clerk
sorting lab results. Ten minutes later, most of the stretchers are full and there is a line-up at the
triage desk. There are ambulance attendants, physicians of various specialties, cardiac
technicians, porters, lab technicians, x-ray technicians, and admitting clerks bustling about the unit, most of them pushing equipment or carrying clip boards.

The three patients that were in the unit ten minutes ago are now lined up in the hall waiting for transfer, two with several friends or family members clustered about. A child is screaming from the first aid area, both phones are ringing at the desk, someone is yelling for a stat ECG in bed #9, and the police are having a scuffle with a man in handcuffs at the triage desk. Gradually the mayhem begins to subside. The patients in the hall are portered up to the ward, the police leave with their prisoner, and the nurses deal with the aftermath, and brace for the next onslaught.

The unpredictability creates a sense of constant vigilance and impending chaos, with which health care providers continuously grapple. The ways in which nurses attempt to gain some control over this unpredictability include quickly processing patients, and allocating the use of their own time, attempting to influence the rate at which others process patients, and attempting to influence the rate at which patients are discharged from the unit back to the community or into the hospital. These approaches all serve the interests of the hospital and health care system in allowing staffing levels to remain where they are, and accommodating cost-cutting measures.

The need to process patients quickly drives the nature of nursing practice and the relationships that nurses form with patients. As the patients are processed quickly, and the duration of stay in the Emergency is very brief, the relationships between patients and nurses are, of necessity, temporary and brief. In turn, the nurse’s ability to fulfill her role depends on the relationships being exactly that: temporary and brief. Therefore nurses employ strategies to maximize their use of time, to keep relationships focused on priorities and to keep relationships as brief as the current but variable workload demands.
Focusing on priorities also means focusing on the person with the presenting complaint. The triage nurse not only sorts patients, but also sorts family members, and tries to limit the demand family members will make on care resources. In one hospital, family members are discouraged from being in the Emergency if at all possible. For example, in the interaction described below the triage nurse attempts, unsuccessfully, to keep a woman from accompanying another woman who has a small child.

I return to the Triage area, where Jane is speaking to a woman (identified to me by Jane as "an abdominal pain") who is with a child of 2 or 3 years and another woman. The other woman (a sister of the patient, perhaps?) is saying that she wants to go in too. "No", Jane tells her, "there's not enough room." "But, you just don't know how she is, how she runs around!" the woman says, indicating the small child. Jane turns, looking exasperated and says in an angry tone, half to me, half to the two women who follow her "its just not worth arguing." (Field Notes, November, 1994)

Nurses often talked about keeping relationships limited and brief with mixed feelings. Serving the economic interests of the hospital and health care system created conflict with the nurses' own interests in providing the level of care they valued.

I get really angry when I don’t have the time to spend with the patients and yet, like I say, there are lots of times that I’m thinking “thank God they don’t want it”. I remember asking somebody, he had just been diagnosed with lung cancer and saying “do you want to talk about it” and he said “no, I’m not quite ready to talk about it” and honest to God I just said “thank God” because I had a gazillion other things to do. (Lenore, Emergency Nurse)

Similarly, Yvette recounted a story of the dilemma she faced in trying to balance the needs of a young man newly diagnosed with leukemia, and the needs of the unit.

There was a young fellow, a couple of years ago diagnosed with leukemia down there, first thing in the morning they wheeled him in... and told him what he had and he didn’t want me to leave. Of course you are torn because you’ve got a lot of other things to do and in many respects he is a priority but the way we worked down there is ABC, life-threatening, limb-threatening and he is neither of those but he still has to be a priority... I waited for while and then I said “do you want to be alone or do you still want me to stay until your family comes”, he was in his twenties and his parents were coming, “or can I get you a Social Worker or something”. I’m trying everything to get another body in there so I can get out and that’s wrong, but what do you do? No one else is doing first aid (or where ever else you are) while you are gone because they’ve got their own people and breaks continue on and I
know that is wrong, I mean breaks maybe could be canceled and it would be okay if the person involved just said “okay, I won’t go for break, I’ll stay with this person” but it affects the whole Department if you stay in there.

For some, the interests of the unit, hospital and health care system may overwhelm individual interests over time. After reading an initial draft of this study, one experienced Emergency nurse wrote

Many Emergency nurses I know make no attempt to establish any relationship with patients and families, even when time and opportunity presents. Many said that they would like to do it but found that it made them feel more dissatisfied with their role. Rather than feel guilty about not being able to connect all the time it was easier to remain constantly detached.

The complexity of providing nursing care under such conditions of variance and unpredictability yields patterns of work that create discontinuity; between nurses and other health care providers, among nurses, and between nurses and patients. The nurses’ work is primarily divided up according to the physical layout of the unit and the ebb and flow of activity. Nurses take responsibility for various areas, and these areas change with times of peak and low activity.

Although each Emergency unit is slightly different, there is usually an area for patients who require cardiac monitoring. The most acute patients, those who might have a cardiac arrest, are placed here. People with problems such as chest pain, GI (gastrointestinal) bleeding, respiratory distress are placed in these stretchers, and there may be a “trauma room” in which people with serious trauma, cardiac arrest, burns, and so on, are treated. Close by, there is usually another area for patients who require immediate attention, but are not at high risk of dying. People with abdominal pain, back pain, hip fractures and "the weak and dizzies" are put in this area. The first aid treatment of people with minor injuries, such as minor cuts and burns, headaches, sore joints and fractured limbs, is usually done in an area which is physically separate from the more acute areas. This first aid area is also often combined with or close to an area for the administration of
scheduled treatments such as IV antibiotics and blood transfusions, and non-scheduled minor treatments such as flu or tetanus shots, assessment of needle stick injuries, and so on. Sometimes these areas are called “fast track” areas, indicating that such minor treatments are dealt with in a streamlined manner to move as many patients through in as short a time as possible.

The physical layout of the Emergency is designed to foster efficiency in the management of physical problems, and to foster the greatest efficiency in managing chest pain. The ambulance entrance and charting station are usually proximate to the most acute areas. The layout usually facilities patient flow, from Triage and the ambulance entrance to the care areas, from the care areas to heavily used departments such as x-ray. The layout is also usually designed to optimize surveillance of patients. This is necessary so that changes in acuity can be seen readily and to permit as few nurses to manage as many patients as possible. The nurses’ station is usually central, with most stretchers visible from the station. Curtains around stretchers are traditionally left open when possible and some visual surveillance is possible even when curtains are drawn, as they are several feet from the ground. Surveillance of smells and sounds are always possible.

Nurses are assigned to the various areas, or to float between areas. Assignments change over the shift as the number of staff and patients change, with nurses starting their shifts at staggered hours throughout the day, and patient numbers increasing during evening hours. These arrangements are complicated by the need for nurses to take care of each others’ patients during coffee and meal breaks. Further, patients are often moved between areas or into a hall or overflow area as the volume of patients and mix of acuity changes. There is generally a charge nurse who oversees the patient and work flow and makes adjustments in the nursing assignments.

This system is usually effective in managing unpredictability and responding to changes as they occur. However, major crises such as severe bleeding, respiratory or cardiac arrest,
impending arrest, or serious aggression by patients require a different pattern of response. If something goes wrong, everyone “swarms”. When another nurse needs help, others are simply there. This means that each nurse who responds leaves her current task or patients unattended.

A new patient is admitted by stretcher. She is very elderly, frail, and VERY short of breath. Her breathing is quite labored, and she looks to me like she should be intubated. I help to get the woman’s nightgown off, and preserving privacy is a losing battle. We get a patient gown on as quickly as possible. Two ambulance attendants stand at the end of the bed, and other people (lab, respiratory, ECG, etc.) begin to arrive. As we work, three other nurses offer help. One gets the IV equipment and returns to help put in the IV; another gets foley catheter equipment, and the third goes to call the respiratory technician back to fix the flow meter. (Field Notes, April 1996)

One result of both the usual pattern of practice and “swarming” to deal with crises, is discontinuity. Many nurses may care for a given patient during even a brief stay; a given nurse may provide care to many patients in short period of time. Nurses are routinely responsible for five to ten stretchers, into which flow a continuous stream of patients. Nurses are also responsible for covering one another on breaks, and covering changing assignments. During a span of less than 2 hours, one nurse counted over 30 patients for whom she provided care in the first aid area. In order to manage this discontinuity, nurses employ various strategies such as blurring the boundaries of responsibility for individual patients, and helping each other out, reporting frequently to each other and using flow sheet-style charts to keep track of care. They also use verbal shorthand and various devices such as white boards and colour-coded charts to keep track of patients and their processing. The charge nurse and unit clerk usually play a significant role in facilitating the information flow. They continuously update the white board, relay phone messages, physician’s orders and information regarding what tasks have been done, summon required help, and generally keep things moving.

Unpredictability of workload, and temporariness and discontinuity in nurse-patient relationships characterize Emergency units. These characteristics are both a product of the
purpose and structure of Emergency units, and essential to achieving the purposes of Emergency. These characteristics arise in service of health care system and dominant economic interests, and are supported by an ideology of scarcity. Nurses both tailor their work to these characteristics, purposes, and interests, creating a predominant pattern of practice of efficient processing, and actively resist the impact of these characteristics on their relationships with patients.

The Predominant Pattern of Practice: Efficient Processing

In order to deal with the unpredictability of patient flow and acuity within relatively static resources, patients must be processed quickly and efficiently. Thus, as the prevailing feature of the Emergency unit is unpredictability, the prevailing feature of Emergency nurses’ practice appears to be efficiency. This requires quickly establishing and constantly reevaluating priorities. Priorities must be established, not only for individual patients, but between all the patients under a given nurse’s care, between all the patients under the care of nurses relieving one another for breaks, and ultimately, between all patients within the unit at any given time.

The predominant pattern of practice is thus one of efficient processing. The patient is stripped down to a manageable problem that can be quickly processed. In stripping the patient down, the person becomes a patient, and a recorded version of the person is created on the chart and other places such as the unit triage logs, white board, computer systems and so on. The manageable problem is processed and the stretchers are emptied as promptly as possible.

Stripping the Patient Down

The process of stripping the patient down, is both literal and figurative. The ultimate aim of this process is to reduce the patient to an identifiable problem that can be treated quickly and efficiently, and in relative priority with the rest of the patients/problems. The process begins at the triage desk.
People coming into Emergency first report to the triage desk, where the triage nurse asks a few questions and decides where to put the person or tells him or her to wait if no space is available. The initial triage process is accomplished quickly. Vail, a highly experienced Triage nurse said “I give every patient 60 seconds of quality time”. This may be a generous estimate at times, as the Emergency Log in her unit illustrates that often there is less than a minute between triaged patients. For example, of the 104 patients seen on one 12 hour day shift, the number of minutes between patients ranged from 0-19 minutes with numerous periods of intense activity, such as one period in which the triage nurse dealt with 11 patients in 18 minutes. Although there maybe longer periods of time between patients, patients often arrive several at a time.

The triage nurse performs an essential function in the efficient processing of patients. She generally asks the person what has brought him/her to Emergency. A typical interaction between a triage nurse and a person coming for care is as follows:

TN:  “Hi there, can I help you?”
Man  “I’ve got this rash here”
TN:  “Where is it?” (pause) “Oh, O.K. Can you have a seat over there and we’ll call you shortly. Probably 15 minutes.”

(Field Notes, June, 1996)

What is not evident in this excerpt is that in order to make the decision (“have a seat over there”) the triage nurse has assimilated and analyzed countless pieces of information. She has drawn inferences from the patient’s appearance and behaviour to make judgments regarding the possible problem and level of acuity. Even before the person speaks, his or her breathing, facial expression, posture, clothing, movements, and so on, are all taken in by the nurse and scanned for significance. Although on the surface the triage process is the beginning of information gathering, labeling and sorting, it is also much more. “Intervention” is simultaneous as the nurse communicates concern, support, competence and so on, all of which are aimed at allaying anxiety and providing support. One nurse said that despite the time constraints, “because they
are needing, you end up giving to them in order to make them feel safe, or comfortable, or ‘it’s going to be okay’, ‘we’ll work through it’, ‘I’ll let you know what’s happening’.”

Once a starting point has been established (usually the presenting complaint), the nurse asks further questions to narrow the problem to fit within categories which correspond to the areas of the Emergency (acute, less acute, first aid, and so on), which in turn correspond with varying levels of acuity. Problems are generally constructed in physical terms. A man comes to the desk holding a bloody rag to his hand and says “I cut my hand on a skill saw at work.”, before the triage nurse says anything. He is quickly categorized as a “laceration” and directed to the first aid area, and seen to be of relatively low priority. Another man arrives with abdominal pain. The nurse asks a few questions to rule out chest pain, and assigns him to the less acute stretchers.

Labeling and categorizing are not always so straightforward. People come with various complaints, some of which are vague, and some of which may indicate a wide variety of problems. Headaches, dizziness, fever, faintness, and so on, require more questions, judgment, and some guesswork. The labels and associated acuity are held as provisional, with the degree of certainty varying with the “index of suspicion” associated with each presenting complaint. A minor laceration is unlikely to be anything but a minor laceration, whereas chest pain can be anything from a mild flu to a ruptured aortic aneurysm. Chest pain associated with a cough carries a lower index of suspicion than chest pain following a Motor Vehicle Accident (MVA). A fractured arm carries a low index of suspicion, whereas a fractured pelvis is associated with a high index of suspicion for internal organ damage, hemorrhage and shock. Due to the tentative nature of the problem, many nurses “triage up”, referring to their conscious decision to err on the side of assigning patients to more acute areas than the presenting problem might suggest.
If the person arrives by ambulance and is acutely ill, the triage nurse often knows in advance that the person is coming. The patient may come “pre-labeled”, as ambulance attendants often phone ahead to say they are bringing “a chest pain”, an “MVA”, “an overdose”, or a “little old lady with a possible hip [fracture]”. The following interaction between Jane, a triage nurse, and an ambulance attendant is fairly typical.

I return to my perch as an ambulance attendant approaches the triage desk. “What'a ya got?” asks Jane. "Seizures" he replies. The ambulance attendant gives Jane the details of the patient and hands her a sheet of paper. Jane does not seem to want as much detail as she is getting. “OK”, she says, “put him in three”. (Field Notes, November 1994)

Patients are also often sent to the Emergency by physicians, and in these cases, are also pre-labeled either by someone from the physician’s office phoning ahead, or by the patient offering the labels and some implicit cues regarding the cause of his or her presenting problem. For example, one man said “I had my first chemotherapy last week and my bowels have been bleeding and my doctor said I should meet him here”. This man was quickly reduced to “lower GI bleed, on chemotherapy”, and assigned to the less acute stretchers.

The triage nurse deals with a great variety of people with a wide range of problems.

At the triage desk, Jane deals with a man with a shoulder injury from work, a man whose wife is being brought in by ambulance with a fractured hip and the ambulance attendant that accompanied her. Several other people stop to ask directions, to inquire about patients who are already in the Emergency or to visit....I sit and watch Jane handle a continuing stream of patients. A child with a sprained thumb, a scuba diver with ear squeeze, a woman with a severe migraine, and so on. The pattern is the same: a brief assessment, information to the clerk, assignment to a stretcher and on to the next person. (Field Notes, November, 1994)

Triage takes only a few minutes, sometimes because there are other patients waiting to be triaged. At other times there are no other patients waiting, but triage still consists of only a cursory sorting, possibly because the nurse anticipates the arrival of other patients, or because the rapid assessment of patients is simply the norm, and is congruent with an ideology of scarcity which includes images of time as being in short supply.
Triaging is a complicated process that determines both the care of the patient and the way in which care of that individual will contribute to the overall functioning of the unit. By being assigned to a particular area, care is to some extent predetermined because there is a preset nurse/patient ratio in each area. Furthermore, simply by his or her presence in a particular area, a patient is assumed to be of a certain level of acuity. Evidence of greater or lesser acuity is required in order for the patient to be moved, and moves are avoided if possible as they require time, not only to move the stretcher, but also to change the known location (e.g. bed #6) by which a given patient is identified.

What you perceive is going on with the person that presents themselves at that front desk often ends up as a direct result of how they are going to get cared for, and if you are too harassed with everything else going on you can’t do it efficiently. There have been some close calls you know, “maybe they should have been put on a monitor” kind of thing. It helps to make the rest of the department run smoother too because if the person is already where they are supposed to be then you are not shuffling around at the last minute and there is continuity, it is a little bit more efficient. (Faye, Emergency Nurse)

As Faye’s words suggest, although the triage process is critical, it often does not proceed smoothly. The triage nurse may have other duties as well, and sometimes there is not a nurse to do the job of triaging. In one hospital, there is no assigned triage nurse during most of the night shift. In another hospital, the triage duties are done by a nurse who is also in charge of the unit, and is often away from triage to manage problems as they arise. In both cases, the role often falls to the admitting clerks, who have varied backgrounds including secretarial work, accounting, and medical records. Whether the triage decisions are made by a highly experienced triage nurse, a novice nurse, an admitting clerk or unit clerk, the patient is assigned a label and associated level of acuity and sent to an area of the Emergency, or if the Emergency is full, sent to a waiting area, or left lying on an ambulance stretcher.
Waiting for service is the most common point of conflict between the members of the community who come for service, and the hospital. The interests of individuals and the interests of the hospital collide at the Triage desk around waiting time. If the Emergency is the primary interface between the hospital and the community, then the triage nurse is the pressure point in that interface. The nurse is the first and central point of contact between the community and the hospital, and thus the tensions between the two are embodied in her. The triage nurse deals with people who are frustrated by the length of the wait for service, and deals with differences in expectations that people have of the Emergency and the type of service delivered to them.

Yvette described the experience that I witnessed during most days of field work, and said that she thought that the physicians were often unaware of the extent of abuse nurses received.

There is unrest, you can feel it coming, it is like a wave of unrest, they start looking at their watches and saying “I only need this done, I don’t see what the hold up is” and you’ve already explained and you explain again “there is one physician, there is a large area over here with more acute conditions, the Doctors know that you are here and they will get to you”. They will tell you that’s not good enough, that’s not acceptable, they will tell you all kinds of things, they will be down right rude. The minute the physician walks in X number of hours later and says “sorry you’ve had to wait” because they generally do acknowledge that, “it’s all right Doctor” and you feel like racing in there and saying “No! it isn’t all right, you just swear at him like you swore at me because I can’t give you the Tylenol you want for your sore finger until the Doctor sees you”. So I don’t think they [the physicians] see that, whereas we think “come on, come on” because we are getting the abuse and they are not. I think the reason they are not is, it is okay to swear at a nurse because we really can’t prevent their care from being the best it can possibly be, but “if I swear at the Doctor he might walk away and not x-ray my finger”.

Various tensions that pre-exist in the community are exacerbated under the conditions of a visit to an Emergency. The patient and family are under added tension due to the health issue, and the nurse is under pressure if the Emergency is unable to provide service that either the nurse, or patient and family, think is adequate. Racial tensions are felt and openly expressed in relation to triage, and the triage nurse experiences and participates in these tensions as well. All the nurses in the study sites (with one exception or two exceptions), are Caucasian, whereas the
community each Emergency serves is incredibly diverse. Lenore described the way she saw members of a specific ethnic group in her community.

Everything is an emergency and it is an emergency right now. If they have a cut finger and they are not seen within five minutes they are up at the desk four times in five minutes and they also will sometimes say that the reason they are not being seen quicker is because they are [a visible ethnic group]. It is a racial thing, when in actuality, it isn’t. But, we need some helpful training on [their] culture.

Similarly, nurses in another hospital were annoyed by accusations of racism made by some people frustrated by the wait for services.

I find that the worst place for me to deal with it [accusations of racism] is out at triage, when I’m at the desk, because especially in the last couple of years, this hospital has always been extremely busy, there are always people lined up in the hallways. There are not enough beds, there is not enough staff, there are cutbacks and it is across the whole of Canada, the provinces. There is not a lot we can do about that, but it is hard to tell that to the relative of the patient sitting at your triage desk who you can not take into a bed. When we are trying to explain to them “as soon as I have somewhere to lie your father or mother down we will take you in” and then they come back at you and scream in your face that you are not letting their relative in because you are prejudiced and you don’t like the colour of their skin and all these things, it sort of takes you aback. It is really hard to come up with an appropriate response to that because it makes you angry, it makes me very angry.

Thus nurses ration health care resources in a context of racial tensions in the service of economic interests. Similarly, in at least one hospital that serves a sub-community of wealthy to very wealthy people, conflicts in expectations are played out at the triage desk. Many nurses said that they are given the message, from both individuals coming for services, and the hospital management, that wealthy individuals are to be served well. Thus the interests of the wealthy are to be served over others. One nurse described the attitudes of the wealthy clientele.

They are an educated community. They are a very demanding community. They hold a lot of power and they can cause a nurse a lot of trouble. They complain a lot about us if we don’t meet their needs....They have a very short wick. They like to be seen now rather than later, the majority of them. We have to learn to defuse them. We have to teach them that the Emergency is based on acuity, which they have a hard time with, because they have to pick up somebody from soccer... well so do the people at [a down town hospital] who wait two hours.
She went on to describe the messages she has had from management regarding dealing with these individuals:

We have allowed them, we have focused our attention on meeting their every need, because we are told to by management and the Head Nurse, “you can not refuse anybody, you have to have them seen, if there is a problem relay it on to the Head Nurse and/or [the President]”, or whatever. Basically, see them. Get them through, be polite and bite your tongue. That’s the truth, that’s the bottom line. There are some very rude obnoxious people that come into the Emergency Department demanding. There have been times that we have been told by [the Head Nurse] and [the Vice President] that there is a PR person coming through and that they should be seen first, whether it is acute or not acute. That is not all the time, but these situation arise because [this community] has a lot of money and the Board of Directors, etc. and that would never happen at [other hospitals without wealthy clientele].

Yet another nurse who had moved from an urban hospital to a community hospital described the difference in approach to wealthy patients, and the impact the difference has on patient care.

There was an immediate awareness for me when I moved over of how very, very much more... careful what you said, you had to be. Very much more careful how you phrased things, very much more careful about how you dealt with someone who was unhappy with the way they were being treated. In the first months that I was there I was absolutely amazed at the contortions that physicians would go through, and nursing would go through, but I’m thinking physicians, to keep someone [in this community] happy... I’m thinking primarily of the people who are in a higher socio-economic bracket who are listed on their face-sheet as being a lawyer or a doctor or a businessman or the manager of a company or the CEO of some oil company. The care and attention that they received was definitely different from what I had witnessed at [the urban hospital], for the same complaint.

Nurses do not necessarily accept overt pressure to serve the interests of the wealthy over other patients. Another nurse talked about how her attitudes to wealthy patients had changed.

Sometimes you almost feel like a servant rather than a professional person. “I pay my taxes so I have the right to be here, and what do you mean I have to wait an hour”. I tended not to be the type to treat them with total kid gloves. I was very diplomatic but I certainly made my point clear that while it is unfortunate that you are having to wait, but that’s JUST THE WAY IT IS. That comes from seasoning. The first 5 years or so you tend to be like, “okay” [meek, submissive tone], then once you break out of that first 5 years in Emergency its “who do they think they are? Just because they have 10 times more money than I have doesn’t mean that if I came here I would be treated any differently.
People cannot be “triaged away”. That is, people who come to the Emergency must be seen. This is so for a number of complex and inter-related reasons. First, as the nurses’ words above suggest, the patients themselves can exert a degree of pressure. The extent of this pressure varies between hospitals. One physician described the difference between the hospital he worked in and a hospital with a distinctly different clientele.

He said that here patients have high expectations of what the hospital can do, and sometimes the hospital can’t meet their expectations. He told me about asking a colleague from [an inner city hospital] if he ever got letters of complaint from patients. His colleague replied “they can’t read; they give us the finger on the way out, that’s how we know the service was unsatisfactory”. (Field Notes, 1996)

Second, as suggested above, pressure from patients may be supported by pressure from management. Third, the economics of physician’s work means that if patients with minor problems were triaged away, the physician’s easiest source of income would be depleted. And finally, the possibility of legal action following a person being inappropriately turned away makes everyone reluctant to encourage patients to go elsewhere. All that can be done is to make individuals with minor problems (at least those people who do not have sufficient power to make trouble) wait while staff deal with more serious problems.

If patients do not go away angry without being seen, or if they have problems which the triage nurse deems sufficiently urgent to be dealt with immediately, the patient is passed from triage to one of the areas. When the patient is taken by stretcher or wheelchair, or directed on foot, to the assigned stretcher, chair or waiting area, the patient’s assigned label is recorded on the white board, and accompanies him or her in one way or another. Sometimes the label is simply inferred by the area to which the person has been assigned, and the receiving nurse repeats the initial questions. Sometimes the triage nurse accompanies the patient, and tells the
receiving nurse what she has determined is the central problem, especially if she wants to alert
the nurse to some aspect of the patient's situation.

The process of categorizing the patient continues as the receiving nurse takes over care. As
the nurse becomes aware that she has a new patient, she is simultaneously assessing the situation,
primarily gauging the patient’s acuity and the urgency of dealing with the patient. If the triage
nurse is not with the patient, or alternatively, is not urgently summoning the army of technicians
and specialists to descend, then probably the person is not in dire straights. The mode of
transportation is often an indicator of acuity. A walking patient is someone who will be okay for
a few more minutes. If someone is coming by ambulance, the demeanor of the ambulance
attendants often suggests the degree of urgency. If the tension is palpable, the nurse drops what
she is doing; if the ambulance attendants are laughing and joking, she can carry on with what she
was doing (although the disposition of ambulance attendants may be more an estimate of their
impatience to “hand over” the patient than an estimate of patient acuity). Thus, prioritization of
the patient has been initiated by the triage nurse and is continued by the receiving nurse before
she has interacted with the patient. The receiving nurse continues the process of triage, now
weighing the patient’s relative priority in the context of the other patients under her care.
Triaging continues until the patient leaves the unit, with the patient’s provisional label and acuity
being constantly monitored and modified as information is gathered and the patient mix changes.

The nurse usually greets the patient as soon as possible, helps the person get on the stretcher
if necessary, and if no immediate action seems warranted, asks the person to undress and put on a
hospital gown. The formal nursing assessment then begins.

The nurse usually begins the assessment by doing vital signs and by asking questions
regarding whatever problem brought the person to the Emergency, which is either communicated
from the triaging process, reiterated by the patient, or reiterated by an ambulance attendant or family member. The nurse follows the “presenting complaint” along multiple lines of reasoning, asking questions around areas related either to the problem (based on her knowledge of what that problem is usually caused by or related to) or to the symptoms described or displayed by the patient. For example, if someone has abdominal pain, the nurse will ask for detailed descriptions of the pain: onset, duration, intensity, previous pain, and so on. Depending on the answers, she will move her questions along a line of reasoning about diet and bowel patterns, about blood pressure and circulation, about family history of specific problems, about related symptoms.

The lines of reasoning that the nurse follows are determined in part by the initial label that accompanies the patient and the way in which the patient frames the problem. For example, the triage nurse brought a woman to a stretcher and told the receiving nurse “renal colic”. The woman said that she had been to a clinic in the morning, that the doctor told her she had renal colic, that she had blood in her urine when it was tested at the clinic, and that she was here for an “x-ray”. The nurse assessing the woman asked questions about her pain and history of pain, but did not ask questions regarding other physiological systems, anticipating that the woman would have a specific diagnostic test and then be discharged.

The label that accompanies the patient may or may not outweigh the way in which the patient frames or explains the problem in terms of influencing the assessment.

Dorothy and I went behind the curtains. Dorothy began her assessment focusing on “what happened” to bring her to the unit. The woman told of her chest pain, and Dorothy began asking more details about the pain. While talking, Dorothy attached the woman to the EKG monitor and began to take her vital signs. When asked if she had had this sort of pain before, the woman said she had anxiety attacks before. (Field Notes, April 1996).
In this case, the woman’s implied explanation for her chest pain led to questions about the “anxiety attacks”, but the nurse completed a full physiological assessment and history, and the physician ordered the full diagnostic routine for chest pain.

Although the patient’s physiological label is provisional and open to revision, the label and the way in which the patient frames the problem may limit the way in which the problem is investigated. For example, Lulu told me the following story:

A woman came to Emergency with nausea and vomiting and pain in her back between her shoulder blades. The woman said that she had become ill while eating a salmon supper and thought that she had food poisoning. The triage nurse put her in a subacute stretcher, and the nurses continued to deal with the woman as though she had food poisoning.

The way in which the patient problems are defined depend on more than just the presenting complaint and the way in which the person frames the problem. In addition, assumptions regarding the person are made on the basis of the appearance of the person, and often those assumptions are related to the person’s perceived age, gender, class, sexual orientation, “race”, and so on. For example, Lulu went on to tell how subtle gender bias influenced the care of the woman provisionally labeled as “food poisoning”.

However, the physician ordered an ECG that confirmed the woman was having an acute MI. The woman was having the typical symptoms of a woman having an MI, but we are trained to associate midsternal chest pain with cardiac pain, because the research on MI’s has been done on men.

In this situation, the woman offered an explanation for her symptoms, and her gender influenced perhaps her own interpretation of the symptoms and the nurses’ interpretation.

Patient characteristics can also influence the way in which nurses interact with patients. Some patients are acutely aware of the influence of their personal characteristics on the care they receive. For example, one man who was receiving IV antibiotics had been in hospital for
extended periods of time following a motorcycle accident a year earlier. His experience in hospital led him to his ideas about the way nurses treat patients.

He was about 28 or 30, with longish, slicked-back brown hair. He wore a short sleeved Harley Davidson T-shirt which exposed a tattoo that covered his entire left arm, and was split by an enormous scar running the length of his arm....When I told him about my study he told me that how nurses act is important. "Nurses can just cut people off" he said....He told me about his experiences with nurses, how nurses not listening "built up a rage" in him, and how a nurse with a little humour could make such a difference. He said that he thought how nurses treated people depended on appearances. He said that he thought a lot of nurses saw his tattoo and thought he was a wild guy. (Field Notes, November, 1994)

Nurses’ willingness to ask certain questions also varied with how they perceived the patient. For example, in one hospital, several nurses explained that patients who are “obnoxious” are dealt with using “P.R.” skills, a situation one nurse described as “a bit different than how we would deal with obnoxious at [an urban hospital].” Similarly, the level of comfort that nurses experienced in asking alcohol and drug screening questions seemed to vary not only between nurses, but also with the characteristics of individual patients. Nurses seemed more comfortable asking difficult questions of certain patients than of others. I shared these observations with Anne, and she said “As far as being more reluctant to question these [wealthy] people, yes ....... If I stop my practice that way it would be because I am a little less comfortable, whereas with Native women I’m comfortable.” Thus it seems that certain people are more open to scrutiny than others, and that this openness to scrutiny is associated with perceived social standing in relation to the nurse.

Behaviours and symptoms are attended to and interpreted within the nurses’ particular frame of reference, so that the problems identified and the revisions to labels are shaped and limited. For example, Helen, a social worker, said that she has learned to be cautious of nurse’s referrals regarding suspected child abuse in “non-traditional” families.

There have been a couple of situations where I have felt the nurses were judging parents harshly because they weren’t traditional parents and I did not feel it was appropriate for me
to go in and do child abuse interviews because they were scolding or inappropriate in terms of their tone of voice with the nurse or what have you. They are not middle class, traditional parents and so the nurses immediately feel maybe that the children are at risk.

Similarly, throughout this study, I observed, and nurses told me about attitudes toward people who use alcohol, and how those attitudes influenced care. For example, Lindsay described the dynamics I often observed

There are people who are, I shouldn’t say cruel, but they are not nice to drunk people and that’s not their fault. It’s just “here give me your arm, take that IV and” (making a violent stabbing motion). They fight. “Well this is your own problem”. You just think “it is time to get out of Emergency Nursing I think dear”.

Both nurses and other health care providers told me that if a person is thought to be drunk, other health problems may not be considered. For example, one woman presented by saying that she had passed out and seized. She admitted an alcohol problem, and had been drinking, but was quite lucid and able to carry on intelligent conversation (we had one about Jazz music). Despite insistence by the woman (and the friend who accompanied her) that she had only two glasses of wine, and that this was very unusual for her (she said she could drink 10 times as much without passing out), explanations other than intoxication were not pursued, and she was discharged.

In addition to alcohol abuse, other behaviours and health problems were seen to commonly lead to unfavourable judgments by nurses. For example, Susanna was very angry about the treatment that certain patients received. She said that young women with PID (Pelvic Inflammatory Disease) continue to be treated like “sluts and drug abusers”. When I asked her what that treatment was, she answered

...They’re not, they’re not given the drugs they need, or the pain management. And everything is brushed off... We’re punishing them by denying treatment... Even talking to them. It’s a tone in your voice, that you’re not worth talking to.

Sooner or later, the nurse will turn to completing the assessment form which is organized by physiological systems. For example in one hospital, there is an initial section for the history of
the presenting concern and "pertinent medical/surgical/psych" history, a section for vital signs and "A irway, B reathing, C irculation", a section for drugs and eight sections divided by physiological systems. In addition there is a section of questions on chemical dependency and another section called "psychosocial and ADL's" (activities of daily living).

Each nurse has her own style of assessment. Some do not overtly use the assessment form, but ask questions "freestyle" in a fairly informal manner and later complete the form. Some nurses ask the questions almost verbatim, and record on the form as they proceed. Although all nurses modify the questions to suit the individual patient, some nurses adhere to the structure of the form more than others. Depending on the acuity of the patient, how busy the unit is, the style of the nurse, and the style of the patient, the nurse may complete the assessment in the context of a fairly social, relaxed relationship, or in the context of a brisk, business-like interaction.

There may be some variations between nurses in regard to the extent to which they will deviate from the assessment prescribed by the Emergency nursing form. However, most nurses felt strongly compelled to complete the form regardless of appropriateness to the situation. Bo told me "we resent all of the questions", and went on to tell me of her disgust at having to ask questions that she felt were inappropriate. When I asked why she asked the questions, she replied "Because they are on the nurse's notes, the ward wants us to have this done so that when they get up there they have an accurate evaluation (I can understand it) of who this patient is."

Another nurse speculated that a court case had prompted the initiation of alcohol and drug screening. Yet another nurse told me that she asks alcohol and drug screening questions, but "I get really choked at doing them because I know this information isn't going anywhere". She said that she asks the questions only "because we are held negligent if we do not." Thus in the assessment, the interests of the hospital are served over the interests of the patient and nurse.
In first aid areas, it is permissible to use a different form which does not require the same extensive questioning. Here, nurses abbreviate questioning and focus more on the presenting concern. For example, a person with a simple laceration may not be asked any questions except, "are you allergic to anything?" Similarly, in a unit where all patients were asked alcohol and drug dependency questions, nurses did not ask the questions in first aid unless the patient was going for surgery or being admitted, suggesting that screening is not primarily intended to better serve all patients, but rather to better serve the hospital and health care providers' interests in preventing problems with admitted patients, problems that require resources.

In the same way that triage may not proceed smoothly, assessment may be disrupted. If possible, one nurse does a patient's initial assessment, but due to the discontinuity in the unit, this may not be workable. Interruptions are common due to more urgent priorities, the arrival of sicker patients, the need to go on breaks, or the arrival of other health care personnel. However, due to the uniform nature of the assessment, this generally poses little difficulty, and a second nurse is readily able to continue where the first ended.

By the time the nurse has completed the assessment, she has confirmed, modified, or rejected and replaced, the triage nurse's initial physiological label and categorization of acuity. The nurse has created certain knowledge about the person within specific time constraints, and under conditions of unpredictability and discontinuity. The patient is reduced to a (more) manageable problem and the nurse has created knowledge for herself, on which to guide her actions, and created knowledge for the physician, on which he may base his actions.

The Manageable Problem

Rendering the patient a manageable problem enables the work of nursing to be done, enables the physician's work to be done, and facilitates interaction with the rest of the hospital.
However, nurses produce different, albeit overlapping, knowledge for these different purposes in a manner similar to that described by Street (1992). Street described how nurses on general wards produced different knowledge for their own and other nurses’ use than for physician’s use. One of the nurses in the present study noted,

...what I’m getting from a patient, the doctors might not even want [to know], they probably don’t care what is happening in the home unless it actually relates to a physical illness, which is to some extent our focus. (Lenore, Emergency Nurse)

The extent to which the physicians use and appreciate nurses’ information gathering is highly variable. Some physicians abruptly interrupt nurses’ assessments and disregard their information entirely, whereas others treat the nurses as partners. Lenore said that at least some of the physicians “are threatened and offended if you make decision, or do really accurate assessments before they have done theirs”. In contrast, Dr. Morgan shook his head and said “Thank God some one is doing an assessment! Thank God for nurses!” when Dorothy discovered that a patient with abdominal distention had cancer and was receiving chemotherapy, facts that Dr. Morgan missed on his initial assessment.

As in Street’s observations, the knowledge created by the Emergency nurses for physicians’ use is primarily recorded on the chart; the knowledge produced for nurses’ work is primarily communicated orally. The knowledge committed to the hospital record is permanent, official, legal, and thus appears more legitimate and valued than the knowledge that is temporarily recorded in the nurses’ minds.

In stripping the patient down to a manageable problem, a certain type of knowledge about the patient is created; certain aspects of the patient are rendered visible, certain aspects are rendered invisible. The knowledge that is created regarding the Emergency patient is confined primarily to physiological problems, problems for which Emergency personnel have solutions.
In a study of practices in the intensive care unit (ICU), a group of nurses “recognized that
the prevailing feature of their work was the subtle, yet powerful requisite to perform tasks which
enabled the appropriate documentation” (A. Henderson, 1994, p. 937). Henderson says that in
the intensive care unit, the documentation process

separates the body into physical components which can be measured. This knowledge has
not only empowered particular kinds of practice, but has also invented a new patient, that is,
the 'recorded body'; a body about which little is known at an emotional level but everything
at a biochemical and physiological level (p. 938).

This “recorded body” is also constructed in the Emergency unit to facilitate consistent definition
of the problem, efficient processing, and use of available resources.

**The Recorded Body**

The recorded body in the Emergency unit is uniform and, as in the ICU, is predominantly a
physical and biochemical body. It is uniform in that nurses ask all the questions of all patients in
much the same manner, despite nurses’ varied styles and some variations due to time constraints.
Differences between patients can be seen mostly in terms of absences, in that some areas are not
completed as thoroughly as others. Nurses felt compelled to complete the assessment according
to the requirements implied by the form, and sanctions are applied by nurses on each other for
failing to complete the form. Emergency nurses let each other know when they have not met the
standard, and ward nurses will phone back to complain, or complain through their head nurses if
assessments are incomplete. For example, in one hospital, other head nurses and managers took
the Emergency head nurse to task regarding the failure of the Emergency nurses to comply with
the standard of completing the alcohol and drug screen on all patients.

Although unique historical events may explain the presence or absence of a given category
on a particular Emergency admission chart, the recorded body is also more or less uniform
between Emergency Units in different hospitals, as it is characterized by the predominance of
physical and biochemical aspects of the person. The social and emotional aspects of the recorded body in the Emergency department are largely absent.

The typical Emergency assessment form allocates very little space to non-physical aspects of the person. One hospital's form had only three places where nurses could enter non-physical data; of a four page assessment document, one line was allocated for "presenting complaint", one line for "history leading to presenting complaint" and eight lines for "nursing problems identified and interventions". Even when space is allocated to non-physical concerns, the available space may include inherent limitations to the type of data allowed. For example, one form had a line for "Living Situation" accompanied by a single box to specify "care facility". The only times I observed inquiries being made regarding a person's living situation were situations in which the patient was elderly or had an obvious serious physical challenge.

Physiological labels are used almost exclusively. Those people who are brought to Emergency because they are drunk or under the influence of drugs, are assigned physiological labels such as "drug overdose" or "alcoholic" (although they may be referred to by other labels such as "bed 6"). In situations where the person's "presenting complaint" is clearly not physical, a psychiatric label is applied if possible, which is often automatic for people who come to the Emergency pre-labeled as psychiatric problems. In fact, in several hospitals a symbol that looks like a devil's fork (Ψ) is put on the white board beside every "psych" patient's name. In one hospital, applying a psychiatric label means switching to another assessment form and referring to psychiatry. In another hospital, it means referring the patient immediately to another service, that of the psychiatric nurses who work specifically with Emergency patients.

The assessment forms also betray the assumption of a dominant ideology. For example, under "Cultural/spiritual needs" on one assessment form, there is a question that reads "what
practices, religious customs/rites or health beliefs are important for us to consider in your care?"
Under this question are two options: "none" (a check box), and "specify" (an empty line). What is interesting for me is that the possibility of "none" exists. As no person could be devoid of beliefs relative to health, the only analysis I can make is that "none" implies the message "nothing different from what you normally would expect". In congruence with the purposes of Emergency and the patterns of practice, even when spaces for non-physical aspects of the person are available, the nurses rarely ask the questions. In my months of observation in the setting in which that form was used, I only heard questions regarding cultural or religious beliefs being asked in a couple of instances; in both situations the patient did not have white skin.

The forms are also tailored to other specific anticipated problems. For example, on most Emergency assessment forms, the list of "personal belongings" is confined to such items as dentures, braces, and hearing aids, suggesting specific instances of the loss of such items belonging to elderly persons. Thus, the recorded body in the Emergency makes visible those aspects of the person necessary for health care providers to complete their work within the legal and economic constraints of practice, and makes visible those aspects of the person that are amenable to the physicians' repertoire of interventions.

Creating the Recorded Body. The process of creating the recorded body, while serving to construct the patient as a manageable problem, also constructs and confines the nurse-patient relationship in a particular manner. First, the nurse is the instrument of surveillance for the physician and the hospital and thus serves the interests of the physician and hospital. Second, the nurse's efforts must necessarily be on the production of "legitimate" knowledge for documentation and in support of physician's work.
As an instrument of surveillance, nurses enact not only their own professional gaze, but also enact the gaze of other health care providers, most importantly, the physician. The act of assessing constructs the nurse-patient relationship in a particular manner. The nurse assumes a position that Hartrick calls "a stance of knowing" (1995, p. 139), while the patient is positioned in a passive stance. Armed with the barrage of preset questions, the nurse interrogates the patient in specific areas, and the constraints of time and unpredictability do not allow for much deviation from the proscribed agenda. It is important to note that while patients are positioned as passive by the assessment process, they do not always accept this position. During field work patients often evaded questions and occasionally I heard patients ask nurses why they needed to know specific information. On one occasion, an elderly woman who was in respiratory distress snapped at the nurse who was trying to speed up the assessment.

We go to check an elderly lady with severe CHF, who we have heard in report we "aren't doing anything for" because she has renal failure. The woman is on Star Wars O₂, and Shelby has grumbled in report about “depressing her respiratory drive.” We proceed to do a lot of this "nothing" as Shelby does her own assessment, sorts her out in the bed, makes her comfortable, digs her nightgown and underwear out of the bedclothes and spends about 10 minutes trying to figure out if she needs anything for pain. Shelby is also trying to figure out if she has responded to Lasix which she has been given. The woman is feisty. "You're asking me too many questions" she says.

In order to create the required knowledge, nurses must use various tactics to keep patients “on track” during the assessment. The necessity of keeping to the required knowledge varies with the other demands of the unit, and with the individual nurse. Some nurses use a brisk, business-like manner to discourage conversation; some ignore openings; some use body language to discourage interaction. Nurses cite the lack of time and the emotional cost of involvement as reasons for limiting interaction with patients. For example, Bo talked about her conscious use of techniques to keep patients focused:

...Open ended questions, all this kind of stuff we took years ago, that we don’t have to do now because we can manipulate answers out of patients. One word answers like you’ve
never seen. But feelings, senses, that’s another story, ‘cause that involves time and it involves an investment on your part. It involves an investment and I think that as an Emergency nurse I have learned, finally, as I’ve just said to you, I am protective now of myself. I am not prepared to give as much as I used to, and I’m certainly not proud of it, but it is safer...I’m not prepared to be bitten, for a little while. I may never be prepared.

Some nurses talk to patients much more extensively than is required for the completion of the assessment form, and consequently, co-workers apply sanctions. Lenore, an experienced, efficient nurse enjoyed the approval of her co-workers, and talked about those nurses whom others believe spend too much time talking to patients:

If you see somebody who is spending half an hour talking to a patient it is like “damn, do you think you could tell her that she has got two new patients, she doesn’t have the time to sit and talk to these patients”.

Nurses who spend too much time with patients get the message that they are slow, and other staff withhold approval. On my first shift with a nurse, I was impressed by the thoughtful explanations she gave patients as she completed assessments. When I shared my observations,

Shelby minimized the compliment, saying that she is too long winded, she gets too carried away. She also told me that she loves that part, she loves the physiology and she can see the patient's anxiety go down when she explains things to them. She said that she has only been here a few years, and that she had real trouble when she first started, because she spent too much time with the patients. (Field Notes, July 1996)

Later that morning, in conversation with a much more experienced nurse,

Shelby makes reference to herself as an Emergency nurse, and tells me that she was real slow when she started "Wasn't I?" she asks of the other nurse. She adds that she has improved a lot. She tells me that she was "really green". The other nurse is apparently relishing the role of "old dog", but does not readily agree that there has been improvement. (Field Notes, July 1996)

In producing knowledge that serves the interests of the hospital and physician, the interests of the nurse are only partially served. A. Henderson (1994) asserts that

The increasing knowledge that the nurse has about the biochemical and physiological status of the patient means that the nurse has power in being able to decipher the chart on which much attention is focused by health care professionals. The knowledge is however, not powerful for the development of the meaningful nurse-patient relationship. The 'recorded
body’ is deficient in a social and emotional sense. This objective knowledge serves to reduce the power of the nurse in relation to the traditional role of ‘caring’ (p. 938).

In the Emergency unit, a “meaningful relationship” may be counter productive to the purposes of the unit, and to the efficient processing of patients.

In Emergency, the recorded body serves to facilitate the construction of the patient as a problem that can be managed efficiently, and contributes to the analysis, understanding, and treatment of the patient as a physical problem. The recorded body in Emergency is emotionally and socially impoverished, and thus does not provide a basis for analyzing, understanding, or responding to non-physical problems. The cases in which emotional or social aspects of a person must be known are those in which health care providers anticipate the person will be different from the “norm”, most notably in terms of culture, or independence due to age or ability.

**Enlisting Support in Creating the Manageable Problem.** The nurse is not alone in the process of enacting the professional gaze to create this recorded body, this manageable problem. An army of technicians, admitting clerks, and various other health care providers also descend on the patient at various times, depending on the patient’s condition. However, one of the most interesting collaborators in enacting the professional gaze is the patients’ family.

In one hospital, a family member or friend usually accompanies the patient, or joins the patient after the admitting clerk obtains the required information. In another hospital, the staff actively limit family members from coming into the Emergency. However, it is most often the nurse who recruits and enlists the collaboration of the patient’s family in enacting the penetrating gaze of the army of health care professionals. (Yes, the military metaphor is intentional, if somewhat overdone). The following seemingly harmless interaction illustrates the interplay between the nurse, patient, and family member as the wife (in this case) works with the nurse to create a more “accurate” account of the patient.
I had a gentleman come in and he was [a member of a not-white Muslim group] and his wife and between the two of them they needed to converse because his English wasn’t very good and the wife was doing a lot of the translating. I had said to him “do you smoke”, “yes I smoke”, “how much do you smoke” and he said “maybe 10 a day” and then there was long discussion between the husband and wife and they were sort of laughing at one another and then he said to me “maybe it is more like a pack a day”, she was saying “listen you know you smoke more than 10 a day”, I’m sure that’s what she was saying “it’s more than 10 a day, come on”. (Monica, Emergency Nurse)

Nurses, and other health care professionals, routinely solicit family member’s information about the patient, with the input of the family member varying with his or her relationship to the patient, the condition of the patient and the frame of reference of the health care provider. If the patient is feeling unwell due to pain, nausea, dizziness, and so on, or is unable to verbalize for any reason ranging from having his or her mouth occupied with a thermometer or oxygen mask, to being unconscious, the family member may be the primary source of information. If the patient is dependent on the family member, as in the case of a dependent child, or elder, the family member may also take a more predominant role. This role may or may not be wanted by the patient, and the family member’s information may or may not conflict with the patient’s information. One Emergency nurse observed that in the case of a woman patient,

Docs may immediately move with the husband of the patient and ignore the woman as a source of knowledge. Also if the patient takes too long to answer, [she] will be passed over to family as a more efficient source for gathering information.

Nurses are the central figures in enacting a process that quickly transforms the person who comes to the Emergency into a “patient”. The patient is stripped down to a physiological problem that can be labeled, further investigated and refined, and ultimately managed. To facilitate this transformation, the recorded body is created; a body that makes visible those aspects of the person required for the management of the physiological problem. The nurse delivers the patient, stripped down; literally, on a stretcher with a hospital gown and draw sheet in place, and figuratively, in the form of the recorded body. This manageable problem, its
necessary aspects made visible, is delivered to the physician for further assessment, refinement of
the problem, and the devising of management solutions that will enable the efficient processing
of the patient to continue.

**Processing the Patient**

Once the person has been turned into a patient and reduced to a manageable problem, the
patient is ready for processing. Once the nurse’s initial assessment is complete, if no immediate
actions are required, the nurse tells the patient what other investigations will be done, what
technicians will arrive, and that the next step is for the physician to see him or her. The nurse
often gives the patient an estimate of time for the physician’s assessment, especially if he is quite
busy. The nurse tells the patient how to summon her, and carries on to her next patient or task.

Based on her assessment, the nurse may need to intervene immediately. Because the
assessment and problems are primarily physical, interventions are also physiologically oriented.
Common interventions by the nurse prior to the physician’s arrival include administering
oxygen, starting an IV, and obtaining certain diagnostic tests, such as blood work or urinalysis.
The nurse completes these interventions within the context of her other patients’ priorities, and
may intervene at once or interrupt her work with one person to attend to other patients or tasks.
The nurse may also seek specific orders from the physician, alert him to some particular aspect of
the patient, or advise him if the patient should be seen sooner than the usual process dictates.

A brief hiatus may occur in the processing of the patient between the nurse’s initial
assessment and intervention, and the physician’s assessment. Once the physician has seen the
patient, another flurry of activity may follow. The physician will order more tests, order
treatments, and/or order the patient to be admitted to the hospital or to be discharged, all of
which create particular work for the nurse.
Nurses process patients within a network of relationships, each of which involves the enactment of power. The nurses’ work is often interrupted by the appearance of various technicians, and the physicians. Most often, the nurse will quickly interrupt her work, do another task or something else for another patient, and come back when the other health care provider is finished. On some occasions, the nurse will see her work as a higher priority and will delay the technician, or less often, the physician.

Dr. T. comes by, asks what the oxygen saturation is (its 83%) and gives some orders, lab, oxygen, foley catheter, x-ray. I can see that most of these orders have been initiated by someone else anyway (the unit clerk? the charge nurse?). Bo tells the lab or x-ray technicians to hold on, that she thinks she should get the IV in first. I agree (and say so) as I don’t think this woman is going to last long the way she is breathing; she needs some Lasix, etc. to relieve her. Bo tries to start the IV, and the poor woman is getting more and more anxious. Bo calls another nurse over to help her with the IV. I back off, as the stretcher is getting very crowded, and the woman’s eyes are getting close to panic. Bo looks up at the scene and says, “I think we have too many people here” and asks people who are not doing anything to back off. (Field Notes, April 1996)

The nurse processes an individual patient while attempting to maintain a balance between the demands of processing the other patients for whom she assumes responsibility in her ever-changing work assignment. This requires that the nurse communicate to patients in various ways their status in terms of her priorities. Nurses accomplish this by telling patients when they will be able to deal with their concerns, letting patients overhear conversations that indicate the nurses’ “busy-ness” and by using body language to let the patients know how busy they are. Lenore told me the following story about a situation in which she was trying to admit three patients with chest pain all at the same time. In this situation she became aware of how the body language she uses to communicate her busy-ness had spread beyond her conscious intentions.

So I am running around trying to get everything done, the whole assessment, ECG’s, the IV’s, the nitro, everything, and my stable patient in bed 8 says “you know I haven’t eaten all day, do you think I could have a sandwich” and I said “yup, sure I’ll get on it just as soon as I can”, I said. “I’m really busy but I’ll get to it as soon as I can”. Well after I got everybody stabilized, their IV’s, everything like that, I thought that guy wants a sandwich, so I went and got a sandwich and some juice from the kitchen and I came screaming over and said “I
guess I should get you a bedside table”, and he looked up at me and said “how about some bedside manner”. I almost started to cry.... I knew what I had said to him so I knew I hadn’t been rude. I didn’t realize how much my non-verbal speaks to them and I’m sure that is what he was picking up on. So now I try to be really, really careful about even how I say things to people, but I’m pretty sure when it gets really busy it comes through.... I mean we do intentionally send messages like that but there are times when we are unintentionally sending it. (Lenore, Emergency Nurse).

Patients are also processed within blurred boundaries of responsibility. Although a nurse is assigned to a particular area or set of stretchers, her assignment changes as staff come on and off shift, as breaks are managed, and as changing acuity demands. Thus a given patient may be under the care of many different nurses during an Emergency stay. Although most of this is managed by verbal reports between nurses and by charge nurses and unit clerks keeping track of patients and information, some patients and problems “fall between the cracks”. For example, one head nurse told me the following story:

An elderly woman who came in with abdominal pain was discharged during the night. Because she was drowsy from Demerol, she was sent home by ambulance. The next day, the head nurse phoned her home because the abdominal x-ray revealed free air. Her husband said she had been asleep since being in the hospital. As he was unable to awaken her, the head nurse called an ambulance. The woman was re-admitted, hypotensive and unconscious, with a ruptured bowel. When the head nurse tried to retrace the woman’s care, she found that although each of the three nurses on shift had either given the woman Demerol, asked her if her pain was better, given her water, and given her a bedpan, no one had actually taken her blood pressure or done a reassessment that would have identified her drowsiness as a consequence of hypotension rather than a consequence of the Demerol she had received. (Field Notes, November 1996)

The majority of patients have problems that can be easily identified and the interventions are known and proscribed. Although people bring complex health issues to the Emergency, the mandate of the Emergency is to deal with the particular issue that initiated the visit, rather than to deal with the person’s overall health. For example, “frequent flyers” (the term used for people who come repeatedly to Emergency) who come with drug overdoses are given oxygen, perhaps a dose of Narcan, some IV fluids and vitamins, and bus money. Similarly, people having
myocardial infarctions are given thrombolytic drugs, oxygen, and morphine, and a stretcher ride to the ICU. Once Emergency staff have identified the problem, initiated treatment, and decided where to send the patient, their job is complete, and all that remains is to empty the stretcher.

Emptying the Stretchers

Because the flow of people from the community to the Emergency is relentless, the primary goal of care, in the interests of the hospital, health care system and work of health care providers, is to keep patients moving through. People are either discharged or admitted to the hospital. The "output" of patients from the unit is an aspect of the patient flow that the nurses are continually seeking to influence. They discharge patients as quickly as possible, hound the doctors to discharge and admit, and use various means to influence the speed with which patients can be transferred to the wards.

About 85% of patients are simply discharged home. The immediate problem is dealt with, and they are returned home, sometimes with referrals to other services in the community. The brief and temporary nature of the Emergency unit interaction limits attention to the causes of problems and prevention of recurrence. If there is time, the physician or nurse may give some teaching around prevention. For example, a patient with abdominal pain that is determined to be due to constipation may be given some bowel management information and advice to follow up with his or her family physician, but generally health care providers focus on the single most immediate problem.

I think you constantly, without thinking of it, try to make a safety valve. If this one can get in and out, I mean you are not trying to not do what they need, but I don’t think you are approaching them from this total patient care that we learned. It is like you come in with your abdominal pain, we will fix your abdominal pain, at least rule out that there is nothing wrong or fix it if there is, and then you will go home. (Yvette, Emergency Nurse)
Some patients, most notably elderly people, or people requiring care at home, require discharge planning for quick discharge, and therefore many Emergency units have social workers who can activate a “Quick Response Program” to put community resources in place to facilitate rapid return to the community.

Often, the physician may see the patient and tell the person that he or she can go home immediately. The physician may or may not communicate this to the nurse. It is not unusual for a nurse to simply find one of her assigned stretchers empty. This causes two problems. First, the nurse will not know what happened, and whether or not the patient was actually discharged. An empty stretcher may mean the patient is in a bathroom, or elsewhere and may be in danger, or that the patient has gone home without anyone’s knowledge. The nurse must find out in order to complete the chart and actually consider the stretcher empty.

Second, the nurse may have different ideas regarding the patient’s readiness for discharge. Dorothy told me that often the physician may discharge an elderly person before she has a chance to consult the social worker. “The physician may say the patient can go home, but can they? They may be able to physically, but can they? Can they manage at home?” Nurses attempt to manage these discharge problems by keeping an eye out for escaping patients, by asking the physicians for updates, and by taking action before the physician has seen the patient.

Around 12-15% of patients are admitted to the hospital. Admission depends on bed availability, the management of which is a complex process. Natasha, an admitting clerk explained that when she comes on in the evening, there will often be patients who have been waiting all day for beds. This practice arises because admitting clerks, like nurses, try to be prepared for the “what ifs”, the unknown.

Working days... sometimes you tend to hold back a little bit to see what else is going to happen. But when I come on [evenings], it all goes. Everybody is going to get placed and
then if we don’t have any beds then at least I’ll know. I keep certain things aside, 1 ICU bed and the telemetry bed for what comes in through the evening.

Patients will get beds depending on the availability of certain kinds of beds, and whether the type of bed matches their problem. If there are no beds available, nurses move the patient to a holding area (if the Emergency has one) or, more likely, the hall, until a bed becomes available.

Once a patient gets admitted and they are waiting for a bed, if the bed is available then the patient goes up right away and the place stays, the beds stay, available for the person coming in through the front door. But if the beds upstairs are full or they are waiting to discharge people it just backlogs back down to the Emergency Department. That’s why you end up with all the people waiting around downstairs. (Faye, Emergency Nurse)

Admitted patients remaining in the Emergency department strain the Emergency staff in several ways. First, the admitted patient over time requires different care than what the Emergency is able to provide, which causes staff moral distress regarding the adequacy of the care provided. Patients may require feeding (for which there are no personnel), baths (for which there are neither personnel nor privacy), sleep (for which there is no environment), and various treatments and medications that are not congruent with the priorities of care in an Emergency setting. As patients may be “backed up” for long periods of time, staff become distressed at the level of care they are able to provide. For example, the staff in one hospital described a situation in which a young woman dying of Lupus spent three days in the Emergency waiting for an ICU bed. Two other patients “bypassed” the woman and went to ICU because they needed to be ventilated, whereas she did not. Eventually this woman was transferred to another hospital.

Second, care provided to admitted patients diverts care from other Emergency patients. In order to deal with the back up of patients in the Emergency, there is a concept called “workload”. In each hospital, when the number of patients “backed-up” in Emergency exceeds a certain number, the Emergency gets “workload” which is an additional staff member called in from the Emergency staff or from staff in other areas of the hospital. The number of admitted patients
required to qualify for workload varies between hospitals, but is usually around 5 or 6 patients; up to that number, the Emergency nurses must manage these patients within their usual staffing level, levels that, as noted earlier, are gauged to manage average rather than peak patient flows.

You still have to take care of those people. Which we often get workload [nurses]. Well, we do have to get workload for them once there are over 5 [patients], but you can have 2 [patients] that take a lot of time. You can’t justify having workload because it is only 2 people. (Faye, Emergency Nurse)

Furthermore, “workload” staff may not be available. The following description is typical of many interactions I had, and illustrates the complexity of the relationship between the Emergency and the rest of the hospital with regard to patient flow.

She is clearly angry and frustrated, and tells me that last Friday, she had patients backed up in the hall, and had 6 extra patients (which qualifies them for "workload") but no workload was available. She says that on Saturday night, the same thing happened, and they had three patients awaiting surgery (with fractured hip, ankle and arm), and the surgeon(s) decided they did not want to do the surgeries, so the OR staff phoned down, and she told the OR staff that they might as well go home.... meanwhile, there was inadequate staffing for the Emergency and no "workload" nurse. (Field Notes, September, 1996)

Finally, the presence of admitted patients in the unit often necessitates moving patients from place to place. Nurses often try to keep patients in a stretcher bay with curtains and equipment, and so may move the patient from a more to less acute area before putting the patient in the hall. Once in the hall, the patients must be moved if equipment such as oxygen or suction is required, or if any privacy is to be afforded. Several nurses used the example of giving bedpans to describe the additional work imposed by admitted patients being “backed up” in Emergency.

“How are you going to pan someone in the hall? So you put the ones who need panning in the room with a door.” She tells me about them wheeling stretchers around so that patients can be given a bedpan in privacy. (Field Notes, September 1996)

Under these conditions, a simple routine nursing act of giving some one a bed pan, (which usually takes under a minute to give the pan, and perhaps two minutes to remove the pan, wipe
the patient, and clean up) additionally requires the effort of finding an empty room or stretcher bay, finding help to move the stretcher, moving the stretcher, and then returning the stretcher.

Even when beds are available, there are two major barriers to getting the patient to the ward, the first created by the work of the physician, the second created by the work of the ward nurses, as the interests of various health care providers conflict. Before the patient can be transferred, the physician must complete an admission history and admitting orders. If the physicians “get behind”, then patients get “backed up”. People who are being admitted are often left without the physician doing admission histories and orders for extended periods of time, and the nurses are then unable to transfer the patient to the ward.

Nurses influence this problem by reminding physicians to do the required work, and by facilitating the physicians’ work in many ways. In one hospital, nurses can exert considerable pressure when physicians see first aid patients to the neglect of patients awaiting admission.

The nurses are able to "close first aid", which means that they can prevent the physicians from seeing first aid patients. I asked why, if the first aid patients are not high priority, do the physicians not see the patients to be admitted first? "Its the Cash Cow" was the answer. The nurses told me that the physicians want to move the patients through first aid as fast as possible, and they told me how much the physician can bill for an Emergency visit. It appears that non-emergent visits are quite lucrative for the physicians, whereas there is no extra remuneration for completing an admission. Apparently the physicians like to deal with as many first aid patients as possible rather than leave them for their colleagues who will replace them on the next shift (Field Notes, May, 1996)

Yvette explained that while nurses have some influence on the speed with which physicians see patients, that influence is limited. She said that physicians prefer to handle busy periods without calling in another physician to help, at least partly because they want to be seen as able to handle the work, and partly because their income would go down if they shared the work.

Well if you are in charge and you notice that the charts are piling up, because that’s part of the criteria for calling in another physician according to the policy .... It is not up to the Nurse-in-Charge to call in another physician, it is up to a discussion between the two, so they will take a chart out and see what needs to be done, “chest pain, okay, ECG, enzymes,
put it down”, the patient is now being processed; they haven’t been anywhere near the patient, the patient still hasn’t been seen, but it is out of the “To Be Seen” box.

Thus at times, within the specific economic conditions of the Emergency, nurses are working counter to the physicians’ interests with regard to priorities, and the exertion of influencing tactics can cause considerable tension. The nurses are paid regardless of which patients are seen, or how many patients are seen; the physician is only paid for patients who are seen. The physician is paid $50-$100 (depending on the time of day) to see someone with a straightforward, minor problem such as a sore throat that will require a few minutes to diagnose and prescribe treatment. In contrast, the physician receives very little more money for dealing with a complex presenting problem such as weakness and dizziness, which may require hours of history taking, diagnostic review, consultation and referral, and which offers no additional remuneration for completing admission procedures. Thus the processing of patients and the emptying of stretchers are influenced directly by the economic conditions of the work.

The second barrier to emptying the stretchers of admitted patients is that the ward staff must be ready and willing to receive the patient. There is ongoing tension between Emergency and ward staff regarding the timing of transfers to the ward. The ward may have a bed, but ward nurses tell Emergency nurses that they are too busy, there are no staff available to take report or admit the patient, or that the Emergency must wait until staff have had their breaks. Transferring patients to the ward requires negotiation regarding the timing of both the report and the transfer.

Then often the floors they have their own little systems and “no, well all the nurses are at lunch”, “she can’t take the report”, or “she can’t take the patient right now”, or “can you wait 1/2 hour”. You get to the point where you have to bite your tongue but you get very assertive and say “no we can not wait, this person is coming up now” and of course that leads to bad feelings, but it can’t be helped. (Faye, Emergency Nurse)

There are certain little hoops you have to jump through for these wards, is the way I’m perceiving it. One is this 4 page assessment, so that when the patient goes up there there’s nothing that they have to do, well there is a little bit but there’s a lot less than there used to be and still you will phone up and “well can you send them after lunch”, “well could you
feed them their dinner first”, “well the nurse has just gone for coffee”. It is frustrating when you are busy, it is very frustrating... (Bo, Emergency Nurse)

Emptying stretchers also requires passing patient problems on to others. That is, the patient may go home, or to a ward, but the patient’s problems may need to be passed on to different places through various referrals, each of which may delay moving to the next problem or patient.

Emptying the stretchers becomes the primary goal of care because empty stretchers are necessary to create a “safety valve” and accommodate the unknown incoming patients, to fulfill the purposes of the Emergency in serving the interests of the hospital and community, and because the nurses are limited to providing a proscribed level and type of care by staff-patient ratios and the unit structure. Emptying the stretchers requires stripping the patient down to a manageable problem, and then dealing with the problem and processing the patient efficiently. This entire process creates conflict for nurses.

The Central Conflict

The purposes of the Emergency unit require that the predominant features of nursing become efficiency and a physiological focus. To focus on the physiological aspects of a person and remain efficient, the nurse must necessarily neglect other aspects of the person. This neglect of other aspects of the person is the focal point of the central conflict for nurses: the discrepancy between the level and type of care they value and would like to give, and level and type of care demanded by the nature of the Emergency and the dominant interests served.

In formal and informal interviews, nurses expressed acute concern about the emotional well being of patients. Their inability to attend to the patient as a whole person caused nurses stress, anxiety, and, for some, unbearable pain. The nurses were aware of the impact of processing and the physiological orientation of their work. One nurse said

We are pretty ruthless in there, we strip them of their clothes, we put machines on them, we take total control of them and I think in itself that’s pretty demeaning and pretty frightening
for them. I mean if you were shy before, you are not going to be shy by the time you leave us. If you’ve had a heart problem we’ve stripped you, you’ve had an ECG, you’ve had a chest X-ray, you’ve had a respiratory person look at you, there’s about ten people that have seen you in an hour. It’s like a big wave, it’s just-coming and coming. (Bo, Emergency Nurse)

Nurses were aware that their work demanded that they neglect aspects of the person that they valued and considered important. Bo went on to say

But of course, it is ABC’s, one has to treat the acuity of the patient and we often don’t meet the emotional needs... If you’ve got the time then you can pull for it and try and ask them “how do you deal with this pain”, but sometimes you can’t. That is a bit of a challenge for us; that is a very frustrating thing.

On my first day of field work in one hospital, I worked with a triage nurse.

As I explain that I am interested in women's health in general and domestic abuse in particular, and what we (nurses) are doing, Jane interrupts and says "Not enough". I repeat her assertion and she says with annoyance "We don't have time for emotional care... not even death". She explains that a 45 year old man has died this morning, that the family is still coming in (it is late afternoon), and no one has time. (Field Notes, November, 1994)

At a later date, in the staff lounge of another hospital Lenore and Monica discussed their frustration with their own practice.

Lenore said “we don’t even deal with the psychosocial needs of the patient”. Monica came in at that moment, and Lenore drew her into the conversation. “Don’t you agree?” she asked. “Yes”, Monica said “I was thinking about this in the shower today and I thought, ‘we totally ignore the psychosocial needs of the patient, we don’t do anything.’” (Field Notes, June 1996)

In an interview later, Yvette explained that while she felt guilty, that the mandate and time limitations of the Emergency dictated practice.

I think you feel guilty because to me that is part of nursing, you are trying to nurse the whole person but you can’t, you’ve got to narrow it down to what is your biggest problem, what else does it impact that is going to damage your whole, like you say the physiological system and if you are upset about it go see your Doctor tomorrow. That is how we tend to operate, which is kind of callous but if we said to everybody “and how do you feel about this and is there anything else going on at home that maybe caused this that we can help you with” you would be with the patients that want to talk for hours.
The issue of privacy was repeatedly brought up by nurses as a limitation to the kind of nursing they value. The layout of the unit, designed to foster surveillance, necessarily precludes privacy. Nurses in this study employed various strategies to permit a modicum of privacy: talking quietly, trying not to talk to each other about one patient in another patient’s hearing. However, the curtains provide only the barest illusion of privacy, because although sight is limited, smells, sounds and movements can be sensed easily, and both patients and nurses are limited in their development of relationships.

Most nurses talked about becoming an Emergency nurse and said that part of the process was a gradual erosion of their attention to the person as an individual and to the non-physical aspects of the patient. This erosion can be seen as a consequence of compliance with the predominant pattern of practice.

I remember from my ward nursing that I had more of an opportunity to learn who the patient was uniquely and to themselves. In Emergency, because of the time constraints and the push to move people through as quickly as possible, and I confess, the continued reliance on the illness model. I think... patients tend to get categorized as what they came in with. ‘This is my eighth abdominal pain today’, or ‘my fifth chest pain’, or ‘my fourth allergic reaction’. There is very little opportunity, or at least people don’t take the opportunity if there is one, and I am just as guilty, to make that person a unique individual. Their pain and the illness that they presented with is unique to them but who they are doesn’t usually come into it. (Susan, ER Nurse)

I think we tend to be, for whatever reason, we tend to be very task-oriented and a lot of us have, over the years, forgotten what it is like to actually sit with a patient and talk to the patient and actually there are a lot of patients out there, so that you lose the subtleness of it. Because there are a lot of patients that don’t necessarily want to talk but you can say “do you want to talk” and they will say “no” but they want you there. They are going to open up soon, just not right now, and it is really hard for a nurse to just sit there and do nothing at a bedside when she’s got a gazillion things to do, but with some people that is almost what you need to do, just sit there for five minutes and not say anything, just be there and that builds the trust. Anyway that’s a dream, we don’t have the time to do that any more. (Lenore, Emergency Nurse)

The dilemma is not simply that nurses are prevented by the context from attending to the whole person and the non-physical aspects of care, and consequently feel badly about the care
they are able to provide. The dilemma is actually much more complex. Dorothy claimed that the Emergency nurses she works with underestimate the extent to which they weave their attention to the individual as a whole person. She drew to my attention the discrepancy between the nursing care I observed, and the critical analysis nurses gave of their own care. I observed very few instances of what I could consider "uncaring" nursing. Most nurses that I observed attended to the emotional needs of clients in a way that was, to my mind, reasonable within the constraints of time and work. Some nurses were at all times that I observed, extremely compassionate and supportive of those patients who were in distress, and used humour, friendliness and other strategies with patients who were not overtly distressed, but by virtue of an Emergency visit were likely to be at least a little uncertain or anxious. All nurses limited their contact with patients due to workload; some spent more time with patients as workload permitted, some limited their contact with patients regardless of workload.

Dorothy explained this discrepancy partly by the fact that criticisms of the department in letters from patients had been taken quite seriously by administration. Nurses in her unit had taken the message that they were "uncaring" quite seriously, and, Dorothy felt, had become more highly critical of themselves. While this may be particular to this specific site, the stereotype of Emergency nurses as "hard" is likely serving to reinforce a self-image of Emergency Nurses that may be quite negative.

Thus nurses' ideas about the care they provide may be influenced by the messages they receive from others about the quality of that care. Another factor influencing nurses' attention to patients may be the relationship nurses have between work and home. Some nurses talked about their work as a safe haven to which they escaped from their personal concerns, some talked about work as a place from which they wanted to escape, and many talked about the variations they
experienced in their ability to provide good care. For example, Lindsay talked about her personal difficulties and her relationship with work.

I tell you work has been a break compared to the rest of it so that is the way I’ve coped with it, I’ve gone to work thinking “whew I’m glad to get away from that emotional stuff, I’m going to come here to somewhere that I feel very comfortable and I can hopefully handle the emotional/physical aspects”. Then other days when you are not in the mood it doesn’t work so well.

Similarly, Susan said

Then there are the days that I go in when I am really happy and wide awake and I’m very proud of what I am doing for a living and I am completely involved then I make that extra effort and I make the personal connection irregardless of how busy it is and it can be done. I think that we tend to do that out of the energy level and the mood we might be in as well as the phenomenon of how fast we need to move people through. I don’t know that it is that directly cause and effect, it might have a lot more to do with who we are that particular day.

Neglect of non-physical concerns was not confined to nurses. Many nurses and other health care providers perceived physicians as reluctant to deal with anything but physical problems.

Many nurses viewed physicians as being more concerned with their own economic interests than the well being of patients, and thought that their economic interests were served by neglecting non-physical problems. For example, Susan said

The Emerg Physicians are there to make money, they are there to see the maximum number of patients in the minimum amount of time and they are somewhat reluctant to deal with patients that are psychosocial or emotional because it takes longer and there is always that feeling of being inadequate when dealing with it, whether due to a lack of experience or lack of resources.

This thinking was actually supported by some of the physicians to whom I spoke. One physician explained to me that he did not deal with women who were battered in his general practice because he could not be reimbursed adequately for “counseling”. Others were very clear that the Emergency is only to deal with the presenting complaint. Dr. Morgan said

The process in Emerg is problem orientated and you are dealing with the presenting problem you are not searching for is there anything else you want us to deal with today. Hopefully you are not dealing with anything else, they are dealt with and they are out.
Thus the entire Emergency unit and many of the health care providers are oriented to providing efficient, physically focused care, and in these interests, non-physical aspects of the person are neglected.

An important exception was noted by the head nurse of an inner city Emergency who told me that some “frequent flyers” are provided with primary care.

...we don’t just take care of the presenting complaint, but they get their annual physical and work-up and screening just to make sure things are whatever, because otherwise if you just deal with what the presenting complaint is, which may be a collapse or something else, it doesn’t work.

However, this same head nurse argued that society has not been clear regarding whether or not this is within the mandate of the Emergency and the resources provided.

The discrepancy between the level of care nurses are able to provide and the level of care they want to provide is not only divided into physical and non-physical care. Nurses in this study were frequently distressed about their ability to attend to basic physical care, and during my field work often expressed concern about situations which they felt were dangerous in terms of patient safety. These concerns arose from having too many patients for one nurse, having patients in two different areas, so that one set of patients could not be seen, and not having enough stretchers to accommodate patients who needed attention. During periods of low activity in the Emergency, attention to non-physical aspects of care is seen as insufficient; during periods of peak activity, even physical care is seen as threatened. For some nurses the discrepancy between how they wanted to work and how they were able to work became unbearable. One nurse saw her own pain and frustration as common among her fellow nurses.

I think I’m tired. I think I am really frustrated by not being able to do something on a major scale. I see a lot of my mates that I work with frustrated in our area. In our department, a lot of people have left out of pure frustration. I thought I never would be, but I am now. It’s money, it’s management, it’s things I can’t really argue with. Maybe that is a bad thing because when we are trying to work with our patients, our clients, maybe we are not doing a good enough job, maybe we are not being as... selective when we are questioning or asking
that one more question or listening a little bit closer. But if there is one thing that I hear in
our department is that our nurses really care and they really give 100%. But I think they are
tired. Emergency is a challenging area, it's not like on the floors. It is so mentally draining.
I feel sad.

The conflict produced by the discrepancy between the desired and actual levels of care is
compounded by the lack of opportunity for follow-up. Nurses (and other health care providers in
Emergency) have little or no way to find out what difference their care makes to patients.
Because most contacts with patients are single visits of brief duration, with 85% of patients being
discharged, nurses have a limited basis for evaluating their care. Many nurses talked about the
lack of follow up as routine.

Funny, you get so wrapped up in coming to work and dealing with mostly the physical
aspects of the job you don’t often have time, or even concerns. I don’t know, I’ve got to the
point where I’ve thought “I’ll just do my job and go home” but still taking the time to do it.
It’s like “well it is another day”. I’ve never really followed up with [the social worker] or
whoever it is and asked “did you get a hold of that person”, because the next day it’s going
to be a whole new ball park and a whole new set of problems and dealings with people. I’ve
often wondered but I never took the time to do it. (Faye, Emergency Nurse)

Although nurses often told me that the social workers had greater chances for follow up, Helen, a
social worker, said such opportunities were variable, and that her work was very discontinuous.

... I don’t get much feedback either. I could work for hours and hours and hours with a
family here on a grief situation. I might have made two follow-up calls after that, I might
have nothing, it really depends on the support situation or the situation they are in, some
families don’t ever want to talk to you again because you are just pain even though you
were there to support and they remember that, they don’t want to deal with you.

Follow-up is possible with hospitalized patients, but nurses rarely have the time or motivation to
do so. Nurses’ work is focused on the immediate, and when one patient leaves, he or she is
quickly replaced. Bo said “tomorrow comes and you get another 25 patients that you feel for and
you try to do the best you can.”

Follow-up generally occurs in four situations: 1) if the patient returns to Emergency because
treatment did not resolve the problem, 2) if treatment did not resolve the problem, but the patient
is unable to return due to something catastrophic (the patient is dead or admitted to another hospital), 3) if the patient is a “frequent flyer”, or 4) if the patient writes a letter or returns to give feedback. In all but the last instance, most feedback is negative. Unresolved problems imply failure of the Emergency, and patients who return for the same problem or with feedback may be angry. Patients who are labeled as “frequent flyers” also have unresolved problems, but the label carries the implication that the patient is responsible for those problems remaining unresolved. These patients are often “drug seeking”, or “non-compliant” with medical regimens. Regardless of the source, follow-up and feedback are rare, and predominantly negative, leading to feelings of frustration, ineffectiveness and resignation. One nurse told the following story which captures the feelings that many nurses have regarding the impact of their work.

Actually I think the longer you are in Emergency the longer you realize people are going to do what they are going to do for themselves. Like the people who commit suicide. Frances and I were talking last night about a woman who jumped out of her balcony... Frances had seen her three times the night before, or that day, and not once in the whole time that she saw her did she ever indicate that she was suicidal and Frances is very, very good at her job. But on a spur of the moment she jumped out the window and killed herself. Well, you beat yourself up as to what could I have done differently. But at the same time you have to stop and look and think if there was nothing I could have done differently. You have to accept the fact that the patient is the one with the disease, the patient is going to do what they are going to do regardless of what you think they should be doing.

At least five of the staff nurses that I interviewed described themselves as “burned out”, and several left Emergency. During my study, Faye, a nurse with 12 years of Emergency experience reached the limit of her ability to be in Emergency and left the department. She described the gradual wearing away of her ability to fulfill her role in a way with which she was comfortable.

It evolved over time. I’m not comfortable with it. In fact, that is why I got out of Emergency because I realized I couldn’t give myself 100% any more. I felt that I was just dealing with the physical and avoiding. I used to try and deal with the whole person and I did the best I could, even under the circumstances where I was burned out. Even if I could do it with one person out of the whole shift at least I could feel satisfied that I took care of the whole rather than just dealing with the physical. (Faye, Emergency Nurse)
Nurses who don't leave the Emergency must find ways to deal with the conflict between what they expect of themselves and what is demanded, and to be able to tolerate the level and type of care that they can provide. Nurses deal with this conflict in ways that align them more closely with the purpose and structure of Emergency and the interests the Emergency serves, and in ways that run counter to those dominant interests. Practices of congruence with the predominant pattern of practice are congruent with an ideology of scarcity and include becoming more “efficient”\(^3\), and emotionally “strong”, and rationing resources according to the deservedness of each patient.

**Practices of Congruence: Going with the Flow**

Working within the influence of dominant interests and the ideology of scarcity, nurses increasingly value efficiency and the physiological focus, and accordingly strive to become more efficient and physiologically focused. Congruently, they see selected patients as more or less deserving of the type of care they value giving, and ration their time and resources accordingly.

**The Efficient Nurse**

As nurses increase their value for efficiency and necessarily focus on the physiological, these values become part of the cultural norm for Emergency nursing. These norms operate to the point that even when there are few patients in the unit, they are treated with the same physiological focus and efficiency. Yvette explained how this norm shapes her assessment and care of patients.

I can’t use that [lack of time] as an excuse all the time though, I mean there are some shifts there that are quiet... I think you get into this thing too whether you are aware of it or not, of “we’ve got to get this patient in and out”. It might be the only patient in 6 beds, but “I’ve got to get them in and out” and that’s not right. It’s like [the head nurse] used to say “the only good stretcher is not the empty stretcher” but at the same time you are aware that the flow is keeping going, there are more coming in all the time, so I’ve got to get my assessment done quickly, get the Doctor in, get the orders done, get the patient home or out.

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\(^3\) I am using the terms “efficient” and “efficiency” in the particular way they have been developed in this study, that is, meaning the rapid processing of patients within particular economic conditions and an ideology of scarcity.
It influences the way you practice so even though you’ve only got the one patient you probably don’t give them a whole lot more time in that assessment.... I am aware that I feel more relaxed doing an assessment if I’ve got fewer patients or their acuity is less, but still I don’t think if you were to time it that I would spend a whole lot more time at the bedside because you get into this way of questioning and you get into this “I’m going to do the assessment and then I’m leaving”. It is a mind set and you are not even aware of it until you have reason to sit down and think about it.

Nurses communicate these values to nurses new to Emergency, and in each Emergency department, some nurses are viewed by the others as not adequately focused (on physiological concerns) or not adequately efficient. One nurse said:

I frustrated them a lot in that department because, I was a really problem for them, because they didn’t quite know what to do with me, and because I spent so much time with the patients. But that is all I knew. That helped because I didn’t know all the physical aspects.

Nurses evaluated one another in terms of efficiency and physiological knowledge, and applied these values in their evaluation of other staff. Nurses routinely shared with me their evaluations of Emergency physicians. Lulu told me that one of the physicians is “an excellent diagnostician”; Bo told me that another physician “is one of the most organized and accurate of the ‘duty docs’”. I was told that another physician “is a slow as molasses in January”. Dorothy admired one physician’s physiological knowledge.

I listened to Dr. L’s assessment, but was not very analytical of it until Dorothy pointed out how organized and detailed it was. She compared it to her own assessment. She thought she had asked a lot of questions, but remarked on the extensiveness of the questions he asked. For example, he had followed up more thoroughly on the “bleeding bowel” issue and asked a barrage of questions around that. (Field Notes, April 1996)

Nurses who are not efficient, knowledgeable, and focused, impact on other members of the team. New nurses, float nurses, and nurses who have not come into line with prevailing values create a sense of distrust among others. Faye talked about the difficulties “weaker” staff pose.

Often their assessments can be incomplete, not to a dangerous level, but it’s a lot more time consuming to have to keep going back say “look at this, look at that”. It makes it hard for the person who is in-charge that they can’t entirely count on that person to do the complete job, so she has to constantly try and oversee the weaker staff and making sure that everything is getting done.
Other staff also evaluate nurses and other staff in the same terms. Natasha, an admitting clerk, described the importance of efficiency from both nurses and physicians.

I mean you’ll have a group of great nurses and everything will run smoothly and efficiently and you can see 50 patients and everything runs just fine. It also has to do with the Doctor who is on because some of them, they are really scattered all over the place and that doesn’t help. You could have the best nurses and we are still all just running around behind him. What are we supposed to do?

The corollary to the value placed on physiology and efficiency seems to be devaluing of attention to the social and emotional aspects of the patient. Lindsay explained that nurses who attend to those aspects are seen by others to be wasting time, and thus not pulling their weight.

There are a few [nurses] in particular who deal with the emotional aspect first, unless of course [the patients] are bleeding out or whatever. They meet the wrath of some of the other staff members quite significantly “She’s not pulling her load, she’s doing that PR crap”.

Nurses who dealt with patient situations that they felt that they could not leave were constantly aware of the pressure of others’ expectations. Having exhausted all avenues of escape, Yvette stayed with the young man who had been told he had leukemia.

At the same time you are feeling this pressure and you know that people are looking for you, the Doctors are saying “where is the First-Aid nurse?”. “Well, she’s in talking to that patient”. “Well, she’s been there half an hour”.

While many nurses were critical of their own approach to care, and talked of reversing the erosion of their attention to the whole person, they saw their interdependence with others and the norms of the unit as barriers to doing so.

I personally would like to start, if I’m quieter, maybe trying to get back to what we started when we first nursed. There were nine subsystems, and I think we are down to, what?, three? [laughs] “Are you going to die in the next 10 minutes or not?” It would be nice to get back to that but... you would certainly be, not ridiculed, but because the other expectation there is that you might be quiet with your four stretchers or your five stretchers but it doesn’t mean that Monica, for instance, down there, isn’t swamped in [the other stretchers].
The interdependence of the nurses and other health care providers makes working as a team critical to each individual being able to do his or her work. The individual’s trustworthiness within the team depends on the extent to which they are judged efficient and knowledgeable. Efficiency and focused knowledge are the characteristics that are required to manage the routine in the Emergency setting. However, dealing with crises requires something more.

The Strong Nurse

Trustworthiness in crises depends on the extent to which someone is perceived as strong. Emotional “strength”, meaning the ability to control and hide emotions, is highly valued. Capturing what many told me about the value of emotional strength, one nurse said “We are basically all trying to be so strong, because if one goes down, you show weakness working in the Emergency Department. Not good, not good.”

The value for emotional “strength” is pervasive. Nurses talked about the well known stereotype of the “hard bitch” Emergency nurse, and the humour reflected this value. For example, during my study, a set of quips completing the sentence “you might be an ER nurse if...” were copied from the Internet, and distributed through several Emergency Units. Some ways of completing the sentence included “if you ever wanted to hold a seminar entitled “suicide: doing it right” and “your idea of a good time is a full arrest at shift change”.

Nurses openly discussed their own process of becoming an Emergency nurse in terms of being hard. Lulu described dealing with a 15 year old who had overdosed, and her subsequent analysis of her practice.

We’d seen her twice before (that was back when we had the red rubber hoses that you shoved down and did gastric lavages)... and I held her down, and she was struggling and struggling, and I said [with a snide, condescending tone] “Now, isn’t this fun? don’t you want to do this every Saturday night?” And it wasn’t until... a psychology class, that I first started seeing the world as grey, and not black and white. But I was seen as one of the best Emergency nurses in the department. I mean, I could get drunk men out of bed by yanking on their ear, and pulling them out of bed to discharge them out the front door, and people
would pat you on the back that you’ve just done a wonderful job, ‘cause you could clear the
department, or you could get that tube down, and you were tough as nails.

The following incident that occurred during my field work was a particularly profound
revelation of the power of this value for “strength”. I was talking to Eric, an ambulance
attendant, and five of his colleagues at the nurses’ station. We chatted about their work, and how
they became Emergency medical attendants (EMA’s).

I asked the woman EMA if she had to do physical testing, and she says, yes on the initial
screening. Another attendant starts telling me how heavy the stretcher is (80 lb.) and says
"then you add a 20 lb. oxygen tank and put an average sized man or woman on, and start
heading up some stairs, and ..."
"And", I say, "not to mention any anxiety you may be feeling".
There is dead silence for a heart beat or two. All six attendants stare at me with shocked
disbelief.
"Anxiety?" one says.
"Anxiety? there’s no anxiety!" says another.
"Oh, I see, you don’t have anxiety, eh?" I say. I realize I have said the wrong thing, but one
or two of them laugh a little. I turn to Eric and say "But you guys must see some pretty
awful things. Do you have any stress leave, or anything, or what happens?"
Eric is wary now. “Well yes, there is critical incident debriefing, and EAP (Employees’
Assistance Plan), and stress leave (long pause) if you need it.” This is said with a hint of
distancing, perhaps disapproval. So I say, "but its frowned on?"
By this point our conversation is mostly just between the two of us. Eric replies that if you
need it, you are weak. "If you aren't tough, you can't be trusted" he says. I am not sure how
much he buys this, but I am confident that he does not display any dreaded weakness. He is
a tall, physically imposing man, and looks a tower of strength to me. We are both quiet,
watching the busy hum of the unit. After a minute or two, he leans toward me and quietly
says "and we are just like chickens". I don't know what on earth he is talking about, but he
shapes his hand like a beak. "If you are weak, we peck you to death.” He makes a pecking
motion with his arm, pecking toward my eyes. (Field Notes, July 1996)

Some of the nurses I interviewed have had the experience of having been pecked, if not to
death, then at least into some sort of misery. Many nurses described their own need for support
as a weakness. One nurse dealt with the brutal rape and murder of a child, and in the aftermath
found the ostracism of her colleagues almost as difficult to bear as the experience of caring for
that dying child.

The trauma did me in. I couldn’t be that hard-nose nurse any longer. I had to be human, I
couldn’t protect myself. So I allowed myself to be human and I got some counseling. We
had a debriefing and that helped, because we never had that before; nurses were never allowed to fall apart, because we were the rock.

Similarly, another nurse who was traumatized by the death of a small child found that the reaction of her colleagues was the most brutal aspect of the situation for her.

Well that situation stuck with me. I stood there and I bawled with them (the parents) and it was just, and the worst part of that entire situation is coming back the next day and having people say “gee, I heard you were crying in the back room” and I just, if ever I said the “F” word, I could have that day and I just thought “back off”. What is the matter with that? There is nothing the matter with sharing with your patients and the families, this awful situation.

**Influencing Each Other**

As the above quotes and stories illustrate, nurses influence and limit the behaviour of one another in subtle and complex ways. However, these enactments of power are not always successful in keeping behaviour within unit norms. For example, in one unit one nurse seemed to be having difficulty every time I saw her. Others told me stories about her being angry and about her behaviour being sometimes quite bizarre. Her behaviour appeared to cause discomfort with the other staff, but the joking, teasing, and other ways I had observed nurses using to give messages regarding appropriate and inappropriate behaviour did not seem to be used. Rather, the other staff seemed to deal with this nurse primarily by ignoring her.

At the desk one of the nurses is clearly angry, and everyone else is clearly ignoring her behaviour. She is furious and muttering under her breath. She glares at me, and I say, “you don’t look very happy”. She quietly explodes, telling me that the head nurse “yelled” at her in front of everyone for having a pop at the nursing station. She says that she is sick, that she has a sore throat, but that she came in rather than phone in sick, and then “got shit in front of everybody” when she was drinking to soothe her sore throat. She is really fuming, and the half dozen or so other staff studiously ignore our conversation. I have seen this nurse most every time I have been here and she is often angry or disturbed, and others often comment about her in ways that suggest they are very uncomfortable with her. I try to be empathetic without taking her side, and without encouraging her (her expressiveness really seems to be making people very uncomfortable). She storms off.
Thus, in order to meet the purposes and goals of the Emergency unit (which serve dominant interests, nurses value those attributes that are most required, and influence each other toward those attributes. They value efficiency and physiological knowledge as essential to the daily routine, and they value emotional “strength” as essential to the management of crises. Conversely, non-physiological knowledge, attention to the emotional and social aspects of patients, and the display of emotion are devalued. These values are shared by other health care providers, and sanctions are applied to those who do not conform to the values.

In congruence with these values, nurses develop their efficiency through practice and modeling, physiological knowledge through experience, listening and courses, and the air of emotional strength, through various means including distancing themselves from patients and becoming “hard”. Efficient, focused, emotionally “strong” nurses allow the team to be confident that none of its members will break under pressure, and insure that the nurses’ limited time and resources will be spent frugally in service of running the unit efficiently, achieving the goals of the Emergency. The final element in achieving efficient processing is judging how to ration care, determining priorities among patients, deciding who deserves how much time and attention.

The Deserving Patient

As nurses have finite time and resources which are inadequate to provide the care most nurses would like to provide, nurses must decide how to ration their time and resources. Most rationing is done on the basis of the patient’s perceived acuity, the determination of which involves value judgments. In addition, nurses make other value judgments about patients to further determine which patients are most deserving. One nurse described her declining ability to care for certain patients.

I’ve lost it. There are some repeaters that we have, frequent flyers we call them, that on a good day, if you haven’t been busy you can deal with them, but on other days you need to
say “listen I can’t deal with this particular patient right now, it is not to the patient’s advantage that I [do]. If I have to I will do so, but if not, I need not to be here.

I often observed and was told about nurses being angry with patients for not taking what the nurse thought was appropriate responsibility for their health. For example, Lulu told me about a woman with whom the staff were very angry because she came in with terrible foot sores that eventually required amputation of her toes. The nurses could not understand why this woman would not have known she was diabetic and not sought medical care.

Lenore told me about a situation in which two different women had been sexually assaulted, one by her husband, another by a date. The first woman was drunk, loud, and demanding. The other was quiet and patient, and waited several hours while Lenore looked after the first woman.

I was pissed off. I thought “here I just spent three hours with this woman who is not going to be traumatized by it and as a matter of fact she is enjoying the attention, this is nothing to her” and I thought “she has taken away from this poor woman who is really traumatized by it”... Again, I’m not saying that it should have happened or anything like that, but when I have limited resources I would rather my resources go to the people I see as needing it.

Emergency nurses deal with people who are drunk, people who are abusive toward health care providers, sometimes to the point of assault, people who are angry at the type of service they receive, people who return to Emergency repeatedly, often with the same drug or alcohol-related problems. Nurses see the casualties of social injustice, and are asked to patch them up and return those people (as quickly and efficiently as possible) to the situations that produced them. However, in keeping with the focus on the immediate problem, nurses do not necessarily analyze the causes of their patients’ conditions, and focus instead on the patients themselves.

The basis of judging who is deserving varies with individual nurses, but those people who are drunk, those who are demanding, those who use Emergency services frequently, those who are perceived to be using the Emergency inappropriately, and those who are perceived to be
making little effort to take responsibility for their health and improve their lives seem to be commonly viewed as less deserving than others.

Although some patients are seen as less deserving than others, most patients are seen as deserving care, and as deserving care that many nurses feel unable to provide. Thus, unable to meet their own standards, nurses become frustrated. Over time nurses must develop approaches to dealing with various difficult situations in ways that keep themselves protected and keeps their own frustration under control. Most of the nurses I interviewed talked about becoming hardened. Nurses use various strategies including distancing themselves from patients, and having another nurse take over a specific patient’s care when the nurse’s (and probably the patient’s) frustration level becomes too high. However, frustration with individual patients or types of patients often becomes evident. As discussed earlier, those who are perceived as failing to take responsibility for themselves, in particular, alcohol abusing people, seem to produce the most frustration.

Nurses talked about other health care providers’ attitudes and talked about their own challenges in dealing with alcohol abusers. Lenore commented on the skepticism she has developed toward people who have been drinking.

When alcohol is in the picture, and it is in the picture continuously, then I start getting, not really biased, I start getting question marks. People say and do things when they are drunk that they would not normally do. When there is alcohol involved, or drugs, I just don’t think you can really believe a lot of what is being said, how much of it is the way the picture happened.

Emergency nurses deal with the most horrendous traumas, assaults, burns, deaths. They deal with people at some of the lowest and worst moments of their lives, and the Emergency nurse is crafted from those experiences. All become assertive, some become hardened, and some cling desperately to their values. The voices of these various nurses give a sense of the ways nurses grapple with the nature of Emergency nursing.
The one thing that I notice down in Emergency is things are a little more cut and dry. People are a lot more assertive. I’ve had to become more assertive without, and that’s what they say about the hardness, without becoming aggressive. Maybe that is where some of the emotional and the nurturing is swept under the carpet and that is maybe where we sometimes are at fault in dealing with emotional sides of issues...(Lindsay, Emergency Nurse)

I have become very tough after being there for five years and I think I’ve had to for protection. I think what you see over that time, traumas that you have experienced, makes your skin tougher and the pain is hard and I find I bring every patient home, every patient. (Bo, Emergency Nurse)

Again and again, nurses told me that what they needed to eliminate from their practice was the caring, and, sadly, that the caring was what they valued most. Lenore told me how distressed she was at being unable to do the kind of nursing she would like to do. I asked her what kinds of things get missed and lost when she is unable to do her job, what goes first? She answered:

The caring. I’ve become an Emergency Technician. I can run as fast as anybody, I can start IV’s as fast as anybody, I can do ECG’s, I can do all of that technical stuff but I don’t have time to talk to the patients. To me that is one of the biggest, most important things but we are so task oriented that when you are looking at your seven patients and you’ve got IV antibiotics to start here, you’ve NG’s [nasogastric tubes] to put down here because this guy is writhing in pain and you’ve got this to do that and the next thing you know you get a new patient and there is just too much to do. So you are running around as fast as you can go, doing as much as you can but you are not talking to the patient. As a matter of fact you are almost a little bit relieved if the patient isn’t talking because then you don’t have to slow down. That is wrong, that is really wrong, that is the biggest thing that bothers me.

Despite the value placed on efficiency, physiology and emotional strength, most nurses also expressed a value for more. Nurses often pointed to other nurses who had lost their ability to care as well as to do the efficiency work, and sometimes described nurses as being in two polarized groups. I asked Lindsay about her observations:

Polarization does occur... those who want to be there and those who don’t. Those who want to be there for the patient and to be there for all of their needs and those who are there. They are tired, they’ve got too many things going on at home.

The central conflict for nurses in Emergency is dealing with the discrepancy between the care they give and the care they value. One way nurses deal with this conflict is to practice in
congruence with the predominant pattern of practice, and to bring their values into line with the care that is demanded and made possible by the structure and purposes of the Emergency. However, conflict persists, and in order to honour their values that run counter to the prevailing values of the Emergency unit, nurses must employ other strategies, practices of resistance that run counter to the purpose and structure of Emergency, counter to the predominant pattern of practice and in defiance of dominant ideology.

Practices of Resistance

Honouring value for the social and emotional aspects of patients and the nurses who care for them, requires preserving the patient as a whole person, providing support to one another, and trying to influence the context of practice.

Preserving the Person

Under the inexorable pressure to process the patient quickly and efficiently, nurses labour to preserve the person. Nurses “humanize” the often de-humanizing encounter in the cracks and crevices in time, in stolen moments, and on top of the job of creating “legitimate” knowledge. Many nurses strive to bring the person’s individuality into every encounter. One nurse did this by actively searching for a personal interest or connection with each individual. Observing her practice I noticed that unless a person was quite ill, her first question would NOT be about the main problem that brought him or her to the Emergency. Rather, it would be about the weather, the family, current events, sports, and so on. In an interview she talked about her approach.

I would go on, do you have any kids, are you married... I like [baseball] so I start talking about that. “Well gee what about music”. I try to find something that they have an interest in so that we establish a rapport....

She talked about weaving attention to the individual person with attention to physical priorities.

Sometimes they will talk about it and sometimes they won’t. You can do all of this while putting leads on, you can do this while taking a blood pressure, while doing a history, you can interject... I think you have to learn to talk a little bit more. Again dealing, if it is an
acute situation, if you’ve got an inferior MI and they are vomiting, you are not going to get anywhere with them, but if it comes hour 2 or hour 3 where they are a little bit more stable and you are starting to establish a rapport with them, constantly being with them, reassuring them, giving them a little bit about who you are as an individual and what you are like then they will often—you can always find something.

Another nurse, reading an initial draft of this study pointed out that she saw the temporary and brief characteristics of Emergency as a challenge to “connect quickly” with patients.

Some nurses modeled for others ways of attending to the patient as a whole. For example, Dorothy was highly committed to patients as individual people, and often actively countered the behaviour of other nurses that objectified the patient.

The nurse started giving report on the patient while standing beside his stretcher. He had apparently just arrived by ambulance as an ambulance attendant was still sitting on the next stretcher writing on some forms. My buddy nurse, Dorothy, very smoothly interrupted the nurse to introduce herself to the patient. Immediately the other nurse began to include the man in her report, rather than talking about and over him. (Field Notes, April 1996)

The effort to preserve the patient serves nurses’ interests in providing the type of care they value, and shapes relationships differently than efforts to strip the patient down to a manageable problem and process efficiently. Relationships between nurses and patients, between nurses and others, and among nurses, are thus influenced by both types of effort.

The effort to preserve the person tends to create relationships with patients that nurses find rewarding. Nurses who talked of their attention to the emotional and social aspects of patients’ lives spoke of the cost, but also of the rewards. One nurse said:

I think trying to be on top and to be very honest and caring with each individual on a 12 hour basis for four shifts is overwhelming. It is challenging, but it is also rewarding. There are a lot of positive strokes. “Thank you very much” and a smile and a handshake from the patient is, as far as I’m concerned, worth a million dollars. You know you’ve helped them and you’ve made them relax or you’ve made them laugh or you’ve included their family or you’ve allowed them to feel, you’ve allowed them to cry, or you’ve allowed them to share something very intimate that they may never have said and lighten their load, carry their load for a little bit. Carry their load, because they are scared.
Nurses who saw themselves as “caring” also saw themselves as belonging to a group that contrasted with a distinctly less caring group. However, my observations suggest that all nurses attend to the emotional aspects of patients to some extent, and that variations occur within individual nurses in relation to certain patients, as well between nurses. Some nurses told of having no difficulty with certain “types” of patients that other nurses found difficult. Some nurses said, for example, that they were more comfortable than other nurses in dealing with people with alcohol problems; some agreed they could not stand looking after “drunks”.

Preserving the person seems to be part of nurses’ routine work, with each individual nurse enacting her practice with various patients with varying degrees of personal connection and attention to non-physical aspects. Some nurses seem to lean away from, and others toward such connection and attention. Some are seen by others as too hard, some are seen as too involved.

In addition to being part of the routine pattern of care, the work pattern of swarming can also be observed in relation to non-physical aspects of crisis. Thus, in a manner similar to the attention given during a seizure, a major bleed or a cardiac arrest, nurses may “swarm” to emotional crisis. Susan suggested that this phenomenon helps break the routine of Emergency nursing, and bridges the distance that nurses must develop between themselves and their patients in order to be efficient. She said “In searching for something that excites and is not routine, we tend to latch on to any detail about a person that is emotional, because it ties us back to our work, we don’t want that distance.”

Efforts to preserve the patient, in at least some cases, create tensions between nurses and physicians. In order to spend time as they see fit, nurses must subordinate the priorities and interests of others, most notably physicians’ priorities and interests. Many physicians interact with nurses in an impersonal and disembodied manner. During one of my early shifts of
participant observation, I was baffled to see a physician standing in the middle of the charting station apparently giving orders to the air. I gradually realized that many physicians aim their orders at the air, partly because which nurse is responsible for what patient is so changeable. The nurses figure out who the appropriate target nurse is, and “catch” the order. Consequently, many resistances to nurses’ time being allocated by physicians are played out in this same fashion.

[The physician] passes by the end of the stretcher we are standing at, having just spoken to the family of the woman who seized. He says loudly to them “the nurse will do it right away”. Dorothy doesn’t even look up, but says loudly enough for him to hear “the nurse won’t do it right away, she’ll do it when she has time”. (Field Notes, April 1996).

Preserving the person also extends to trying to influence the practice of others, including physicians. Nurses told various stories about taking concerns regarding physicians’ practice to the head nurse, or, less frequently, confronting physicians directly. Most of these stories were regarding physician’s “bedside manner”.

Relationships among nurses are also influenced by the effort to preserve the person. Although nurses pressure one another to be more efficient, to keep to the physiological focus, and to avoid emotional display, all of the nurses I interviewed also expressed value for preserving the person and attending to the whole person. Even some of the nurses who valued a physiological focus and efficiency and were critical of nurses who had a different orientation, simultaneously held such values. Many nurses expressed admiration for those nurses who were generally perceived as not being in line, and as being too involved. For example, Lindsay said

We have this stigma that we have to be strong and all encompassing. That is why people like Bo, who you saw on Monday of last week, is such a superb nurse. Because she allows those emotions to show through and help her patients. I look up to her for that.

After Lenore told me how nurses perceived other nurses who spend time talking with patients, we had the following interaction.

C: People have told me that they get a lot of negative feedback...
...when they spend time with a patient and it is unfortunate, you are right. I hadn’t thought about that, that we devalue the very qualities that I think are important. I don’t know how to change that though. I don’t know how to change that because I look at the time that Dorothy spends with the patient and I think it is wonderful, I mean if I ever get sick and come in to the hospital that is who I want looking after me because she does. I don’t know why we put such importance on the tasks. I don’t know. How do we change it?

Preserving the person is thus counter to dominant interests. It may require more of a time commitment, meaning that time may have to be appropriated from other tasks and patients. Such time commitment may mean that patients are processed more slowly, and thus, less efficiently.

**Supporting Each Other**

While nurses pressure one another to behave in proscribed ways, for many nurses there is also a sense of teamwork, belonging, and some kinds of support. Team work is essential to getting the job done, because responsibility for individual patients is shared between nurses. Teamwork allows for accommodating extreme variations in patient flow and acuity, and thus works in the interest of efficiency. Teamwork also works in the interests of individual nurses, providing support in dealing with unreasonable workloads.

There are a few [nurses] that aren’t but generally they are very helpful in recognizing when you are drowning, because maybe the next day they will drown. I am very thankful for them. Very, very thankful, and proud to work with them. (Bo, Emergency Nurse)

Working as a team also helps deal with overwhelming problems and patients with whom nurses feel uncomfortable. One nurse described how the team was helping her through a difficult time.

I’m not like I was, I’m not a good nurse right now. But, I can live with it, I am living with it. Because, I’m just rejuicing myself. Some days are better. Some days are better with staff members that work as a team.

When nurses’ frustration levels with particular patients rise to unmanageable levels, they are able to call others in to take over. I observed nurses doing this on a number of occasions during field work, and several nurses commented on this feature of practice.
You need to work together and then you don’t feel so isolated, and then you don’t own that whole patient and all of their problems. That’s a good thing. Also, when you have a team like that and maybe you don’t connect with that particular patient, and they don’t feel good with you, maybe you could go in on whoever’s patient and something strikes up and you can get a little bit more information, so there is always that aspect of it.

The nurses talked about a sense of belonging that is earned over time. Many told me that it took several years to be accepted by fellow nurses, and even longer to be trusted and accepted by physicians. Palen said “You really struggle to try and pass whatever the magic thing is, and then you finally belong...You have to constantly prove yourself at every level.” I buddied with and observed nurses who were highly respected by their colleagues, nurses who were thought to be adequate, but over-involved, and nurses who were far from being accepted by their team mates.

Whereas some nurses felt very unsupported, especially in regard to dealing with tragic circumstances at work, other nurses, perhaps those who have “proven” themselves, feel that there is emotional support. For example, Monica, a nurse with many years of experience who was spoken of with high regard by the rest of the staff, felt that there is emotional support for both work related and non-work related situations.

Although supporting each other works predominantly in the interests of efficiency, the sense of teamwork, belonging and support that many experience can provide a foundation for some nurses to go beyond their concerns for individual patients and efficiency. These nurses attempt to influence care by countering the dominant interests served by the routine provision of Emergency care.

**Influencing the Context**

The context of Emergency is a powerful determinant of nursing practice. Dominant interests in the hospital, health care system and society are served by the very purpose of the Emergency, the structure of the unit and the pace and patterns of practice. Nurses themselves
create their practice primarily in congruence with these forces, and compel each other to comply. In service of these subtle, unspoken, unacknowledged interests, nursing practice is often directly dictated by others. While nurses work in relationship to various health care providers, the most significant influences are the physicians and the hospital administration.

Nurses are motivated to influence the context of their practice by dissatisfaction with the conditions of practice and the ways in which they are (or are not) able to enact their practice. Thus nurses' interests in providing a certain level and type of care are counter to their interests in efficiency in congruence with, and service of, the dominant interests of others, those interests embodied by physicians and hospital administrators.

The nurses in this study saw physicians as part of the work team, and as being at the mercy of the context at least to some extent. Thus the influence of physicians was largely dealt with on an individual basis, with nurses routinely negotiating physician demands on their time and constantly seeking to influence physicians with regard to individual patients. Nurses time and individual patient’s needs, and interestingly, often non-physical needs, were the most common issues around which competing interests were contested with physicians.

With many physicians, there was an uneasy truce in the contest between the interests of physicians and nurses. Lenore described her initial struggle to identify the boundaries of nursing decisions, and her continued struggle over decision-making with physicians in which she balanced pursuing her interests against maintaining acceptance by the physicians.

... when I first came [here] I wasn’t used to, and I thought “okay I have to tread very, very carefully here” even though we do a lot of things without proper authority in Emerg I really and truly didn’t know where that line was and I had a hard time, sitting over policy books and so I thought I will either ask before I do anything. I mean even starting IV’s, I won’t necessarily ask but with a GI bleed I’ll just walk by and say “[Ted] I’ve got a GI bleed, so I’m hanging a normal saline”, I got in the habit of telling them what I was going to do, not really even asking, but telling. I figured if I was way out of line they would turn around and say “No”, which never happened, but it took a long time because they don’t like that. Then I started to think is that really what nursing is about?
Some nurses told me that they were confined in their ability to influence physicians by their own reputations. Lindsay described the comparative freedom she experienced in being able to establish herself differently when working at another hospital.

It is nice just to go in and do my job and do what I think I do best...and to actually not have a stereotype on me and being able to go up and tell some of the doctors things I don’t like, whereas [here] “there’s little baby Lindsay running along, she’s been here since she was [young], she can’t tell me off”, you know, you’ve got that little stereotype. So it is nice to go out there and just be assertive and not have people go “that’s not like you”. You tend to mold away and you get molded in this particular clump and you lie there and you sit there and you allow it to fester and get around you.

Occasionally complaints about individual physicians were taken to nurse managers, and dealt with through them, but on the whole, nurses and physicians played out their competing interests on the floor of the Emergency unit over individual patients, and there was sometimes a sense of solidarity between physicians and nurses when their interests coincided in opposition to the interests embodied by administrators.

The nurses seemed to see their context of practice as being primarily peopled by the hospital administrators, and this aspect of the context was dealt with collectively if at all. Resources and staffing levels were the most common issues around which competing interests were contested with administrators. While inadequate resources are an obvious source of frustration and anger from nurses toward administrators, the related control of nursing practice was a more subtle but equally powerful source of frustration. Some of the greatest anger and frustration arose from nursing practice decisions being dictated from outside of the Emergency department, most of which stemmed from economic interests. There were many examples of specific situations which angered staff. In one hospital, administrators “forced” an extended assessment for alcohol and drug dependency screening on the staff. In another, the Emergency Unit was amalgamated with another unit, and staff from this other unit, who did not have Emergency nursing skills,
were required to "float" to Emergency. During the study period, neither of these hospitals had shared governance structures (although there were intentions to do so) or mechanisms through which nurses have input on a routine basis. Typically, the head nurse or unit manager holds meetings with the staff, and then interacts with the hierarchy.

The willingness to engage in contesting these competing interests varied from nurse to nurse. Many nurses came to work, did their shift, and went home. Several told me quite clearly that they did not want any more involvement at work than what is required to do the job. This position was influenced by the fact that many nurses work at more than one job, meaning that they may have divided loyalties, or may not feel committed to any one work place. It also seemed that those nurses who were highly regarded by peers, and thus more secure in their work (and probably themselves) tended to be those who were involved in political action on the units.

While many nurses expressed an attitude of "just do my job and go home", others were informally and formally active in trying to improve conditions of practice and to gain control over nursing practice. In each hospital, nurses worked on various committees and groups, set up petitions, drafted proposals and did research. For example, in one hospital nurses petitioned administrators about a specific decision, in another, they compiled a document about problems.

She took me into the lounge and gave me a copy of a 10 page document that outlines the concerns of the nurses and the problems in regard to equipment and physical constraints, staffing and administrative issues. The document identifies four situations which they deem to be "intolerable and requiring urgent resolution" including repeated episodes of inadequate staffing, role expectations of the 0900-2100 R.N. (it is seen as impossible to care for patients in four stretchers and children in peds - a separate room, patients in the hallway, and relieve for both Triage and first aid), lack of a system to accurately document workload, and lack of written standards to guide patient care issues. (Field Notes, September 1996)

Because nurses are paid on an hourly basis for patient care, and because there is no budget or support for unit activism (and unlikely to be, given the interests served), nurses must contribute their own time unless a project is conceived by the management. In each hospital,
there were mixed attitudes regarding the relationship between nurses and management, with some nurses feeling supported by management and others feeling dismissed. There were also mixed attitudes toward the value of participating in such activity, with some nurses feeling that they had to try, and others feeling that such activity was a waste of time.

Some nurses were disillusioned about the possibility of influencing anything beyond the care of their immediate patients.

They talk, they pacify you and you put a lot of work and effort into it but either it gets sabotaged by ourselves as nurses because we give up, or management, or money, usually funding is the major problem. Setting up situations that prove this will be worthwhile and making up budgets and all of this and determining where we would get the money, submitting these cases. I mean, it’s great doing it but when you’ve been pushed down so many times, for me, there are other things I can do on a smaller scale now. I can be a better nurse at the bedside.

I actually in my own practice have not had the experience of advocating or agitating or identifying issues at that level and having it filter up and getting a response that would resemble a positive response to what you were doing. The response is always acknowledged and you are always appreciated for the effort that you have made but it doesn’t necessarily make a difference.

Others continued to struggle with influencing the wider context, and found satisfaction in such activism. One nurse was angry and dissatisfied when I began my study. Months later she said:

I actually feel better than I did a couple of months ago, partly because I sat on the committee there, partly because I thought “I’m in charge here, I can make whatever changes I can possibly make” and that makes me feel better. Several times I’ve thought “I’m too tired to fight this crap”, I just need to get out and find some place where I can lick my wounds I guess, and I thought “no, I’ve put a lot of time and effort in getting here, if changes need to be made then let’s make the changes, let’s do it”. That has actually changed me so that I’m feeling better about what I’m doing.

The kinds of changes that nurses sought varied from large scale staffing and policy proposals to more minor practice changes. Most activity consisted of following “channels” and attempting to influence the hospital administration. Occasionally, nurses would talk about the importance of working in relationship to the larger context of the community, and thought that a
wider examination of the interests served was important to determining practice. Lenore considered the health of her patients as extending beyond the automatic doors of the Emergency.

[Trauma] doesn’t hold that novelty anymore, you just start to look at the big picture and what is happening in the community. Where are these people going after they leave our department? How have their lives changed? What is set up in the community to help them through their whole crisis? (Lenore, Emergency Nurse)

Countering dominant interests is not only accomplished through direct confrontation and action. Nurses also “break the rules” and bend their authority in order to get the job done and in order to do what they think is best for the patient. During field work I witnessed many small ways in which nurses refused to complete required charting, refused to follow particular dictums, and pushed the limits of their authority.

The Patient as Agent

To this point, I have focused on the patient only as constructed by nurses. However, throughout fieldwork I observed and talked to patients as they negotiated their own care. Patients enacted their own agency during the Emergency visit in various ways. Some resisted instructions to get undressed, some skirted questions, some gave purposely vague answers, some told nurses that they were tired of answering the same question. Many agitated to be seen more quickly, to be given more information, or given more help.

Some people enter the Emergency with disadvantages in negotiating care. At one extreme, health care providers took away the clothes belonging to people who were drunk or bore psychiatric labels to keep them captive and applied physical and chemical restraints to control their behaviour. Others entered Emergency with advantages in negotiating care. At another extreme, those that appeared to be wealthy, sober, self-reliant, and so on, were more likely to be viewed as deserving and may be treated with deference.
Summary

The beehive is an apt metaphor for the Emergency unit. The unit is abuzz with activity, there is continuous flow to and from the unit, and although the results of communication can be seen, the actual communication is not obvious to the novice observer. The steady movement of activity is punctuated by crises that are dealt with by a swarm of workers. Each type of health care worker has a unique role to play, and each contributes to the overall efficiency of the unit. And as a hive must be sufficiently efficient to meet the honey requirements of the keepers, the Emergency unit must meet the requirements of the hospital, health care system and society.

The efficiency of the unit is critical. Efficiency allows individual health care providers to do their work within the strained economic context of the hospital, community, and health care system. The Emergency serves as the central interface between the community and hospital, offering specific services that complement and supplement those available in the community, sorting health and social problems and regulating the flow of patients into the hospital, providing a degree of resource flexibility to the hospital, and importantly, providing employment.

While dominant interests, along with some of the interests of health providers, are served in the pursuit of efficiency, such efficiency is achieved at a cost for both nurses and patients. The patient is de-humanized to a physiological problem. As the interests of patients and nurses collide with dominant interests, the nurse is faced with conflicts arising from a discrepancy between the type of care that is demanded by patients and the type of care that is provided, and between the type of care that is provided, and the type of care to which many nurses are morally and philosophically committed. It is within this conflictual context that nurses deal with violence against women.
to Lisa

you hit me in the heart
a sweet on rush of pain
clutches at my throat
as you live your fight again
CHAPTER SIX

INTERPRETATION: INDIVIDUAL PRACTICE

Individual Emergency nurses enact practice, including practice specific to violence and abuse, within an ideology of scarcity and in varying degrees of congruence with the predominant pattern of practice. Practice is not, however, mechanically determined by influences within the context. Rather, collective practice is created by many individuals enacting practice in both congruence with, and resistance to dominant ideologies and patterns of practice. Nurses bring to the context of practice various sources of knowledge which influence their practice. In regard to violence and abuse, nurses in this study drew upon formal educational experiences, popular media, and most importantly, personal experience to determine their practice in relation to the influences from the context of practice.

It is important to emphasize that these experiences were interpreted within what Dorothy Smith (1987) calls the "ideological apparatus". Smith cogently argues that the ideological practices of our society provide us with forms of thought and knowledge that constrain our ways of seeing and interpreting the world. Thus, embedded in the meanings nurses created from various experiences are ideas and images not of their own making. Smith says that as women, "we have learned to set aside as irrelevant, to deny, or to obliterate our own subjectivity and experience" (p. 36). And, I would argue, this is particularly evident in regard to the way in which dominant lenses foster the concealment of personal experiences of violence.

The purpose of this chapter is to begin specific consideration of nursing practice in relation to violence against women from the standpoint of nurses. This chapter will consider what individual nurses bring to the context of practice, the bases upon which individual nurses contribute to collective practice in relation to violence, the ways in which diverse experiences are
interpreted within various ideologies to support practices congruent with or resistant to dominant interests. Understanding the standpoints from which individual nurses practice will provide a foundation for understanding how nurses draw upon and reproduce dominant ideology in the efficient processing of patients, and thus may overlook violence, or alternatively how nurses resist such ideology and develop other practices. Such discussion may also create space for considering personal experiences of violence relevant for creating critical consciousness.

Nursing Practice in Relation to Violence: Practice is Personal

Nurses in this study based their practice in relation to violence (within the constraints of the context) upon understandings woven from various sources: some drew on research through reading or education, some drew on images and ideas from popular media, some drew on their work experiences. Most, however drew predominantly on their personal experiences of violence.

When you walk into a hospital setting you are surrounded by generally mostly women and then the hierarchy goes up and it tends to be a lot of men, so what I find is a lot of a woman’s own personal feelings come into play when it deals with battered women, battered children, anything and we tend to personalize it. It becomes a very personal experience and you get really wrapped up in it and then a lot of the people at the hospital have actually gone through a bunch of marital problems and some of them it has been physical, so it is very difficult to separate the personal from the professional. You’ve also got black and white and gray instances that are coming in here, so what we are technically taught isn’t a lot, on how to deal with battered women. I mean, having gone through an Emergency program there is a section on violence in the family but I don’t think it really shows us how to deal with it appropriately. Those people with personal experience may find it easier to deal with battered women than those without, but it can also make it more difficult.

(Lindsay, Emergency Nurse)

Lindsay's words capture the importance of personal experience to nursing practice in relation to violence against women. Her words also capture the complexity and social embeddedness of such experience, and the potential for personal experience to contribute to, or hinder, nurses in their practice. In the following section, the importance of personal experience to nursing practice will be discussed, and the various ways in which nurses used various
experiences will be explored. It is important to emphasize that I was not interested in the nurses’
experiences per se, rather, I was interested in the ways nurses use their experiences to construct
their understanding and actions in relation to violence.

For nurses in this study, personal experiences of violence seemed to be important as a basis
for nursing practice for at least three reasons. First, having little education about violence, the
nurses had few other sources of knowledge to prepare them for dealing with violence, and thus
relied on the media or personal experience. Second, nurses found educational experiences and
popular media limited or problematic. And third, personal experiences are, by their very nature,
laden with emotion, potent, profound.

**Education As a Limited Source of Knowledge**

Formal sources of knowledge, such as research, professional literature, and education, were
not prominent in nurses’ explanations of the basis of their practice in relation to violence. Nurses
occasionally referred to educational experiences, however, unlike physicians, clinical nurse
specialists, social workers and nurse managers, staff nurses generally did not refer to research or
professional literature during interviews.

Most nurses told me that they had little or no educational preparation in regard to violence.
The nurses I interviewed described a lack of education about violence regardless of their own
educational backgrounds, which were varied. Most of the staff nurses that I interviewed had
diplomas in nursing with post-basic certificates in areas such as Emergency Nursing, Critical
Care Nursing, and Outpost Nursing. Many of these nurses were working toward baccalaureate
degrees. Several had baccalaureate degrees already complete, and these nurses also had post-
basic certificates. Only one nurse had a baccalaureate degree as her first credential in nursing.

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1 I was conscious of the possibility that to do this research might be to participate in the sensationalization or
glamorization of violence. I had no interest in using other women’s experiences of abuse as entertainment value,
and have tried to underplay those possibilities.
Some nurses attributed their lack of education to the era in which they were educated. For example, when asked if she had educational background in relation to violence, Monica, like others, said “Not really, no. I trained in the 70’s and that [education regarding violence] wasn’t really going on”. Yvette, who graduated much more recently with a baccalaureate degree said “No, I haven’t taken any specific education about [violence] at all.”

In addition to a lack of violence education in formal programs, several nurses commented that such education had not been part of their continuing education. For example, Susan said “It has not ever been addressed in any in-servicing I have dealt with, in a staff meeting I have ever been to, it is not an issue for the hospital, it doesn’t seem to be.” Nurses talked about the lack of education in relation to the larger issue of organizational disinterest in issues of violence. In one study site, there was no particular interest or support, and in the other study site, initially there was none, but interest and support grew over the study period, largely due to the efforts of an interested nurse leader and a social worker. Nurses from other hospitals also told of having only what education might be initiated by a particularly interested staff member. Margaret was one such staff nurse who had tried to implement violence-related programs in her hospital.

M: I mean I’ve educated the nurses in my group about domestic violence. We’ve had some interesting discussions around culture and so on, and but they’ve learnt from me, and their life experience of course, but...
C: But have you ever had any formal education?
M: No, never.

Of the 21 Emergency nurses interviewed, three mentioned that they had attended in-service sessions on violence, and during my study, both hospitals held educational sessions on violence, again, largely due to the efforts of individual nurses at each site. Only one nurse talked about the education she received as part of an orientation to Emergency, and that was in another province. Palen said
When I moved from the surgical floor that I was working on to enter the Emergency Department in [another province] it was part of the orientation. You got a little section on it, we probably spent maybe half a day on it in our 3 week orientation.

Post-basic certificate programs provided the little violence-related education to which nurses referred. However, most nurses said that such education was brief and provided inadequate preparation for practice. For example, Lindsay, as cited earlier, said “having gone through an Emergency program there is a section on violence in the family but I don’t think it really shows us how to deal with it appropriately.”

Only two nurses said that they had educational experiences that contributed to their practice in relation to violence. Both Anne and Lenore thought that their post-basic nursing programs had provided some preparation. Anne said

I did a postgrad in Emerg and we did do a component of battery...so I’ve had sort of the whole kind of Battery Syndrome explained to me and we discussed it and had some case studies...[and] one of the things that the postgrad program taught me was to start looking for the not-so-obvious, dig deeper and think about things that could be considered (pause) instead of what appears to be.

Similarly, Lenore said that in her post-basic program she had been taught that “...when everything comes back normal and you aren’t sure what is going on, ask ‘what is going on at home, is there something happening?’”. Furthermore, Lenore had been required in her nursing diploma education to do pastoral care, which she felt was important in dealing with women who have experienced violence. She said

That [pastoral care training] was one of the best things I ever did. It is one of the things that a lot of my classmates had a lot of trouble with, because you couldn’t be doing any tasks, your whole task was to sit and listen to the patient and if they didn’t want to say anything you were just there with them and that is a really, really hard thing to do. I am really glad it was a part of my training because... I can see how easy it would be to just ignore that part of it.

What these two nurses thought was important from their education was not factual knowledge about violence, but rather the thinking skills that they gained, the idea of looking deeper, and the
ability to listen beyond what is being said; practices resistant to the predominant pattern of
Emergency practice.

Nurses’ ideas about the education they thought they needed also supported the idea that
their education in relation to violence was limited. For example, Monica said

I suppose the other thing would be to have lectures on violence against women... we need
some sort of education. Maybe lectures on violence against women, recognizing factors or
situations so that when we go in we have that in the back of our minds.

After reading an initial draft of a paper about screening for abuse from this study, Susan
thought about the ways her education had been insufficient in preparing her to practice in relation
to violence.

...my basic Nursing [education] never addressed who I am as a person and what
I believe, feel, think and where all that came from and how I bring that in, not deliberately, but every
single time I open my mouth and how important it is that I know who I am before I go back.

Susan’s thoughts about the deficiencies in her education were not concerned with her lack of
knowledge about violence, but rather, with the lack of consideration for how her personal
experience and knowledge shaped every interaction she has with patients.

In conjunction with the lack of formal education in relation to violence, the nurses I
interviewed had not read much literature in regard to violence against women. Two nurses
talked about reading about violence. For example, Anne said “Certainly I’ve been reading about
it, the journals are exposing us to much more”. Monica also said she had done some reading, but
had not gained significant direction for practice from that reading. “The nursing magazines are
going on about abuse in the home and that sort of thing. But really the media and from what you
read there is no specific preparation for nurses to deal with violence.” Similarly, Anne was
discouraged by the distance she saw between research and practice:

Sometimes I say ‘why did I read that?’ because nobody is practicing it. There is always that
gap between research and practice which we all butt up against. I guess they call it where
the river meets the road... It is a hard gap to... work with. The more you get educated the
harder it is because you see, it’s finding the bridges between research and where we should be, and where we are and the gulf between.

Anne had a sense of futility about reading and education, a sense that was closely related to many Emergency nurses’ perceptions that they did not have much influence on the Emergency unit and the way decisions that influenced nursing practice were made. Her sense of futility can be read as arising from the conflict between the care nurses are able to provide, and the care they would like to provide; and this futility can be read as sustaining the difference.

Only one nurse talked about exposure to research. She had been at a hospital when a study was done about the attitudes of nurses toward sexual assault. The remaining nurses did not make reference to ideas from literature or research or talk about reading in relation to violence, and several specifically pointed out their lack of knowledge or reading in relation to violence.

The lack of attention to violence and abuse within nursing education, apparent from the experiences of nurses in this study, suggests a lack of concern about violence within the larger nursing community, and was reinforced by the lack of commitment to dealing with violence by the hospitals in which these nurses worked. Educational experiences were limited in that they were rare and the preparation provided was seen as inadequate by the nurses. With limited education, little or no exposure to research regarding violence against women, and, in most settings, little organizational support for dealing with violence effectively, most nurses did not seek knowledge about violence in a systematic way. During this study, several nurses became interested in doing so. For example, after reading an initial draft of findings, Susan said

“...violence against women is not something that I’ve done a lot of reading about, a lot of contemplation about or had a lot of direct experience with, so it raised my awareness and I have plans to follow through with some readings”.

In lieu of systematic and purposeful pursuit of knowledge, nurses relied on sources that were freely available: the media and personal experiences of violence in their families and work.
Popular Media as a Limited Source of Knowledge

Throughout this study, nurses and others drew on the popular media to discuss their ideas about violence. They referred to general understandings they derived from the media and to specific situations. Some specific instances that were referred to were high profile cases that had occurred in the past, others were current; some were local, some were international. The murders of Nicole Simpson and Ron Goldman, and the O.J. Simpson trials occurred during the span of this study, as did the trial of Calgary socialite Dorothy Joudrie for the attempted murder of her husband, Canadian Tire chair, Earl Joudrie. Reliance on popular media was problematic to the extent that media functions ideologically to sustaining certain ideas about violence.

Some nurses said that popular media had given them a greater awareness and understanding of violence and abuse. Anne drew on various television and radio programs to enhance her understanding. She said

I’ve seen more on television about violence against women, you know the Burning Bed and all of these movies have given us their insight. I think the Burning Bed was really one of the first really good insights into how bad it can be for women.... A few weeks ago on [a phone-in radio program] they had a lady speaking about women and violence and the question they were posing to the public was “why not just leave”, I think that was the question, and so women were phoning in and saying - “why don’t they leave?”.... We see on television about what it’s like to be in a battered situation in a very well-to-do area, where you are maintaining your social commitments and whatever, and that you may not even recognize yourself as [battered]. I’d love to see those scenarios played out so that they become real for me, because reality is partly your perception. I can’t intervene in something that I can’t see.

In this account can be seen certain ideas about violence. For example, posing the question “why don’t they leave?” presupposes ideas about choice and abuse, and points to the individual woman as responsible. The points about being “well-to-do” and “recognizing” oneself as abused betrays ideas about class and violence and about victimhood. At least to some extent, Anne shared the
ideas conveyed by the radio show and thus the media message functioned ideologically, sustaining Anne's ideas.

Most people that I interviewed cited at least one specific story from the media. For example, in explaining her ideas about the origins of violence in the family, Faye described a newspaper article that to her illustrated how poor parenting can lead children to become angry, violent adults.

There was that article in the paper which was really interesting - somebody cut it out at work - it was about [our] Hospital, about this little boy that was going for surgery and his Dad spent most of the time on the phone and then once things got settled that he was going to stay his Dad took off and this poor little boy was lying there in tears in the Emergency Department, left for us to take care of. Well how is he going to feel in 10 years, "they don't care about me". Naturally he is going to go out there, hopefully not but, get into trouble simply because he is getting attention from his peers and one thing leads to another and they are having fun. It is sad but I think that example right there because of the way things are. Father is business, business, business, Mother was at work too. Suddenly the Emergency Department is left to baby-sit this poor little boy. There is a good whole example right there.

Again, this nurse shared the ideas conveyed in this account, and interpreted the message in congruence with her own ideas that violence is at least partially caused by poor parenting.

Media accounts also function to sustain ideologies about “race” and violence. Several nurses told me that they got their ideas about “cultural” differences in the incidence and presentation of violence from the media. In a conversation during my initial fieldwork, Teri asked me why I was not doing my study in Surrey.

Aren't there like cultural, like there was that story in the paper about that East Indian guy that shot his wife and...well maybe we just don't see it..." At this very moment, Elaine, the assistant head nurse, returned with my letter and interrupted by pushing the letter in front of me. Beside the question "What education/preparation/support do nurses receive with regard to violence against women? she had written "NONE." Beside the question "What do nurses in hospital settings base their practice on when encountering violence against women?" she had written "MEDIA". She pointed these out and said "that's what we practice on, media." Teri joined in. "Yeah, that's right, I was just telling her about that story in the paper, about the guy that shot his wife". (Field Notes, November, 1994).
If the media tends to report more sensationalized cases, and have a class or racial bias in reporting, nurses might incorporate these messages in their practice.

Media messages are not always accepted uncritically in support of dominant interests; media messages may also be used to challenge those interests. In resistance to what she saw as silence and the neglect of violence, Lulu emphasized that violence exists in her community with another story which had received considerable media attention.

The other issue that is difficult, because of the community that we live in, is that violence is not upper most, people ignore it, but it happens and it is here. I mean it was across the street with [a specific woman] who was murdered and we don’t know where she is or what happened to her body, but anyway it is right here in the community.

Nurses were also critical of the relationship between reality and media representations of violence. Talking about a nurse who had shared her childhood experiences of physical and sexual abuse, Lulu said

It was like a TV movie, you know, a Sunday night TV movie. It was like what happen to her was what we deem as entertainment on the television and I thought, it’s real people, it’s not that fictional character on the television, this is a real person who has had this horrible, horrible, horrible upbringing.

Nurses were also critical of the representations of violence against women in the media.

I feel frustrated with society at large that we don’t do more about the violence in media, for one thing. I think that is really not helping our cause. I think it is bringing up a whole bunch of young little men that recognize that violence is part of life and I just think that sets the mode for more violence not less and I really feel we have got to change that side of young people, diffuse the exposure to violence not providing them with it and then expecting them to behave in a rational, logical, humane way to each other. How can you expect them to work together. So I get very frustrated with that because I see a whole society getting aware and society becoming, I guess the word I would use is desensitized to a lot of stuff. That’s my frustration. (Anne, Emergency Nurse)

Despite frequent referrals to stories from the media, most of the nurses in this study said that the media had a limited impact on their practice. Although Anne found value in the media, she contended that personal experience was much more powerful. “You can almost be exposed to a
lot of stuff from all sorts of media, people telling you that this happened and that happened but what really influences the way you practice is what you’ve experienced.”

The nurses in this study drew on the media to inform their understanding of violence, often using high profile stories as cases which illustrated their thinking. There may be instances in which media biases are unchallenged and may serve to inform nursing practice in an uncritical manner. However the nurses in this study were often critical of media representations of violence, and often balanced media stories with their own personal experiences. Thus, although education, research, literature and the popular media were mentioned as sources of knowledge regarding violence, each of these sources was minor, and each was dismissed as being less important than personal experience.

**Personal Experience as a Basis for Practice**

For nurses in this study, personal experience appeared to be the most important basis of nursing practice in relation to violence against women. The personal experiences that the nurses described as grounding their practice occurred in the nurse’s family and in the nurse’s work. Nurses described the experiences as especially powerful and influential when they were associated with close relatives, and if the experiences involved physical violence. Nurses described their experiences of violence in their families in ways which can be categorized as 1) being the direct victim of abuse, 2) being the witness of another’s abuse and the indirect victim of abuse, or 3) being the witness of the consequences of another’s abuse. The experiences from work that nurses discussed as a basis for practice were those experiences in which they provided care for a victim of abuse.

Talking about personal experiences of violence was understandably difficult. Some nurses began their interview by asking if I wanted to know about their personal experiences. I always
left the decision to share personal experiences to the person being interviewed, and instead, focused on the research questions regarding the influence of the social context. Then, invariably, each nurse would weave her own personal experiences through her interview. Nurses used personal experiences to illustrate various points, and often left the subject abruptly, and later returned to talk about it some more. Several times, nurses shared personal experiences after I thought the interview was over, and occasionally after the tape recorder was off. Sometimes personal experience was talked about indirectly. For example, one nurse told me about a boyfriend hitting her, but then chose mostly to talk about her cousin's similar experience to illustrate her ideas throughout the remainder of the interview.

Interestingly, some nurses told me that they declined to participate in this study because they had no experience of violence, either in their families or at work. This was quite telling, because many of these nurses had many years of emergency nursing experience, suggesting that they practiced with little awareness of violence.

Other nurses may have declined to participate because they had personal experiences of violence, a possibility suggested by the fact that I was told by various staff members which nurses were currently living with, or had separated from, abusive partners, and these nurses did not participate. Nicole speculated about the decision to participate in the study and personal experience of violence, and told me of the reaction of at least one other nurse.

If you had asked me directly [for an interview], I might not have... because I knew this was going to happen. As soon as you talked to me I thought "well, I should do this", but I knew I would end up disclosing. I thought I could trust you in a way. Nurses who haven't faced their own history, haven't disclosed, they would say no [to being interviewed]. I told [another nurse] what I was doing today and she said "I wouldn't have anything to say, I just get frustrated. It took my mom eight years to get out", so I think that she just thinks there is no point, it takes along time and she just is frustrated.
Of seventeen Emergency nurses I interviewed in the primary study sites, none had experienced abuse in the position of wife, except perhaps one nurse who had been abused by a non-cohabiting boyfriend as an adult (see Appendix 12). Two other nurses told of being the primary targets of violence or the direct victims of abuse: one was abused as a child by an alcoholic father, one was physically struck once as a teenager by a boyfriend. Six other Emergency nurses had experienced violence within their families. These six nurses were “witnesses” of violence, and/or the consequences of abuse done to their mothers, daughters, sisters, or partners who had been abused as children. Four of these six nurses saw these experiences as fundamental to their practice. The two others had sisters who had been abused by partners, but did not claim personal experience as foundational to their practice.

Seven nurses did not experience violence in their families; some of these had few or no experiences of violence at work. Two had cared for patients who had experienced significant, dramatic violence, and saw those experiences as seriously influencing their practice. For those nurses who had neither direct experience in their families, nor significant dramatic experience of violence through caring for patients, the lack of experience influenced their practice.

The non-study site nurses who were interviewed had a slightly different mix of experience: two had no experiences of violence in their families, one had a sister who experienced wife abuse, and two had experienced abuse in the position of wife.

In addition to the nurses who were interviewed, a number of other nurses and other health care providers shared their experiences of abuse with me. In one study site the number of stories, combined with the level of stress from work-related sources, were so overwhelming that I found it difficult to continue with field work. For example, in one four hour field work visit, I was told by a nurse about her abusive husband’s (from whom she was divorced) continued abuse of her
son, told by a patient of abuses she experienced in a Vietnamese refugee camp in Hong Kong, and told by an admitting clerk about the sexual abuse of her 8 year old daughter by a neighbour. Thus, while this study draws on the experiences with violence in the families of the nurses interviewed, these represent only a small proportion of the experiences of nurses and other health care providers.

Before analyzing the way in which nurses used personal experiences as a basis for practice, I will briefly describe the types of experiences the nurses I interviewed shared with me when explaining their practice.

Experiences of Violence at Home

Those nurses who experienced violence directly or indirectly in their families used that experience as a basis for their understanding of abuse, and as a basis for practice. I did not ask nurses about their personal experiences, rather, they offered such experiences in explanation of the basis of their practice. For example, when I asked Faye if she had any particular preparation for dealing with violence, she answered

Well, actually, yes. I didn’t realize it until after I left my second husband that he was beating my daughter. Not on a regular basis, but his anger would come out in a violent way and it would happen when I wasn’t home. She told me this after, a couple of years after, we were on our own. Then that’s when I, you know when you experience it yourself you tune in to it a lot more. Looking back on it I saw the signs but I didn’t see what I was seeing. So it is easier to pick up on other people, the body language, the little comments and stuff like that. I try to tune in to it. I always try to tune in to it at work and I would try and identify, if I had the time. Life experience on its own is a big teacher.

Like Faye, most of the nurses who had experienced violence in their families were explicit about their use of personal experience in practice and were convinced of the importance of that experience. For example, Anne said

I think probably we have all had violence in our backgrounds somewhere I suppose. I certainly know I have had, and I guess part of... the way we come at wanting to say that ‘well I feel that the problem can be helped and I have a better way’, or ‘I have my own way of dealing with it’ would be to come from what I experience; what violence experience I’ve
had. And certainly at home in my own parental relationship there was some violence, not a lot, but enough that I had to deal with it.

As the words of Lindsay, Faye, and Anne suggest, the nurses I interviewed not only emphasized the importance of their own personal experiences, but also talked about the importance of such experience to others. In a casual conversation after an initial interview, Nicole talked about the importance of personal experience in developing an awareness of violence and related issues.

Nicole referred back to personal experience and how it informs practice. She told me more about the charge nurse she was working with when caring for the Chinese woman who had been choked. She said that the charge nurse was so "tuned in" that Nicole thought to herself "you've got history". (Field Notes, November 1994)

That certain nurses “have history” with violence is seen as problematic by some nurses. At my initial meeting with one head nurse, her primary concern was what to do about nurses in her department who are currently being abused by partners.

She talked of problems with confidentiality when staff members confide in her and she does not know what to do. She gave an example of a staff nurse who she knew was being abused, and said that it was frustrating to not be able to do anything. She described the nurse as “thin as a stick, a little thing” and seemed very frustrated at her inability to “do anything”. (Field Notes, November, 1994)

Another head nurse said

Not only does [violence] happen here with the patients but just look at our own department and the odds are, there are [many] women here, you know, what are the odds of many of them having been privy to violence in their own lives at any particular time?

She told me of many instances in which she saw the influence of experiences of violence, or was told of the influence of such experiences by nurses themselves. For example, she said

There are nurses in the department, that I know were in abusive situations. The two that I am thinking of in particular, have left those situations, but what hasn’t left them is the negativism. I see that in their practice everyday and I guess it is an anger.

Each of the five head nurses interviewed knew of staff who had been or were living with abusive partners, and struggled with the impact of these experiences on nurses and their care.
The nurses who had direct experience with violence in their families often thought that others who lacked similar experience were limited in their nursing practice. For example, Nicole discussed the basis of her practice in contrast with others:

C: Have you had any form of preparation, education, support, anything like that to help you, or...
N: Well, probably, oh... past experience, with family, my own upbringing, alcoholic family, so you know what its like. I know what it is to be in an alcoholic family. Maybe that’s why I am more in tune. I think that people, nurses, anyone that’s never been in that position, don't really know what it feels like you know. People comment, “Wow, I don’t understand it, I can’t see why anyone would stay with an abusive person.” Yet, I’ve seen my mother stay with someone.

What was immediately striking was the way some nurses responded to questions that clearly invited descriptions of formal educational preparation. Rather than talking about formal education, Nicole, Anne, Faye, Jackie, Shelby, and Lulu all replied by talking about personal experiences of violence in their families. For others such as Lindsay, Margaret, Palen, Susanna and Kathy, the experiences were influential, but seemed more integrated with other sources of knowledge, such as experiences at work, and education. Some nurses, such as Susan and Vail who had sisters who were abused by husbands, had not explored to any great extent the ways these experiences might be influential.

No Experiences of Violence at Home

For nurses with no direct experience of violence in their lives the lack of experience influenced their practice. Again, the nurses interviewed were explicit about where they lacked experience and therefore lacked guidance for practice. After five years of emergency experience, Bo repeatedly emphasized her lack of personal experience.

I don’t like the thought of a woman being violated like that. I makes me sick and it makes me sad, but maybe because I’ve never experienced it on a personal basis with any friends... and that I have never worked with it at work, it has never been strong in my mind.... But I don’t have any basis within my own upbringing or my own friends. I have never seen really seen anybody come in to our [unit], or I have never recognized anybody, maybe because of
my ignorance... That is not something that’s in my history, to be very honest with you, until you came around.

Like Bo, several nurses who said they had no experience with violence in their families saw such a lack of experience as a limitation, and thought that such experience might contribute to nursing practice. For example, when considering the idea that some nurses might have personal experiences with violence, something she had not previously considered, Yvette pondered

Would they (nurses who had experienced violence at home) not tend to be more empathetic? Obviously they wouldn’t share their own story, but would they not even pick up clues better than others? Like “I’ve seen this before in me and I know why it is in you”, or is that not true?

Most nurses who did not have experiences of violence in their families drew on experiences of patients they cared for at work. When I asked about her background and preparation, Elaine said

Well, background, as far as managing domestic violence, I don’t really have any because it’s sort of... I’ve gone to lectures and in-services, but as far as...and it’s been sort of media and reading brochures and listening to social workers and that sort of thing...but, no, no background as such, and I never had to deal with it myself so, you know, no first hand experience... But we see a lot of people, you know, especially women that are abused.

Experiences of Violence at Work

All of the nurses who had experienced violence in their families, and some who did not, were able to tell of providing care to victims of violence. Interestingly, two of the nurses who did not have any experiences of violence in their families did not recall any experiences of giving care to women who had been abused, and several could recall only a few instances, despite many years of emergency nursing experience.

Those nurses who referred to experiences of violence at work, described experiences in which they cared for direct victims of violence. Interestingly, despite evidence that violence against nurses by patients and physicians is a significant problem in health care in general and Emergency in particular, (e.g. Croker & Cummings, 1995; B. S. Mahoney, 1991; Schnieden &
Marren-Bell, 1995) and I saw several episodes of patients striking out at nurses, or being verbally abusive, nurses did not cite these experiences in discussing their practice in relation to violence against women. Rather, they drew on experiences of care giving with victims of violence that they found remarkable in some way. Some of the experiences nurses related were either marked by serious and dramatic violence, by very vulnerable victims, most notably children, and, in several cases, by what the nurse considered to be a successful outcome.

Each Emergency had experiences that became part of the history of the unit, because they were extremely violent, or highly publicized, or involved very vulnerable victims, or had a lasting impact on staff or were in some other way memorable. These incidents were often discussed by several nurses in separate interviews. For example, a “Chinese” woman who had been strangled to unconsciousness by her husband was seen in one Emergency during the time I was there, and was discussed by several nurses. Another woman was strangled by her brother to the point where she suffered a stroke, and was discussed by many nurses and others in informal conversations and interviews. Several of the cases that nurses drew on where so highly publicized in the media that the nurses’ stories could identify both them and the hospitals that served as study sites, and thus will not be detailed in this account.

Nurses often cited experiences of caring for children who were victims of abuse. For example, Lenore was profoundly affected by the children for whom she had cared and contrasted her empathy for women with her empathy for children, whom she found more deserving.

I worried more about the children, the women, yes it is an issue but the higher priority to me is the children...within six months I had a five year old with Chlamydia, a three year old with gonorrhea and a two year old with anal lacerations, so that was really heart breaking.
Other nurses, such as Elaine and Faye also drew on many stories of different children they had cared for, children who had been abused or neglected, or witnessed abuse. Each of these stories was told with empathy for the children.

In summary, the nurses interviewed in this study talked about their personal experiences with violence, both when asked about their education, and when they explained their ideas about violence, abuse and the nursing role. They described experiences of violence both within their own families, and at work. Most nurses who experienced violence in their families drew predominantly on these experiences as a basis for practice, especially, it seemed, when the experiences had a significant effect on the nurse herself. Nurses who had experienced violence in their families were also able to describe and draw on experiences of violence at work. Nurses who did not have experiences of violence in their families described the lack of experience as disadvantageous to practice, and most drew on experiences of violence at work as a basis for practice, although a few could recall no or few instances despite many years of Emergency experience. Nurses used these varied experiences to develop their understanding and practice in relation to violence, with each type of experience being limited. The ways each type of experience is limited will be described, with particular attention to the influence of dominant interests.

Experiences of Violence at Work as a Limited Source of Knowledge

Experiences of violence at work were limited as a source of knowledge in at least four ways: 1) nurses could recall very few such experiences, 2) the experiences that were recalled were usually instances of obvious physical violence, 3) the experiences that were recalled often involved 'non-white' women, and 4) there was little sense of whether what the nurse had done was or was not helpful to the woman.
As previously noted, most nurses could recall only a few experiences of violence, despite many years of emergency nursing experience. For example Monica, who had over 12 years of nursing experience in several different Emergency units, could remember only a very few women that she had known were abused, and estimated that she had seen perhaps a dozen women in as many years.

C: In that time you don’t think you’ve seen very many situations in which you think ...?

M: Not that I’ve been aware of. Now that excludes people who are sexual assault - people who I guess would fall into that category of abused women. Maybe I’ve seen a dozen, half a dozen maybe, or some of them were women with psychiatric problems who’d come in and were being victimized by the person they were with, but there must be people that go by that we aren’t aware of, that we miss.

Faye, who had even more Emergency experience, could remember very few women, and Anne could remember only one specific woman for whom she had cared. This suggests that only certain instances come to nurses’ attention, or are recalled as having an impact on the nurses’ understanding.

Almost every example of abuse that nurses could recall involved acute, dramatic, obvious, physical abuse. This suggests that less obvious forms of abuse such as minor physical injuries, systemic consequences of living under stress (such as migraine headaches, depression, gastrointestinal complaints), chronic injuries (such as back injuries, hearing loss, arthritis) and the signs of mental and emotional abuse are not used by these nurses in developing their understanding of violence. Perhaps these situations are not recognized as abuse, perhaps individual situations are “lost” in the endless flow of patients, perhaps most abusive situations are “forgotten” as uncomfortable experiences, and only extreme instances of violence intrude into memory. However, that only instances of physical abuse tend to be recalled is congruent with the predominant pattern of practice; nurses are focused on physical concerns and efficient processing
of those problems. Focusing on physiology leads to the recognition of physical abuse which in turn reinforces ideas about abuse and recognition of abuse.

Nurses commonly identified the women they could recall as abused as belonging to a specific ‘non-white’ ethnic group and/or as being poor. With a rare exception, all of the nurses in both Emergency units were visibly ‘white’ (at least to my eyes), and, by virtue of their work, had both education and income at least above the poverty line. Thus, nurses’ social positions and ideas were often congruent with dominant ideologies about “race”, class and violence.

When initially discussing my interest in how nurses care for women who have been abused, one head nurse said “My staff are good at identifying people. We had an Inuit woman here just a few nights ago”. Depending on the ethnic make up of the community in which the nurse worked, some nurses recalled experiences with particular racialized members of that community and often saw these groups as more likely to experience violence. For example, one nurse said “I guess I would have to say from my practice that the case scenarios that come to mind most easily would be with Native Indian women”. Later, this same nurse said

Native Indian women are very vulnerable to that sort of thing, and I think they come to us for help and when I have seen them they have been fairly significantly battered and it is usually not something where you are wondering about the woman having had some abuse.

Some nurses thought certain groups of people were more prone to violence (the men more violent, the women more passive, and so on), and congruently, tended to recall women from these groups that had been abused. Many nurses were aware of the effect of only recognizing particular people as experiencing abuse. One nurse said,

Culturally, because I have had a lot to do with [a certain group of] people in the last [few] years, I would say overall, that as a group of nurses at [this hospital] people are more suspicious of abuse in a multicultural type of patient situation than they are in an actually Caucasian situation.
Not all nurses assumed that there were differences in the incidence of abuse based on “race” and class. In response to my telling her that several people recommended that I go to another community to study violence because there were in the words of one person, “more welfare and East Indians”, another nurse said sarcastically, “Yes, that’s it, it only happens to Native women. I mean this is [our community], everybody is rich and they don’t have anybody like that”.

Some of the nurses considered why they might or might not see abuse to a different extent among different groups of people. For example, one nurse pondered

I think in general, if you take the population of the Vancouver area they [nurses] are aware that violence goes on but whether different ethnic groups would have different perceptions I think would probably be very true. Especially in societies where it tends to be very much male dominated it might be very hard for the person to come out and say “yes I am having problems”.

However, the majority of experiences that were recalled by nurses involved certain groups of people, and these experiences were often used to support the assumption that there were differences in the incidence of abuse between ‘white’ people and ‘others’ (racialized groups).

Finally, personal experiences at work were limited by the fact that there is very little opportunity for nurses to experience success, due to the nature of nursing practice in the Emergency setting. In congruence with the predominant pattern of practice, and in the service of “efficiency” nurses do not follow up patients who are discharged, and have only limited follow up for patients who are admitted to hospital. Only four of the study site nurses recalled experiences with women in which they had a sense of making a difference. The following story exemplifies the types of scenarios that nurses recalled. This nurse is talking about a First Nations woman whom she cared for in Emergency.

I can only remember one lady who came in with very battered chest and breasts, lots of bruising that we dealt with... actually we almost both cried together because it was such a sad scenario that I remember asking her if she felt it wasn’t time, that she counted, that the... support was out there and really making it, getting the feeling that she really was going to, at least, use the resources that was there to try and make a change for herself and I can’t
remember having seen this lady again so, (pause) you don’t get the feeling that you are making all that much difference, no.

As in this situation, few work experiences were recalled, and those that were recalled were usually of obvious physical violence, were often marked by the woman’s ‘non-white-ness’, and were rarely associated with any sense of whether or not the nurse had been helpful. Thus, although nurses relied to some extent on their work experiences, such experiences were too few to provide a significant foundation for practice, offered little in the way of challenging racial or class assumptions, and offered no basis upon which to judge the effectiveness of nursing actions. The nurses in this study drew to some extent on these experiences from work, but wove these experiences with and relied more extensively on personal experiences within their own families.

Creating Understanding from Personal Experience

As nurses in this study practiced in relation to violence primarily from personal experience, they created their understanding and interests\(^2\) in relation to violence from interpretations of those personal experiences. It is critical to examine the relationship between nurses’ personal experiences with violence, their ideas about violence and how they view their own interests, because these experiences, understandings and interests influence nurses’ practice and their congruence with or resistance to dominant interests and patterns of practice.

Rather than being a simple relationship in which, for example, nurses with more experience or more direct experience with violence were more interested in ending violence than nurses with little or no experience, the relationship between personal experiences and interests was much more complex. Some nurses with quite varied experiences of violence were passionately

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\(^2\) Oliga (1996) argues that “there are self- or individual interests, sectional interests, and common or collective interests” (p.85). In this section, I am concerned with how individual interests in relation to violence are related to interpretations of personal experience, and may work in congruence with or opposition to collective dominant interests.
committed to ending violence; others with equally varied experiences were largely oblivious to violence. Some nurses' interests were served by anti-violence action; others' interests were served by ignoring violence. The only apparently “simple” relationship between personal experiences and interests were embodied in the three nurses who had directly experienced violence in the position of wife; each was committed to ending violence to the extent of doing specific anti-violence work in her professional or community life; each saw neglect as counter to her own interests.

Examining personal experience as a basis for practice in nursing requires examining the ways in which such experiences are interpreted, and thus how nurses frame their own interests. Nurses varied greatly in the extent to which they described having thought about their personal experiences. Lulu, for example, gave an incredible amount of thought to the influence of her daughter’s murder on her nursing practice. She described how this tragic experience initially impacted her practice:

In the two years... after her death I was a maniac, an absolute maniac. It didn’t matter which patient came into the hospital that I was dealing with, I was on those women right away. I had one woman in tears one night, she came in with a broken arm, her husband had slammed her arm in the door and broken her arm, and it was intentional. I terrified her, I absolutely terrified her, “I said, you’ve got to leave now. You can’t stay with him. You have got to believe him if he says he is going to hurt you, he could kill you, he could buy a gun, he could (pause)”. I mean I can’t imagine what I did to this poor woman, because obviously that wasn’t helpful. But I was terrified. I mean if this little wimp, that I could beat up if I tried, could kill somebody, then what about other men? So I think I probably didn’t do a good job of helping women for about two years because I was just this bulldozer, bulldozer is a good word for it. I had blinders on and I couldn’t see anything.

Immediately following her daughter’s death, Lulu’s own interests were served by focusing on violence and attempting to force women in to actions that Lulu believed were in the women’s best interests. However, Lulu described not only the initial impact of this tragic experience on her practice, but also the way in which she engaged in a process of knowing over time. She
reflected thoughtfully on her experience, synthesized various perceptions, and developed connections between her personal experience and other sources of knowledge. In the following passage, Lulu struggles to imagine experiences which she finds unimaginable, in order to synthesize her experience with other perspectives.

"I have come full circle from that now, I believe, in that I can really understand women and why they stay in relationships and what is at stake for them and all of the variables, instead of just the one variable. I think that makes a big difference to them. I can't imagine what it would be like to be alone, without a job, maybe with kids, or without kids, maybe in a city where you don't know anybody else, versus being with somebody who is actually supporting you, even though he is hurting you at times, he is still bringing in money and feeding you and the kids. So it would be a horrible, horrible situation to be in."

Gradually, Lulu’s interests were tempered with a growing understanding of experiences of other women, and her own interests became aligned with the interests of women she saw as patients.

"Life experiences come raw and undigested and require the engagement of the mind in the process of knowing to develop those experiences into knowledge. Unlike conceptual or empirical knowledge in which someone else has done some of the analysis, personal experience can only be analyzed by the knower. Not all nurses had actively engaged in processing their personal experiences to the same extent as Lulu. Some nurses simply applied their personal experience to their judgment of others with little consideration of how one’s personal experience might differ from others. For example, one nurse, Nicole, described the experience of growing up with a physically abusive alcoholic father. She said bluntly “I figure if I can get out, that other people should”. She had not explored the ways in which her resources (personal, economic, social, and so on) might have influenced her ability “to get out”. She saw herself as a strong person who had overcome a difficult situation, and thus her own interests were congruent with ideas about triumph over violence as personal victory. Like Lulu initially, her own interests arose from and shaped her interpretations to the exclusion of other perspectives."
Despite the variations in critical analysis of personal experience, both nurses who had, and
did not have personal experiences of violence in their families saw the experiences as
advantageous to their practice in relation to violence. The primary advantages nurses thought
such experience provided were an increased awareness of violence as an issue and possibility,
and a greater understanding for women’s experience.

Heightened Awareness and Understanding Through Experiences of Violence at Home

The nurses I interviewed claimed that their experiences of violence in their families raised
their awareness of violence and helped them to be “more in tune” to violence, more alert to cues.
Nicole said “Maybe that’s why I am more in tune”. Faye said “...you know when you experience
it yourself you tune in to it a lot more”. Anne said

What is part of my practice, and I think that I have some personal experience, much more in
the last few years, is the awareness that it is an issue with women and always feeling
comfortable about asking them if they come in for whatever reason, for trauma, whether or
not the violence is part of the issue.

Congruently, those nurses who did not have experiences of violence in their families felt this
lack of personal experience limited their ability to recognize violence, an idea supported by the
fact that they tended to recall few, if any, experiences of giving care to women who had been
abused. For example, Bo said “because I have never dealt with it... honestly it is something that
has never entered my mind.

Nurses who had experiences of violence in their families thought that these experiences
provided them with a better understanding of violence, and similarly, nurses who did not have
such experiences thought that their understanding of violence might be deficient due to their lack
of experience. Faye thought that her personal experience made violence “easier to pick up”,
Nicole thought her experience helped her understand “what it feels like”, and Yvette, Palen and
Bo thought their lack of experience made understanding more difficult. However, closer analysis
of the ways in which nurses use their experiences to create knowledge suggests that it is not only *what experiences* the nurses have, but *what nurses make of those experiences* that determines the advantages and limitations of using personal experience as a basis for practice.

**Experiences of Violence at Home as a Limited Source of Knowledge**

Although the nurses I interviewed thought that experiences of violence in a nurse’s family heightened awareness and understanding of violence, there appeared to be several limitations to the use of such personal experience as a basis of practice. These limitations were related to 1) assumptions about the extent to which the nurse’s own experience applied to another person’s experience, 2) the emotional investment some nurses made in women taking a particular action, and thus the goal of care the nurse held, and 3) the empathy nurses had when viewing other women through the nurse’s own experiences.

Analyzing the way nurses use personal experiences of violence through a critical thinking framework suggests that the extent to which individual nurses engaged in critical thinking varied greatly. Brookfield (1991) offers one of many frameworks for critical thinking. He suggests that critical thinking is comprised of 1) challenging our own assumptions, 2) exploring alternative ways of thinking (taking various perspectives), 3) challenging the importance of the context, 4) exploring alternative ways of acting, and 5) practicing reflective skepticism. Thought of in this way, critical thinking is a primary form of resistance to ideology. The extent to which nurses think critically about their experiences can be related to the congruence of their thinking with dominant ideology.

The assumptions made, the emotional investment in a particular outcome, and the nature of empathy seemed to vary *not with the nature of the personal experience* that the nurse had, but rather, with the *process of knowing* in which the nurse had engaged. Nurses both with and
without experiences of violence in their families left assumptions unchallenged, and applied their
own experiences to others without considering the impact of the context, and how other
perspectives might vary from their own. Conversely, nurses both with and without experiences
of violence in their families challenged their own assumptions, considered the influence of the
context, and synthesized their experiences (or lack of experience) with other perspectives and
sources of knowledge. Consequently, the goals of nursing and the ways to achieve those goals
(ways of acting) also varied greatly between nurses as different approaches served different
nurse’s interests, depending on the way the nurse created knowledge from her experience.

Challenging Assumptions

The nurses I interviewed both made and challenged assumptions about violence and abuse,
women who are abused, and the role of nursing in relation to violence. For example, different
nurses took quite different positions regarding women’s roles in provoking violence and
responsibility for violence. Some nurses entertained the idea that women are responsible for
provoking men’s violence (an idea which, if used to make women responsible contributes to
sustaining unequal power relations), whereas others questioned this assumption and concluded
that men bear responsibility for their own violence. Similarly, some nurses thought that women
were to blame if they stayed in relationships, whereas other nurses questioned this idea. These
different positions did not arise from direct experience with violence or the lack of direct
experience. For example, Anne had lived in a family in which her father beat her mother.

The other issue that I find that they deal with, or don’t deal with actually, is if, in fact, there
is any part that they played in either exacerbating or stimulating this scenario to occur in the
first place. It is a part of the whole violence against women issue that I have a bit of
difficulty with, and that is how do women, what do women do, now though I feel, I don’t
want to get into a difficult scenario here, I feel very strongly about women and violence and
that women should not have to put up with it, but, I keep wondering what is it about
women’s personalities that allows us to get to a point where violence is an issue (Anne,
Emergency Nurse).
In a subsequent interview, Anne reflected on her earlier thinking, and concluded that because prior to this first interview she had been refusing to admit that her father had been violent toward her mother, she had been thinking about violence in particular ways that helped her to continue to avoid such painful thinking.

It was coming to the realization ... that there ... was, in fact, some abuse in our family, that I hadn’t really come to terms with, made me think about the fact that I’m missing out a whole bunch of clues, because I refused to use that input... It would just go by me because it’s almost a wall.

In contrast, Bo, who had no exposure to violence in her family or friends challenged the idea that women bear responsibility for violence done to them. She said “I think there was a stigma attached to these women, like maybe they had asked for, which in fact I don’t think they did ask for it at all. I believe very firmly “No” is “No”!

These two examples illustrate the ways in which different interests influence thinking, and how experiences give rise to certain interests. Anne had an interest in protecting herself, Bo had no specific personal experiences to influence her interests in viewing violence in a particular way. These examples also illustrate, especially in the case of Anne, how thinking and personal interests can evolve and change.

Several nurses were explicitly critical of the way in which ideas about violence function ideologically. Lindsay, whose marriage had been seriously affected by the consequences of her husband’s experiences of violence talked about the way in which women are viewed by many nurses as being responsible for their own situations if they stay with abusive men. Her personal experiences led her to be angry about the neglect of violence and the way blame is cast. Lindsay talked about one woman who returned to Emergency repeatedly.

She seems better, but I just think to myself, having listened to other people’s comments as well, “if she doesn’t get the hell out of there then it’s her problem and it’s her fault”. Well again that is society’s stigma that is causing that, and that infiltrates nursing.
As her words indicate, Lindsay was critically aware of the influence of social values on her thinking and the thinking of other nurses. She went on to say “We all go in with our own thought processes, morals, values, judgments, standards, etcetera, and even though you are a nurse and you are supposed to be Florence Nightingale, those problems enter into nursing.”

Importantly, the assumption of blame made by some nurses was experienced as damaging by the women who had experienced wife abuse. For example, Louise talked about how responses of health care providers can replicate the violence in a woman’s home when the response includes assuming that the woman contributed to the violence she has endured.

...wondering what did you do, you know, perhaps you shouldn’t have said what you said, or perhaps you shouldn’t have done what you did. Just even the doubtful look rather than coming along side and saying “whatever happened I hear you, I understand you, or I will make an effort to understand you and I’ll try to be a help to you”, rather than that quizzical look and “well what brought this on?”, it makes someone feel like they were responsible for it happening.

Another woman, Nadia, talked about various ways health and service providers had implied that she bore responsibility for her husband’s violence. She was adamant that she would prefer to leave without help rather than be blamed for the abuse.

This is not what I want nurses to do in a hospital because if that is the case I don’t care how painful it is I am going out, I am going to go home, back to hell, [rather] than having somebody else reinforcing that it is all my fault.

Nurses also made assumptions about women’s thinking in relationships where violence occurs. For example, Anne thought that women fail to recognize abuse as such, and therefore should be educated to become more astute in recognizing violence and taking immediate action.

She later thought that her ideas about the violence her mother experienced and the way she thought her mother should have dealt with her father influenced her thinking. Initially she said

I think women are going to get to the point where the very first time a man shows violence she is going to know that she’s got a violent, the possibility of a violent relationship. She won’t wait until it happens five or six times to start thinking about it, the first time it happens she knows.... I think she would be better to swing way over to the first time it
happens that’s where I am and that’s how I am going to deal with it, that’s how much behavior change I am prepared to do, these are my limits, set my limits and then if I am having to go beyond them then I am either deciding that is my choice and I accept it or I’m not going to change my limits. But that is all educating women how to deal with preventing violence, first of all, when they have a violent relationship. I would rather see them, as I said, go right to the other side. First time it happens, that’s it.

This thinking contrasted sharply with the thinking of the women I interviewed who had experienced violence as wives. For example, Lisa spent years, in her words, “being pecked to death”, without thinking of her husband’s behaviour as abusive, but before the first instance of physical violence she had begun “to put words to it”. She described her reaction to his first use of physical violence as follows:

Well, the first time he was physically violent, then I asked him to leave, I didn't want to be in the same house with someone who would be physically abusive, and so I just said you know, like move out, and that’s it.

Lisa found, however, that the reactions of others and the alternatives of poverty and social isolation were worse options for her than living with a man who had the capacity for abuse and, convinced he had reformed, she allowed her husband to return.

Nurses also accepted to different extents assumptions regarding women’s choices about leaving relationships. Some nurses thought women should simply “get out” whereas others questioned assumptions regarding whether women can or should leave their homes. Again, the variations were not related to whether or not the nurse had experienced violence in her family. Nicole, Anne, and Lulu all had experienced violence in their own families, but each dealt differently with the assumption that women can and should leave their relationships when abuse occurs. At several points in her interview, Nicole spoke of her frustration with women who did not leave, and drew on her own experience of successfully leaving her home in which her father was abusive. Again, her view of herself as having successfully dealt with violence was maintained by a view of violence as something that someone can and should just get “out of”.

Maybe that’s because of my upbringing, and because I got out of it. I figure if I can get out of it, that other people should and I get frustrated with these people that come in and come in and all they’re doing is moaning and groaning...

Anne, who had also lived with a father who was abusive, thought that women should leave abusive relationships, and had difficulty understanding why women stayed, but thought that leaving was not always an option. She said

... I can understand that a woman has an issue of violence when she doesn’t know her partner, or it’s a first incident, but repetitive abuse, I wonder what part women’s personality reaction to it is playing.... often the choice for, now I don’t deal with the choice of leaving the scenario, because often that is just too much for them at that time. I mean they are sore, they are sometimes still under the effects of drugs or alcohol or whatever and I just don’t think that telling them “well you should just leave” is going to do any good for her.

Although Anne had difficulty understanding why women stay in their relationships (and I think, had difficulty understanding why her mother stayed), she had tempered her own experience with understandings that she had derived from experiences at work, and questioned the assumption that women always have choices and that leaving is always an option. Lulu, in her own words, had “come full circle”, from trying to push women to leave violent relationships to understanding “women and why they stay in relationships and what is at stake for them and all of the variables, instead of just the one variable [violence]”. Lulu’s idea that there is more than violence to any relationship was very close to the ideas of women who had experienced abuse from the position of wife. For instance, Nadia explained how every time she gets close to leaving, her husband becomes who ever she wants him to be.

...this is a time when usually the husbands turn out to be the man you kind of wanted because they are losing their control...He wants children, he wants me to do whatever I want to do. But this is just another way of control. The moment everything goes back to so-called normal, what both of us are used to, things will be the same, abusive, maybe worse because I will have less of an energy to fight it.

As Louise said, having left a marriage of over 20 years, “there is a lot going on in those relationships. It is not just the beating... That is usually not what your whole life is about...”.
Lulu had thoughtfully reflected on her own thinking and assumptions and detailed how her thinking had changed over time. After several years of critical analysis, her daughter's violent death provided a very different basis for practice than it had initially.

Personal experiences of violence in the family were not the only source of knowledge about the complexity of abuse. Some nurses also used their experiences at work to understand. For example, Susan had thought about a certain woman she had cared for in Emergency.

I thought about that lady at length after I left, because I think it was the end of my shift. I thought to myself that it was very much more than what she was telling me about her husband being violent. It had to be, that from the novels I've read, or the movies that I've seen, or what thinking that I have done about it, it is actually your entire life and how you relate to people, not just how you relate to that one person, but what you believe about yourself and how you believe you should be treated and what you think respect is and how much you need to be needed and visa versa. I mean it is a very complicated and confusing issue and it is much more than the fact that he actually took his fist and hit her.

Assumptions about the nature of violence and abuse, how women deal with abuse and the role of nursing in relation to violence were challenged to lesser and greater extents by different nurses, but thinking was not determined by the nature of the nurses' experiences. Rather, nurse's assumptions varied with the extent to which they had thought about their experiences and abuse, and their thinking seemed to be shaped by what perspective suited their own interests.

**Taking Other Perspectives**

As nurses varied in the extent to which they challenged their assumptions, they also varied in the extent to which they took perspectives that differed from their own. Some nurses, both with and without experiences of violence in their own families, were able to take a variety of perspectives with regard to violence. They were able to imagine what experiencing violence might be like. For example, Lulu used the experience of her daughter's murder to imagine the difficulty of a woman choosing between a home and some security for her children and living with violence. “Even though he is hurting you at times,” she said “he is still bringing in money and feeding you
and the kids.” Lulu was also able to contrast her perspective with the perspective of the woman who told her about being physically and sexually abused by her father. She said

What I thought of afterwards was that I found it extremely draining in that [time] and I thought, my God, all I did was listen to her and if I found it draining what was it like for her to live through that?

Similarly, without experiences of violence in her family, Bo used her experiences of violence at work to imagine direct experience with violence. She said “Imagine not feeling safe. I can’t wait to get into my house and feel safe, I just can’t wait”. Referring to the experience of a specific woman, Bo went on to imagine that woman’s experience.

Imagine me not having my children, as much as I curse them and whine about them, I would absolutely die, and imagine living what she went through. It would just kill me, I would rather die.

Having no experiences of violence at home, and few at work, Yvette struggle to imagine what telling someone about abuse might be like. She said

If you have been abused and somebody all of a sudden wants to help you and you are at the point where you are ready for help I would imagine it would be like opening a faucet, you would never get it off.

Interestingly, nurses who did not have experiences of violence in their families drew on other personal experiences to imagine the perspective of women who have been abused. Susanna dramatically brought this to my attention. She had been talking about how hard it was for women without resources to ask for help when dealing with a socially stigmatizing problem.

C: When you said it takes a lot to make that call, my guess... I just want to tell you I’m reading between the lines here, so I want to run it by you, my guess is that with anything that has a social stigma whether it’s violence or alcohol, drug abuse, depression... it is hard to take that first step. And my guess is that you know that...

S: Personally... yes I do. I’ve tried to commit suicide. The only thing that stopped me was that I had three small children, severe depression... And there was no physical abuse, there was no emotional abuse, I just moved. And I left, I left with ... 2 small children. And it’s real hard to do that. Because you have no money, you have no... you know, not right now, right here, you’re not working. Where do you get the money? You know... I did everything to get enough money but it took a long time, but I didn’t know what was
wrong with me, and I mean literally the doctor said, "do not leave her with those children, she is not safe yet."...That experience has given me an insight into what women can go through. And that makes a difference.

Notably, the three nurses that I interviewed who had experienced abuse in the position of wife attempted to take the woman's perspective throughout their interviews. For example, Shelby said:

...when I think about how long it took me to build up that confidence and that strength to realize that I deserve better, and I needed to get out, and I needed to work on me, etc., etc., and how that wasn't necessarily something I did while I was in a relationship. Like, I guess I just sit there thinking, "how did they do all this altogether when they don't have the reserves to begin with?" Like where are they supposed to get it from?"

As these excerpts illustrate, the imagining of another's point of view was accompanied by expressions of empathy by each of these nurses. These imaginings brought nurses' ideas very close to the experiences of women who experienced violence in the position of wife. For example, Lulu's understanding of the ways economic variables may entrap women was vividly reflected in the stories told by Lisa and Louise. After demanding that her abusive husband leave, Lisa allowed him to returned largely because poverty and neglect were not acceptable alternatives for her children.

What I was not prepared for was the systematic, the embeddedness of abuse of a woman. Because when he left... I had two little tiny children, it was very difficult, I mean I didn't enough money to buy myself a pair of jeans, it was awful, very, very difficult. I didn't realize the legal system, once he moved out, how awful it was for women, I didn't realize the cost of child care, I didn't realize the difficulty of getting care for my kids if I was working nights or evenings.

She allowed her husband to return, lived with him for over 15 years, despite continued sporadic abuse, and was proud of the decisions she had made.

And I had just said, okay, that's how bad the system is, I'll deal with it and I did, and I've raised my...I got my kids raised...I raised them, I didn't raise them in poverty, and I just tucked in and did it, and I did it my way you know.
Similarly, Louise, who had left a violent, wealthy, husband also talked about the losses associated with leaving, saying “they know they are going to have to give up a great deal of that life-style and those might not be very good reasons but those are reasons that people stay or put up with it”.

In another example of the way in which perspective-taking drew nurses’ closer to the experiences of women who experienced abuse, Yvette’s ideas about the impact of an offer of help were echoed by Nadia’s experience of being offered an opening. Nadia told of her response to her physician asking “are you okay at home, is your marriage all right, financially, what is going on in your life”. She said “as soon as he asked the question I started to cry hysterically for half an hour and he, needless to say, figured it out right... then we talked about it.”

Some nurses with experiences of violence in their families seemed to have difficulty taking perspectives other than their own. It is important to remember that most of the nurses I interviewed who had experience with violence in their families had not experienced ‘wife abuse’ and were not the primary targets of violence and abuse, but rather described themselves as witnesses to the abuse of others. These experiences of violence were indelible in the minds of these nurses, and the ‘witness perspective’ was an overriding perspective that influenced the nurses’ practice exclusively if the nurse had not actively engaged in taking alternate perspectives. Taking such active engagement requires thinking about the experiences of violence and abuse, thinking which, understandably, the nurse may not want to do.

It may not serve the nurses’ own interests to engage in reflection on her own experiences, and it may serve her interests to construct knowledge one way over another. For example, Anne was firm that the role of the nurse should be how to teach women to recognize when violence is
going to occur and to defuse potentially violent situations, and was quite clear that she based her practice on her experiences of witnessing her father beating her mother. She said:

I remember how my mother dealt with it and I remember how my mother could have prevented it and I remember how little she did, so that is where I am coming from, from what I remember and growing up with it. I think that, so it is partly personal experience.

Although Anne used this experience to argue for a nursing role in which nurses would teach women to become sensitive to their partners and learn how not to provoke them, she apparently had mixed feelings. In the following passage, Anne is talking about women who live “walking on eggshells” in order to avoid “triggering” violence from their partners. The contrast between the nursing role she envisions and her perception of how she would deal with violence in a partner suggests that she had not yet resolved the conflict between her situating the responsibility for dealing with violence with women, and her sense of self.

That a woman would choose to change her behavior to that extent for anyone, the idea is just foreign to me, it is not part of how I think about myself or how I could perceive women feeling for another person, because nobody would mean that much to me to do that.

Operating from the perspective of a daughter of a woman who had been abused, Anne did not take the perspective of a woman being abused. She was hampered from doing so through her mother, because her mother had died. I asked her if she had been able to learn her mother’s perspective.

C: Maybe changing practice sometimes is a matter of re-framing your personal experience. As an example, if you went back and talked to, have talked to your mother about ....

A: She passed away, she was only 53. So no. And yes, I have thought that. I have, in fact, I have cried about it several times that I would have liked to have been able to talk to her as a woman to woman to say “what was that like for you, how could we have helped you, or how could we have prevented the whole experience”. I could cry now because it’s not easy to miss that relationship, because she didn’t have a chance to really get to a point with her daughters that she could start talking about the woman and the things that happened at home and that’s sad.
Similarly, Nicole viewed violence from the perspective of the daughter of an abusive and alcoholic father.

When I see a patient come in, be it abuse or whatever, I think, I know it must be hell, ‘cause I know what it was like for me. But I got out of it, and I think to when we have got out of it, you know how life can really be and I just wanted to give that to everyone...you know, because I think, like, ‘just get out’, like ‘life’s too good to live like that, don’t just sit in there’ and that’s where I get frustrated myself, ‘cause I feel like I was very lucky, fortunate for where I am today and I just feel like I just want to give the information to people.

Neither of these nurses “imagined” what others’ experiences would be like during their interview, or speculated how their own experiences and circumstances might differ from those of the women they might encounter. Not stepping outside of their own perspectives, some nurses did not understand that women who have been abused see violence as only one aspect of their relationship, see changing their behaviour as a way to preserve the valuable aspects of their relationships, and see leaving as a step that incurs losses. However, the possibility of taking the perspective of women who have been abused did not always seem to be in the interests of individual nurses.

Not surprisingly, the empathy nurses expressed for women seemed related to the extent to which they were able to take the perspective of women who had been abused. Further, taking the perspective of others also affected the ways in which nurses could account for the influence of the context. Not imagining the experience of others meant not imagining outside of the nurses’ own social context.

**Challenging the Importance of the Context**

Along with variations in the extent to which they challenged their own assumptions and took perspectives other than their own, nurses varied in the extent to which they considered the influence of the conditions of women’s lives on experiences of violence and abuse. While most of the nurses I interviewed wondered why women don’t leave, the women who experienced wife
abuse explained *why they stay*. They explained that they stay with partners who are abusive because there is much more to any relationship than abuse. They explained that they stayed because of the welfare of their children, finances, fear of their partners, fear of the unknown, their own isolation and limits to their own strength. They explained that they stayed because they did not want to leave their own homes, and all their belongings, and their lives as they knew them.

Nurses struggled to understand and continued to puzzle why women don’t leave, and often considered relationship variables, but not the influence of the larger social context. For example, Palen described herself as “bewildered” at trying to understand.

I don’t understand it but I also believe that there is a large amount of fear that goes with it, a large amount of uncertainty, a large amount of lack of self confidence. There is just so many things that the person that is being abused needs to pull together in order to have the strength to leave. In a repeated situation I really don’t know if I understand, I don’t think I’ll ever really understand why they go back, why they stay. I understand that the people that are abusing them are probably different in certain situations so that they can be very convincing about changing etc., but it all boils down to her choice and her decision. I don’t know. I think bewildered is a good expression for myself, it just bewilders me why they go back and why they don’t leave and what is so hard about this decision, but I’ve never been there so unless I’ve been in that situation and it took her years to leave the guy, so I don’t know. I don’t know what else is going on, I don’t know what else is involved...

Uncritical use of personal experience (or lack of experience) may be problematic because nurses’ understandings may be limited to their own experiences in terms of their own social context and their own ethnicity, class, religion, and so on.

Without experience with poverty or child-rearing, Anne had difficulty understanding how some women prioritize. Talking about women on a radio program, Anne said

The reasons why they hadn’t left were pretty good reasons, all of them were either with children involved or socioeconomic problems. They would bring all of these issues in and yes, they are very real issues, but if a woman has to prioritize her safety and her health according, against socioeconomic things, I can not, personally I can not understand how she could ever put those things above that, so how a woman values herself that gets them to make these decisions more of a priority for themselves, and they believe them, to my mind,
they believe that it is really this issue that is keeping them there, but what they really are not
telling us is the fact that they don’t value themselves above this issue.

Another nurse thought her understanding of “culture” was a limitation for her practice, and
shared some of her assumptions.

Culture, I’m very poor on the culture, although I’ve been led to believe that (in a particular
Muslim group), the presentation of women in the family is different than what the
presentation is in my upbringing. Repeated admissions for emotional unsteadiness.

Although this nurse thought she was limited in her understanding (and here entertained the idea
that women in a certain group are more “emotionally unsteady” than the cultural or ethnic group
with whom she identifies), she was able to consider some aspects of the context of a woman’s
life. Later she talked about the difficulties women may experience in trying to leave partners
who have been abusive.

They may have children, where are they going to go, they may not have a facility to live,
their family members may not be supportive, they may not have that ability to move on, so I
think it is a massive subject.

Although she was able to entertain stereotypical thinking in regard to certain ethnic groups, she
challenged stereotypical thinking about women and violence. Again, the extent to which nurses
considered the impact of the context, regardless of what personal experience with violence they
had, influenced the distance between the nurse’s understanding of abuse and the understanding of
women who had experienced wife abuse. Nurses interpreted their world within their own
experiences of wealth, “race”, gender, and so on, as well as within their experiences of violence,
and enacted their practice in congruence with those dominant interests to the extent that those
interests served their own, or to the extent to which they had examined those interests.

Exploring Alternative Ways of Acting

The extent to which the nurses in this study challenged their own assumptions, took varied
perspectives, and explored the influence of the context affected the extent to which nurses
considered alternative ways of acting. Nurses who practiced directly from personal experience without considering the ways in which their experiences, circumstances and perspectives differed from those women they met as patients, recommended nursing actions that they thought *were or would have been beneficial for them personally* and using ideas which served their own interests.

Nicole was frustrated by women who did not ‘get out’ and said

> Sometimes I will tell patients, you know, I was in the same situation you know, my dad was alcoholic you know, if you want out, you can get out, you just have to want to have the willpower to do it and I figure there’s so much support services already out there that people have a chance....I don’t think you should be babying these people and being sympathetic and giving and giving, my point is, and I’ve done this with friends, you know you’re in this relationship, its not going well, what are you going to do about it? You either get in or you get out, and I know that’s easy for me to say, because I may not be in there, but I said there’s no point in you whining to me on how he’s treating you, I’m telling you like there’s no question, you either make a decision, you either live with it and accept it, or you change.

Nicole had found it useful to talk to other people who had dealt with alcoholic family members, and so thought that women who have been abused would also find it useful. She thought that women who had been abused would be able to access other women with similar experiences in a manner similar to the way in which she had accessed people through Al-Anon, and further implied that women would be able to take such action.

N: ....maybe that’s where I get this point, the only way that a battered woman can get the best help is talking to other battered women, that I succeeded and got out of that position.

C: So, how do you think battered women can get in contact with other battered women? How do you think that can happen?

N: Well, through the shelter, if you go there. Otherwise if they call a toll free number you know, if they’re expressing they maybe could give information on maybe meeting someone for coffee that is in the same position. You know its like I said, it happened to me when I was just sixteen, picking up that phone, saying I want to talk to someone.

Anne envisioned a very different role for nursing than the one Nicole described. Based on her experience, Anne saw the nursing role as being focused on teaching women to anticipate violence and “to defuse potentially violent situations”.

I remember when my mother was actually hit have been so strong in my mind that (pause) I wouldn’t call my mother a battered woman really, but it was a point of an escalating scenario caused by an outburst where if she was twigged earlier - “I have a man that pushed to a certain level will lash out, I don’t want to be hit so what can I do to either diffuse it or what can I do to prevent this getting to this scenario”....The goal that I would have for women, particularly, is to become very much more astute, as far as what triggers violence in their partner and which buttons not to press and how not to press them. If she can learn how not to press the buttons that cause violence then she will be protecting herself against, now she can’t always do that, sometimes she is just in the way, but I think that women have a lot of learning to do about what sorts of things can trigger the danger of things erupting into violence; when an argument becomes an argument that leads to violence.

Although Anne wished her mother had been able to prevent her father’s violence, and thought that she could teach women to limit men’s violence, these ideas contrasted with the words of women who had lived with men who had been abusive. Repeatedly, women told me how carefully they had tried to “keep the giant happy”.

...we are so used to having the right answer at the right time to protect ourselves and we instantly look for the problem so we can protect ourselves, like “what does he mean by that”, “what am I going to get out of this, where do I get into trouble with this”. (Nadia)

I learned how to keep the giant happy too and so you walk on the cracked eggs and it was only when you were caught off guard, and I think a lot of women live like that, they just learn how to dance the dance, how to keep the guy happy. (Louise)

Maggie Lui, a woman I worked with on a community project, wrote her story for a media campaign we were developing against abuse. She wrote about how she felt when she and her children fled from her husband.

When we left we had no possessions. We moved into an apartment, slept on the floor, ate with plastic cutlery off Styrofoam plates. Yet, we were so happy. We no longer knew the constant fear of not knowing when his anger would explode. We could speak without having to carefully reword our thoughts over and over and over in our minds, trying to edit words which he might use to spark his anger to a rage.

Whether nurses did or did not have personal experiences of violence in their families, those who practiced without challenging their own assumptions, taking various perspectives and examining the influence of the context held a single goal for nursing action. Usually these nurses
saw women leaving their relationships as the goal of nursing action, and described their
frustration when women refused or failed to meet this goal.

You feel you want to sometimes take them by the shoulders and just shake them and say
"you don't have to do this, you don't have to stay in this kind of a situation" and some of
them are responsive but most of them generally, say "yeah I know" and often you see them
coming back in again. (Faye, ER Nurse)

You want to warn them, you almost want to shake them and say "wake up, you are going to
come in here dead, it doesn't get any easier, give your head a shake". (Lenore, Emergency
Nurse)

Lulu felt the same way before she had spent time reflecting on her personal experiences and
the way in which they influenced her practice, saying "I terrified her, I absolutely terrified her, "I
said, you've got to leave now. You can't stay with him"

Frustration was the most common reaction of nurses to women's decision not to leave their
relationships. Throughout field work conversations and interviews, nurses and other health care
providers expressed their frustration with women for remaining in relationships in which there
was violence. For example, Faye said

It's just frustrating to see them go back into that kind of family. It takes a lot to break the
pattern. I haven't had a lot of direct experiences, just a few, like I said we don't really see a
lot.

Not surprisingly, the women who had experienced abuse could see the frustration of the nurses.

Nadia told of her experience with a nurse.

She turned to me and said "you know, none of the nurses, none of the Psychiatry people,
nobody out there can solve your problem". I knew what she meant, what she was saying
was "I am getting sick and tired of this, deal with it".

In contrast, regardless of whether or not nurses had personal experience of violence in their
families or not, challenging assumptions, taking the perspective of a woman who had been
abused and considering the influence of the context of a woman's life led to ideas about nursing
actions that were based on what the woman thought she needed. Notably, these nursing actions were often contrary to the predominant pattern of Emergency practice.

My belief about the role of the nurse is to assist the patient in any way that she can in dealing with whatever the problem is. Generally speaking it would be a health problem that the nurse would be assisting the patient to deal with that health problem, not diagnosing the health problem or not fixing the health problem but how is the health problem affecting you as a person and what can I do to help you? If the problem would be an unsafe home, then how can I help you deal with that and if I can help you by protecting you, by keeping you here then that is what I will do. If I can help you by just listening and allow you to tell me what has happened to you then that is another aspect of my help. (Lulu, Emergency Nurse)

Those nurses who described imagining the woman’s experience were not committed to a particular outcome, such as having the woman leave immediately. These nurses tended to be less certain about exactly what they would do, more open to what women thought they wanted and did not express frustration at the women. Thus, these nurses had less investment in their own interests, and more openness to the interests of women who come for care.

If I was there and it was my opportunity to participate with them, I really like to work with people. I like to try and help them out, find a vehicle for them. When I first started nursing I thought I could solve it all in one day, but now I’ve found that I think I am a facilitator and that I need to facilitate them to resources that can meet their needs and if you can pick it up and if you can allow them to verbalize and recognize that there is a problem, then that for me would be my goal met. (Bo, Emergency Nurse)

These nurses’ ideas were similar to women’s ideas about what they wanted from nurses. Louise wanted nurses to listen and not take control. “Listening and not necessarily taking an authority position always over a woman...” Nadia also wanted nurses to listen and not judge or take control. She said

This is a very new thing so people don’t know how to react but as long as everybody keeps in mind that helping doesn’t necessarily mean being judgmental or making the decision for other people, sometimes all it takes is to listen because by the time you have finished a conversation you know exactly what to do.

She did not have extremely high expectations. She did not want to be rescued, or saved, or even necessarily understood. She asked that we just be human.
Just being human, we don’t ask [nurses] to be friends or angels or survive these things with us, it is just explaining when they are going to ask those questions why, and listening to the answers and not being judgmental.

Some interpretations of personal experiences of violence in a nurse’s family seemed to help some nurses to develop a deeper understanding of violence and abuse and to develop ideas for nursing practice that were close to what women said they needed and wanted from nurses. However, creating these understandings and ideas required that the nurse actively and critically think about her personal experiences. Not doing so, nurses ran the risk of privileging their own personal experiences over those of their patients. However, creating understanding required active thinking that may not serve the nurse’s interests, and further, the nurses’ interests may be so well served by avoiding thinking that personal experiences are rendered inaccessible.

**Inaccessible Personal Experiences**

The interviews and conversations reported in this study are from nurses who were willing and *able* to talk and think (at least to some extent) about their personal experiences of violence. Importantly, the nurses not represented here are those who did not want to, or were not able to talk about such experiences. I believe that this is a crucial point for two reasons. First, I have been arguing that critical analysis is instrumental in creating knowledge from experience, that interpretation is integral to producing interests. If experiences are unavailable to the nurse because she is unable to think about her experiences, then those experiences are inaccessible for analysis by the nurse. Even if the nurse is willing and able to talk about her experiences, the Emergency Unit cultural norm of the valuing “emotional strength” and the lack of understanding and frustration expressed toward patients who have been abused mean that the workplace is not likely to foster conversation and analysis of nurses’ personal experiences or obtaining outside support. Second, if experiences that are only partially analyzed limit empathy and understanding
and lead to goals of care that are not helpful from the perspective of women who have experienced abuse, then what influence do experiences have when they are so painful that they cannot be discussed or even thought about? The importance of this dilemma was captured by a story a head nurse told me about a former staff member.

There were a few things in her practice that, I don’t want to say she ignored -- we had a child that was abused one day and she had a very, very difficult time with it, I’m not saying that it was a worse time than anybody else, but it really hit her hard. We talked about it and she seemed distant afterward. She left the hospital [a short time later for another job]. A year after she phoned me at home and came to my home and reiterated 3 hours worth of her childhood, of being abused by her father, both sexually and physically abused. I was blown away. All I did was listen, but I was shocked that it was me that she was telling.... but it did seem therapeutic for her to tell me. It was as if she was justifying things that had happened clinically by telling me the history.

In addition to the fairly obvious likelihood of not remembering painful experiences of violence in the family, it may also be that nurses are unable to recall experiences of violence at work not only because few are recognized, but also because they are too painful to remember. This possibility is supported by the strength of the anger and sorrow that nurses expressed when they did recall work-related experiences of violence.

Further, some nurses had understandings based on experiences of violence in their families that they did not use in understanding those they encountered through their work. For example, Faye described her interactions with her daughter after finding out that she had been beaten by her stepfather. “I felt like I had failed her, but we talked it through. You always ask the question “why didn’t you tell me” and she said “I didn’t think you would want to hear it.” However, neither Faye nor any of the nurses suggested that women who have been abused consider whether or not health care professionals “want to hear” about their experiences of violence.

In addition to the challenge of dealing with past experiences that cannot be recalled, or are too painful to recall, some nurses are currently living with partners who abuse them. Nurses
sometimes know which other nurses on their unit are living, or have previously lived in abusive relationships. I found three features of the ways these nurses are thought about and talked about by their colleagues particularly interesting. First, the nurse’s experience of violence was often told to me, or hinted at by others as a central feature of the nurse’s existence. Perhaps this is not surprising given that I was studying violence and abuse. Second, there were often concerns that these nurses’ experiences got in the way of their work, and thirdly, some expressed frustration at the nurses’ situations, and the perception that they could not help. One head nurse told me about several nurses who were currently in abusive relationships, and seemed protective.

She said “well, I will want to pick who you talk to.” I said (in some alarm) “well, I really wouldn’t want anyone to feel that they had to talk to me”. “No”, she said, “but some of them [nurses], where they are at just now, it, well, it wouldn't be a good idea for them.”. “But they could decide that for themselves” I stated (fairly emphatically and perhaps a little scandalized). “Oh yes, but you might get somebody’s baggage” she returned. (Field Notes, November, 1994)

Summary

Interviews in this study suggested that nursing practice in relation to violence against women was largely based on personal experience. Nurses were explicit about their use of personal experience as a basis for practice and believed that such experience is important. However, personal experience is limited as a basis for practice in at least three ways. First, the way in which personal experiences were interpreted varied greatly with the extent to which each nurse engaged in critical reflection on her experiences. Second, personal experiences at work are limited by the fact that nurses have very few experiences, tend to recall experiences with certain characteristics, and have very little experience of success. Finally, all personal experience is not necessarily accessible to the nurse, perhaps because she does not want to talk and think about her experiences, or perhaps because she is unable to recall her experiences. Critically reflecting on painful personal experiences, or the painful experiences of others may not be seen by many
nurses as an activity that is in their interests. Personally, I would rather not think about violence either. Coming to see such analysis as being in one’s own interests may be essential to developing practice based on critical awareness, rather than on unexamined assumptions.

Personal experience was viewed as a valuable teacher for all of the nurses involved in the study. However, critical analysis greatly increased the extent to which nurses were able to challenge their own assumptions, and understand perspectives of women who have been abused, and identify nursing actions that were similar to those that women who had been abused thought would be helpful. In the process of participating in interviews, many nurses further analyzed their experiences and identified ways in which their personal experience could be reexamined and their practice modified. After reading an initial draft paper from this study, Susan said

I mean it is the whole way you grow up and the whole way you relate to other people. My sister had relationships that were, in my opinion, abusive and one that was actually physically abusive in the traditional sense of the word and we came from the same family, we had the same upbringing, we had the same beliefs and values more or less, so what would make her accept behaviour that you maybe wouldn’t accept? Why would one person accept what another person wouldn’t, what do they believe and feel about themselves and the way they are with the world? It really came home to me then, that it is very pervasive, it is not just what I do in the Emergency Department, it is who you are and who you become and what you believe about yourself.

Toward the end of our first interview, Anne said

I don’t think I’ve ever spoken to anyone a length about it before and I think there are certainly parts of it that I realize that I’m not probably as attuned as I could be, so I think maybe [I will have] other thoughts or questions or even [change] the way I look at my practice from today on.

Lulu concluded our first interview by saying

It is amazing to me though, again it is the reflective practice and if you don’t reflect there is a lot that you miss, and I can’t believe what I have missed by not thinking about the issues, and now in talking to you I’ve heard myself talk and I have more thoughts.

Two days later she called me back for a second interview to discuss insights she had from the first interview, and the implications she saw for her practice.
Interestingly, each of these nurses said that their professional practice needed to override their own personal comfort. Most profoundly, in our second interview, Anne told me that prior to our first interview she had not admitted there had been violence in her family, and that she thought that she had been avoiding recognizing abuse, and said

If you protect yourself from it [violence] and from your personal experience, then aren’t you protecting yourself clinically by saying, “OK, I recognize there are some things here, but because I don’t address them in my personal life, I’m not going to make the effort”, so that’s what I said, the two of them are so related that we can’t separate experience from practice, from a professional knowledge base, the two of them ... should work in sync.

These excerpts illustrate that while nurses interpreted their experiences from education, the media, work, and home, in ways that both drew upon and refused dominant interests and ideology, their interpretations were evolving. Individuals interpreted their experiences in congruence with and resistance to dominant ideologies and patterns of practice, and with critical reflection became increasingly aware of stereotypical thinking. Although certain ideologies and practice patterns predominate, they are not monolithic.
Shut Out The Night

Shut out the night
Keep the wolves at bay
Close the door, and with me stay,
Inside.
Where we are the same.

For out there lurks
The Yellow Peril
The Great Black Horde of terrors,
Unknown.
That have a name.

And we can name
Those evil threats
Naming keep them all away
Outside,
Where they belong.

Lighting our way,
By what we are not
Blind the pain, hide the rot,
Well known,
Here in our home
CHAPTER SEVEN

INTERPRETATION: RECOGNIZING VIOLENCE AND ABUSE

This chapter turns to the specific consideration of nursing practice in relation to violence within the context of Emergency practice, with particular attention to how violence and abuse are recognized. Violence and abuse were largely unrecognized in this study. This lack of recognition is conceptualized as a component of the neglect of violence, and seen as occurring as violence is obscured by the predominant pattern of practice: efficient processing. This chapter examines how the context of practice shapes and constrains nurses' recognition of violence and abuse. Specifically, it explores how efficient processing is manifest in relation to the recognition of violence and abuse, and how various ideologies used in determining the deservedness of patients are evident in the recognition of violence and abuse. This chapter also considers the ways nurses draw on their experiences, ideas and interests to recognize or not recognize violence and abuse in congruence with, and resistance to the predominant practice pattern.

Recognition of Violence and Abuse

Data from observations during field work and interviews in this study were congruent with the research which demonstrates that abuse is often not recognized in health care settings in general and within Emergency units in particular. Most nurses in this study did not think that they saw much abuse, could recall relatively few instances of abuse, and, in my presence, rarely recognized abuse. Although over 20 patients told me about past or present abuse by a partner, only four of those disclosures occurred in the presence of a nurse, and only one in response to the nurse's assessment.

From my analysis of field observations and interviews, I believe that the lack of recognition occurs because non-recognition of violence is congruent with the predominant practice pattern,
congruent with many of the values, beliefs, assumptions and goals of health care providers, congruent with the mandate of the Emergency unit, and congruent with dominant social values.

For the most part, health care providers recognize only violence and abuse that is blatantly obvious, that is, health care providers recognize violence and abuse only when recognition is unavoidable. Health care providers avoid recognition of violence and abuse by overlooking cues and acting in ways which limit disclosure. Non-recognition serves the interests of individual health care providers in that they can avoid the emotional cost of recognizing abuse and they can avoid the time commitment involved in dealing with abuse. Non-recognition serves the interests of the health care system in that the patient can be processed more quickly than if abuse was recognized and addressed.

When a person comes to the Emergency unit, the person is quickly reduced to a problem to be managed. Nurses identify problems by relying on 1) the presenting complaint, 2) inferences from the patient's appearance and behaviour, and 3) information provided by the patient, and the way in which the patient frames the problem. Nurses interpret this information within the frame of reference of the emergency unit, and within their own personal frames of reference. Within the frame of reference of the Emergency unit, the manageable problem has two elements: a physiological label and an associated acuity level. Both the label and the related acuity level are provisional, and held open to modification based on the "index of suspicion" for other problems, and the findings of further assessment. The nurse identifying the problem also interprets the information by drawing on her own personal frame of reference, and brings her own knowledge, skills, attitudes and assumptions to bear. It is within these routine practices that violence is overlooked, ignored and neglected. Violence is not purposefully nor intentionally neglected.

1 The term "index of suspicion" is the part of the routine language of Emergency, used to denote the relative likelihood of a particular cause or consequence of illness or injury.
Rather, violence is obscured by efficient processing in the routine provision of care in service of the interests of individual health care providers, the hospital, health care system and society.

The Presenting Complaint

Violence is not foremost in nurses’ thinking as they begin the process of reducing the person to a manageable problem. Nurses begin the process of triaging all patients from the complaint with which the person presents. Women who have experienced abuse come to Emergency with presenting complaints that are 1) a direct result of violence, 2) an indirect result of violence, or 3) unrelated to violence. The presenting complaint can be obviously due to violence, suggestive of violence, or seemingly unrelated to violence, and may or may not be a direct indicator of the cause of the problem.

If the presenting complaint is a direct result of violence, the cause may be more or less obvious, ranging from injuries such as a fractured jaw and black eyes (which seem “obvious”), to bruising on the upper arms or face (which seem suggestive), to abdominal pain, pelvic inflammatory disease, or a migraine headache (which may seem unrelated to violence). If the presenting complaint is an indirect result of violence, the cause will not likely be obvious. Problems which may be caused by living under conditions of chronic stress and abuse (for example chronic bowel problems, arthritis, depression, alcohol abuse) may be difficult to associate with violence, even for the woman herself. Finally, if the presenting problem is unrelated to violence, such as a cardiac dysrhythmia or renal colic, there maybe no basis for identifying violence and abuse.

The physiological focus of the Emergency unit, and nurses’ ideas about violence contribute to the facts that violence and abuse tend not to be recognized, and that only “obvious” physical consequences of physical violence are recognized from the presenting complaint. Emergency
nurses are looking for the obvious, and, as Lenore noted, the presenting complaint may not be obvious or suggestive of abuse.

I guess it [violence and abuse] is an area where you should be able to pick it up fairly quickly but it is not that easy to pick it up because usually they [women who have experienced abuse] come in with another vague kind of a complaint.

Further, as both Monica and Yvette explained, Emergency nurses may not look beyond the presenting complaint in their urgency to process the patient.

I suppose part of it, 1) is that it is not always blatantly obvious, and 2) if you are an Emergency Nurse you are probably busy, you are probably on the go, and if things aren’t blatantly obvious, that this woman has been abused, you may not just be mentally tuned into seeing what is going on. You are maybe taking the complaint at the time, “I’ve got a urinary tract infection” or whatever and treating the woman for that. (Monica, Emergency Nurse)

If you’ve got abdominal pain because you are depressed because you are being abused at home I am unlikely to pick that up. I’m more likely to trot in there after the Doctor has found nothing wrong and say “you can go home now, how are you going to get home”. The reason for that, and again you are not thinking of it consciously, is because you might only have that one patient but you’ve got to get her out because in 10 minutes you might have eight of them. (Yvette, Emergency Nurse)

Recognizing only blatantly obvious physical violence leads some nurses to say that they do not “see” much violence. Many nurses told me in both study sites “We don’t see much of it here.” By this they were implying not that they were blind to violence and abuse, but rather that not much violence is presented by patients. Thus, attending primarily to obvious physical cues in the interests of efficient processing, leads to limited recognition of physical abuse, which in turn provides the idea that violence is not a common problem, and leads to a low “index of suspicion” of violence and abuse.

Even though the Emergency deals with multifaceted health concerns with physical, social, and emotional aspects, the Emergency is primarily structured to deal with the physical aspects, and to process patients quickly. Thus the physical layout and triaging process limits the way in
which people can present their problems. Triage areas in both primary study sites (and in the work places of most of the other nurses interviewed) are open to the waiting area and afford little or no privacy. Therefore, the person presenting the “complaint” must do so in “public”. Further, it is common practice for the person with the health concern to present with, or be presented by, who ever accompanied or brought him/her to the hospital. Finally, only a few minutes are spent in triaging. These factors may influence the way in which the person presents his/her health concern, and the way in which nurses question the person’s presentation.

Overlooking violence in pursuit of the manageable problem when dealing with the presenting complaint is in the interests of processing patients quickly and efficiently. This serves health care providers in getting their work done, serves the hospital and health care system in maintaining efficiency, and serves patients in identifying the most immediate physical problem, and in reducing line ups and waiting time.

The presenting complaint is not always accepted at face value. Rather, nurses may question the presenting complaint, and draw on the patient’s behaviour and appearance, the information provided by the patient, and further assessment, to supplement their identification of the problem. However, the nurses’ willingness and ability to look beyond the presenting complaint is complex, and depends upon the influence of the context and the nurses’ “index of suspicion”.

Inferences from the Patient’s Appearance and Behaviour:

Anticipating and Not Anticipating Abuse

Emergency nurses also rely on inferences they make from a patients’ behaviour and appearance to identify the problem and triage the patient safely and efficiently. The inferences are drawn from a multitude of observations: the patients’ breathing, facial expression, posture, clothing, movements, and so on, are all taken in by the nurse and scanned for significance. The
nurse makes judgments about the patient’s condition and acuity, and sometimes about the possible problem, before the patient speaks. The nurse will respond quite differently if the patient is acutely ill (if the patient collapses or arrests at Triage, for example) than if the patient is apparently well (smiling, walking and talking, for example). The former will be dealt with by a “swarm” of health care providers, the latter will be asked to sit in the waiting area.

In relation to violence then, this pattern of practice contributes to the fact that only “obvious” physical consequences of physical violence are recognized. Nurses are looking primarily for physical health concerns, and cues regarding the patient’s acuity. In terms of identifying violence as a possible problem, nurses and other health care providers told me that they relied predominantly on “blatantly obvious” indicators of physical trauma, the emotional state of the patient, suspicious stories, suspicious behaviour, and occasionally, repeat visits for indeterminate problems.

First, nurses thought that certain physical injuries might alert them to abuse. Anne said “I’d have to actually see something physical, a physical injury.” Although evidence of physical violence was identified by most nurses as the most important cue for abuse, many nurses said that they did not use physical evidence as cues in their practice. For example, Bo thought that certain types of bruising might be suspicious, but did not look for such bruising in her practice.

When assessing my patients, and I’m looking at total body, I can honestly say that I am not looking for bruising, finger bruising. That is not something that’s in my history, to be very honest with you, until you came around.

Bo also thought a fall might cue her to suspect violence, but thought that she ignored such cues because of her ideas about the community. “But I would think a fall, I wouldn’t think that, particularly [here] where supposedly everyone is human, but that’s not the situation at all. It hasn’t been a priority in my mind.”
Non-traumatic physical cues and more ambiguous complaints were not part of nurse’s thinking regarding when to suspect abuse. Anne thought she would be alerted to abuse by physical injuries, but said “but if someone just came in with abdominal pain, a woman, whatever age, it wouldn’t be my first [thought].” When I suggested to Lenore that women may come to Emergency because of health problems related to abuse, but not necessarily trauma, she replied:

That makes sense. Urinary tract infection or lower abdominal pain that has been there for 2 weeks or vomiting, any of the anxiety, headache type; interesting, I hadn’t thought about it like that. You are right. That’s a good point. If you are in a stressful relationship at home being abused then, of course, you are going to get a headache.

Some nurses thought that the emotional state of a patient might suggest abuse, but that abuse did not necessarily come to mind, and that the significance of the patient’s emotional state was not necessarily part of the assessment.

I am sensitive to how tearful they [patients] are and how emotional they are, but is not something that I think of “well could this be a possible situation which is not conducive to a healthy life-style”, that honestly is not in the... model of assessing a patient. It’s all physical that we are looking at. (Bo, Emergency Nurse)

As Bo implies, people who come to Emergency may be anxious, stressed, distraught for many reasons, and abuse is not necessarily thought of as an explanation. Even when abuse is considered, as Lenore suggests below, such suspicions may not be pursued.

L: If they are in crisis they don’t want to talk about it yet, because you can see something sort of register like you are getting close to something but they aren’t ready to talk about it.

C: How do you feel about that?

L: I guess I probably feel sorry for them because I think I have my suspicion that something is going on at home, but again I don’t explore it to the point, maybe it is they are being abused but also maybe they are under a lot of stress because they have got their Grandparents and they are the sole caregiver for a large big family. I’m not really sure what their stress in the home really is.

Occasionally nurses cited patients’ behaviour as suggesting abuse, especially behaviour in relation to a partner, but once again, such ideas were not used significantly in practice. For
example, although Faye thought her personal experiences made her sensitive to indicators of abuse, she thought that, due to time constraints, she did not employ her sensitivity. “I always try to tune in to it at work and I would try and identify, if I had the time.” Bo said “Sometimes I’m twigged on it when the partner comes into the room, from the behavior between the two people, sometimes that will, the other person, that kind of scenario” but had not actually seen any situations in which she suspected abuse. Susan had similar ideas, but thought that she only recognized situations after the fact. She said

   Especially people who come in by themselves and then [their partner] shows up later and their demeanor changes but it is only after the fact that maybe it clicks on for me, so I think it probably goes on a tremendous amount [here] and everywhere else.

The behaviour of the partner was also often suggested as possibly alerting the nurse to abuse. The smell of alcohol on the partner, over protectiveness and refusal to leave the woman were cited as possible cues, but nurses also thought that each of these behaviours could be interpreted in various ways. One head nurse said:

   One of the nurses told me that she asked a man to leave because she wanted to talk to the woman and it was not particularly because she suspected abuse, there was another reason, and the man said “it’s okay if I am here isn’t it dear?” and you can think of in many instances when that might not imply anything negative. But then again it might imply controlling behavior which is one of the signs of an abusive relationship. And then what do you do? Once we’ve let them in do you get all rowdy and insist upon it and bells and whistles and Security and everybody else or do you leave it alone and then miss out on helping somebody that might need help?

In addition to physical evidence and the patient’s emotional state and behaviour, many nurses said that suspicious stories might alert them to suspect abuse. For example, when asked what patients she would ask about violence, Anne said “It would have to do with the type of trauma, whether I believe the lady’s story.” Faye thought suspicious stories were important but felt she did not have time to pursue her suspicions. She said

   You suspect it might be as a result of say a battered situation but their story is different from what your gut feeling is going on, and you don’t really have the time, because of the
busyness of the department, you don’t have time to sit down and say “really, what really happened?”

Similarly, when I asked Lenore how she tried to identify abuse, she told me that physical evidence and stories that do not match should alert her to the possibility of violence.

L: ... I mean if it is obvious black eyes that don’t fit the “well I fell against the door”, anyway you identify their obvious injuries but I also start, if they come in, with vague complaints and everything comes back normal. That was something they told us [in a post-graduate course] to ask... When everything comes back normal and you aren’t sure what is going on, ask “what is going on at home, is there something happening”, we didn’t come right out and ask, well sometimes we did, “are you being hit, is there something else? Is there something happening in the home?”

C: Have you done that recently in your practice? Have you had an example of a situation in which you?

L: No. The most recently would probably be this woman last night who when she came in the last time, again it was a nuts night, absolutely nuts but there was the question, so again I asked [another health care provider] to go see her. That’s when it became more obvious, like when he [the woman’s partner] wouldn’t have anything to do with [the other health care provider], your degree of suspicion goes up even higher. But no I didn’t actually say to her “is there something going on at home”, we had already suspected it without asking her.

Finally, some nurses thought that frequent visits to the Emergency might suggest abuse.

However, pursuit of these suspicions is limited, Palen suggests in the following passage, by the lack of continuity of care and time constraints.

P: And often times what will twig us to a possible abuse victim is the frequency of the person coming in with the vague, not that I’m making light of anybody’s physical problem, but almost silly complaints like “why are you here again” and they don’t know how to quite come out and say why they are here and they have no other alternative but to tell their significant other that they are ill in some physical fashion to get to the hospital. So after 3 or 4 visits, if they are not seeking drugs or anything really, focusing on something specific you have to think “is anything happening, are you distressed, have you been hurt in anyway, do you have any problems happening right now?”. Often it is a frequent, I hate to say frequent flyer but you know, someone who comes in frequently that has really vague complaints and often that will trigger to us well there must be something else wrong with this person or

C: And so does it?

P: Hopefully. Now if you have the time to make that connection or if you happen to be on and recognized that that person has been in maybe two or three times in the last couple of months, but if it is busy enough and you don’t recognize the patient, or they happen to get a different nurse every time, like it is a hit or miss thing, it is not a very accurate way but it is something that will, every once in a while, help us out.
Monica suggested that frequent visits, and problems related to alcohol and drug abuse might, or should, raise her suspicions about violence and abuse, but that because the focus is on the immediate problem and the physical, such suspicions are not pursued.

Part of it also is that we need to be attuned to people who are vulnerable, somebody who comes in constantly with small complaints with one thing and another and a woman who might be in a situation where she is living with someone and you wonder at the time when she comes in if there is any problem, somebody who is on welfare, somebody who is vulnerable, somebody who has substance abuse you would wonder if there is something, a trigger that caused all this...Probably they [heath care providers] don’t [think about abuse] because again you are treating the actual problem. They’ve come in with a heroin overdose and you are worried about maintaining their breathing and making sure that their level of consciousness improves and all the rest of it, so you may not be thinking about why this is going [on]. The same with a woman who comes in who has been brought in collapsed because of the effects of alcohol. I mean you are concerned about what her alcohol level would be and have we seen her before, so a lot of the time we are actually treating the physical problems but we don’t go to the root of what is triggering this.

Nurses cited inferences from the patient’s behaviour and appearance as being useful in identifying abuse. However, for those nurses who had not recognized much abuse, their thinking was often in the form of conjecture rather than in the form of actual examples from practice. Further, each pattern of inference was limited in practice. Some physical cues were thought about but not looked for, other physical cues were not associated with the possibility of abuse, emotional cues and behaviours were thought about but not associated at the time with abuse, or not pursued, and frequent visits were thought about but overlooked. Thus, inferences from patient’s behaviour and appearance appear to contribute only marginally to the recognition of abuse as a problem.

In addition to making inferences from the patient’s behaviour and appearance about the patient’s level of acuity and the possible problem, nurses make other judgments. For example, nurses use various observations to anticipate how they should deal with the patient. If the nurse thinks that the patient is drunk or under the influence of drugs, she can prepare herself to deal
with confused stories, the smell of alcohol, verbal abuse, or unpredictable, combative or assaultive behaviour. If the nurse thinks that the patient is frightened or anxious, she can prepare herself to deal with the fear and anxiety; if the nurse thinks the patient looks angry, she can prepare herself to deal with anger and the possibility of abusive behaviour. The nurse anticipates certain health problems, certain acuity levels and certain behaviours based on inferences she makes from the patient’s appearance and behaviour. And her inferences are made from her particular frame of reference and draw on her personal experiences and knowledge.

Making these judgments is essential to the nurse’s safety and patients’ well being. For example, as Lenore and Yvette illustrate in the following passages, the involvement of alcohol modifies the nurses’ approach. Talking about the difference between dealing with a polite, well dressed woman and a poor, drunk woman, Yvette said.

You are anticipating that she may swear at you, your whole approach is different and quite often they do, which doesn’t necessarily make her less of a person but I think your approach is different. You know “I’m probably going to hear the F word over here” or “here we go again”.

Lenore talked about the extent to which she considers the patient’s information valid when alcohol is involved.

When alcohol is in the picture, and it is in the picture continuously, then I start getting, not really biased, I start getting question marks. People say and do things when they are drunk that they would not normally do, so when I have a woman saying to me, and she is drunker than a skunk, I just have a high sort of, “what is she telling me?” Not just with women, with men too. When men are so drunk and they are trying to tell me that so-and-so stabbed them and they were in a fight and they were in a this and a that. Well I have no doubt about the fight but I wonder, you know, they are trying to come across as the victim when in actuality I wonder how much they are the perpetrator. When there is alcohol involved, or drugs, I just don’t think you can really believe a lot of what is being said, how much of it is the way the picture happened.
Like most of the nurses in this study, when alcohol is involved, Lenore becomes more wary, more skeptical of the information patients provide in order to maintain their own safety and make better judgments about patient care.

Besides dealing with people who are intoxicated by drugs or alcohol, there are many other patterns of inference and anticipation that nurses employ. In regard to violence, there are two critical, interrelated patterns of inference and anticipation that are employed. I will refer to these patterns of inference and anticipation as the pauperization of violence and the racialization of violence, patterns which are entwined as “class” and “race” intersect.

The Pauperization of Violence

Many nurses and other health care providers in this study associated violence against women with poverty. This means that violence is anticipated to occur with people who appear to be poor, and not anticipated to occur with those who appear to be wealthy. Such ideas led nurses to think there is more violence against women in one community than in another, depending partly on the levels of poverty and wealth in each community.

Karen commented “Well, I think it [violence against women] is important, but we don’t see a lot of it here. Where I used to work we did”. After a few minutes, the charge nurse, Elaine, came in with some papers... I explained my study to her, and she commented “we sure see a lot of it here!” I notice Karen’s face out of the corner of my eye and see she has noted Elaine’s direct contradiction of what she just said. A few minutes later, another nurse, Teri, came in to talk. As we chat she says “well, we don’t see much here. I saw more where I was before, we had more welfare people.” (Field Notes, November, 1994)

Because nurses have education and can earn a wage of about $20 per hour, they may have limited personal experience with poverty. Most nurses in this study did not have formal education about violence, often had not engaged in critical thinking about their own experiences

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2 As noted previously, I have placed “race” in scare quotes specifically to distance myself from the concept and to emphasize that I consider “race” to be a social construction, not a biological reality. “Class” may be similarly problematic, but within the North American context seems to be more readily accepted as a social construction arising from material wealth.
of violence in their families or at work, and may not have thought about their own class position in relation to clients. Although they may hold unexamined assumptions about poverty and violence, many nurses readily challenged those assumptions. For example, the nurses quoted above went on immediately to examine their own thinking. In the exchange below Teri is telling Elaine about my response to her ideas about the relationship between “race” and violence.

But Colleen says its in every culture, maybe we just don't see it. I know its in every culture...” Elaine interrupts, addressing me, “But don’t you find its like common-law and, I mean in my experience its often common-law and they won't press charges.” Karen joins in “maybe rich people just have fancier excuses: 'I fell down skiing’”. “Yeah,” says Elaine, “or maybe they just know how to not make it show.” (Field Notes, November 1994)

Throughout this study, my questions about the influence of the community context provoked and solicited speculation regarding the ways in which poverty and wealth provided different levels of protection from scrutiny.

With the money issue, I think the assaults are still happening but they are covered up better. The women are probably more isolated that way because this shouldn’t be happening to them. (Lenore, ER Nurse)

I remember one of the nurses saying to me once that she saw more abuse coming from [the wealthier] areas than really from the [less affluent areas] and where it was more middle income and lower income. But it was hidden, more hidden. (Natasha, Admitting Clerk)

These perceptions were certainly echoed by Louise, a woman who was married to a wealthy, influential man. She told me that her high profile husband had to seek methods of abuse that would not produce evidence after her doctor threatened her husband with exposure. She said

That certainly stopped him from that degree of beating because that was a pretty severe beating. But after that he still couldn’t control himself so he would still do the squeezing and he would push me up against things or throw me to the floor and he said “I will never give you the satisfaction of leaving another mark on your body”, so that I couldn’t go and show anyone. So because I think he is a pretty high degree abuser he looked for other ways of abusing me that didn’t make him the culprit...

She also talked about the reasons that both women and the men who abuse them have for keeping violence hidden. She said:
I think the trappings of the higher socioeconomic group probably keeps women more a prisoner of the life-style and they weigh that out in the image too. "Golly when everybody finds out about this, it is so humiliating". I mean it is humiliating for the victim as well as it is for the perpetrator and they know they are going to have to give up a great deal of that life-style.

Some of the nurses I interviewed talked about the way in which the appearance and behaviour of patients conveyed wealth and privilege, invoked privacy and pre-empted the anticipation and recognition of abuse. For example, Monica explained how she saw the assumptions of health care workers and the presentation of patients colluding to maintain silence about violence and abuse.

Again, people who have money also have power and they are sort of, their presentation is that you wouldn't dare question that there would be anything going on, when in fact there is. It is the same as child abuse, a lot of it goes on but we just assume that because these people have money and are well educated that nothing is applicable.

These dynamics made many nurses uncomfortable about questioning certain patients about their stories or about the possibility of violence and abuse. As cited earlier, Anne was very clear that she was more reluctant to question wealthy patients than First Nations women, and noted that although she could recall providing care to First Nations women, she could not recall an instance of abuse from among the more wealthy patients. She said

I certainly do recognize, and I have seen it in certainly the [wealthier] population, but I can't remember a specific case study that I could bring to mind, I wish I could but there just isn't one case that comes to mind right now.

In this interaction, Anne contrasted wealthy people (whom she identified by naming a particular community) with Native women, which is not surprising given the poverty among First Nations people in Canada. This illustrates how class and "race" intersect, but more importantly illustrates how people are differentially open to scrutiny based on "race" and class. Wealthier (and usually white) people are less open to scrutiny by health care workers because of how such people present, and because of health care workers' assumptions. Health care workers may be more
comfortable scrutinizing the lives of poor people, (and especially racialized poor people), and
more likely to anticipate violence when the person’s behaviour and experience suggests poverty.

This differential scrutiny and anticipation of violence suggests that the recognition of
violence and abuse will be less likely with wealthy white patients than with poor people of
colour. The following example illustrates these dynamics:

I had a woman, with her husband, come into the department. I triaged them. She had a
laceration above her eyebrow and as I took them into the first aid room the nurse laughed
with the woman and was joking about her husband hurting her. So it was, I mean the
husband was there and he was in a suit and he was on his way to work and the medicine
cabinet she had opened while they were in the bathroom and she lacerated the top of her
eyebrow. That was the history that I got as I walked the patient in and gave the history to
the nurse, and the nurse, who is an excellent nurse, jokingly said, “so he’s been hitting you
again has he”, which at that particular time they both laughed at and said, “yeah, I bet
everybody at work is going to be thinking that” and a discussion ensued, but it could have
very easily been true [italics and bold added].

This situation illustrates how the subtle appearance of wealth (“in a suit” and “on his way to
work”) preclude violence and abuse as a consideration. In another example, Susan told me about
a woman with whom, in retrospect, Susan thought health care providers colluded in silence
because of her position of privilege.

...all of the women who come back over and over and over with complaints that are the
same complaint or variations of the same complaint that have no, there is never any concrete
finding. There is a lady that comes in that I used to be frustrated about her and you know
she just breaks my heart because she is a 50-51 year old lady and she is lovely, exteriorly
speaking, and she has lovely manners and she is very sweet and she comes in probably
every two or three weeks for Demerol shots for migraines and it is known throughout the
department that is what she gets when she comes in and there is no question of using any
other methods or methodology and there is no question of follow-up for her in the Migraine
Clinic or the Pain Control Clinic, she gets this Demerol every time - she is a Doctor’s wife.
In fact, “the Doctor’s wife is here again and she needs the Demerol”. She has probably had
150 admissions for the same thing and then she goes home. To me she would be right up
near the very top of my index of suspicion for someone who was not coping well and who
maybe had something going on where she was in an abusive cycle and not once has it ever
been dealt with.
Several nurses pointed out how assumptions about wealth and violence influenced thinking, and one nurse was adamant about the fallacy of such assumptions. She challenged the idea that violence does not occur as often in more affluent communities.

What if their children are beaten? What if I have to see another trauma like that? So don’t tell me it doesn’t happen [here]. It is presumed that we are an educated, highly respectful community, but we are not. It’s everywhere. There is no perfect middle class respectful of a human being anywhere now. Anywhere.

Thus white privilege and wealth may obscure violence, and being poor or “non-white” may be more readily associated with violence. And these dynamics may in turn reinforce the stereotypical associations of violence with poverty and people of colour.

**The Racialization of Violence**

Class intersects with “race” both in that wealth and white privilege tend to coincide, and in that many nurses and other health care professionals in this study associated violence with “non-white” people, as well as with poverty. Throughout this study, most of the stories I was told regarding patients who had experienced abuse and violence were marked by the ethnicity, religion, or language group of the patient signifying ‘not-white’. I was told stories about “Inuit”, “Indian”, “Native”, “Chinese”, “Iranian”, “East Indian”, “Farsi”, “Muslim”, “Asian” and so on, women. There were very few stories of abuse in which the racialized status of the woman who had been abused was not noted. This phenomenon is congruent with the fact that people of colour are “visible” to white health care providers, and that as class and “race” intersect, some people are more readily scrutinized than others by health care workers.

One of the most common responses to my study was that I was in the wrong place, and that “we don’t have it here”, or “we don’t have as much here as [elsewhere].” Nurses, physicians,

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3 I am using the term “non-white”, not to indicate that “white” is the norm against which “others” are identified, but rather to indicate that “non-white” is the sense in which white people in this study are identifying cultural, language or “racial” groups. When possible, I have used the term “racialized groups” to signify people to whom this social operation of racialization is applied.
admitting clerks, patients, and various health care personnel responded in this way in both of the primary study sites. During my initial meeting with the Emergency physicians at one site, some physicians were quite taken aback at the statistics I was using to justify the importance of the problem of violence against women. One physician said “I don’t know where you are getting those numbers, but I think that when you are here, you will find that they are nothing like that”.

A nurse at the other site asked “What are you doing here? You should be somewhere, downtown, at St. Paul’s, or, no , I know where you should be, you should be in Surrey (a community known for its populations of poor and immigrants, especially from India)”. A physician who works in Surrey as well as in one of the study sites said “if you want to see violence, you should be in Surrey”. Dana, a float nurse, asked about my study.

What made you decide to come here? Do you think you’ll find much here? Don’t you think you’d find more downtown? I mean in all the time I’ve worked here (she explained earlier that she is a float, but regularly comes to Emerg and has done so for about eight years), I can only remember a few times when there was even a question of violence. (Field Notes, April 1996).

I was asked repeatedly by both physicians and nurses why I chose to study the selected sites. This was not merely curiosity regarding how I made the choice, because such questions were invariably accompanied by statements to the effect that I should be studying somewhere else. Underlying these messages was the implicit, and sometimes explicit, belief that violence is more common elsewhere. Often these beliefs were accompanied by ideas of violence being associated with “race” and class. When I asked a nurse why she thought I should be in Surrey, she said “well, they have more welfare and more East Indians there”. Similarly, a physician at the other site told me that there is more violence in Surrey because it is “in the culture”.

Even those familiar with statistics showing that violence against women spans all groups of people, did not believe that there is as much violence in their communities as in other
communities. One physician said “The numbers would suggest that its just as high here, but I don't think you'll find that it is.” These responses were not confined to health care providers within the study sites. When talking about my work with other health care providers, many assumed I was studying at specific sites and were surprised to find that I was not studying where they thought I should. When explaining my study to those who come to Emergency as patients and family members, I was also frequently asked if I wouldn't be better elsewhere. For example, one woman who was admitted with chest pain asked “do you see much of it [violence] here?” She said “I thought there would be more of it down town”, and explained that she thought this because of the greater number of First Nations people down town.

This problem of thinking that abuse occurs elsewhere was well recognized by workers in the community, especially in one community where the contrast between rich and poor, white and racialized groups seemed to provide excellent material for "them and us" thinking. The director of crisis services in one of the study communities said that the idea that there is less violence in her community is common. She said that she tries to counter the belief with statistics from the transition house, crisis line and counseling services. She told me about being unable to keep a former transition house as a temporary shelter, because community members said “we don't have enough of it here.”

People’s ideas that violence is not as prevalent in their own communities as in others are accompanied by ideas regarding where violence does occur. When I asked how the community influenced practice in relation to violence, the racialized population of a given community was associated by many health care providers with violence. For example, when I asked Dr. Morgan about the influence of the community, he discussed the demographics and said “... there is also a Native population that drink a lot and there is a lot of physical violence in the family units and so
you certainly get twiggled when certain people come in to the Emergency Department.”.

Similarly, Anne, who worked in another hospital, also associated violence more commonly with First Nations people, saying that “Native Indian women are very vulnerable to that sort of thing [being battered].

The Impact of the Racialization and Pauperization of Violence

Ideas about where violence occurs were influenced both by health care worker’s personal experiences and the context within which they live and work. The impact of these ideas on practice is profound. First, health care providers were not generally looking for violence in their communities, and were less likely to be sensitive to cues of violence and abuse. Second, they were likely to have a higher “index of suspicion” for violence and abuse among certain patients, and be less sensitive to indicators among others, and the difference was likely along the lines of “race” and class.

Some health care providers analyzed the impact of assumptions about where violence occurs. For example, one social worker said that abuse is sometimes suspected because of the social distance between the health care provider and patient.

...I have felt the nurses were judging parents harshly because they weren’t traditional parents and I did not feel it was appropriate for me to go in and do child abuse interviews because they were scolding or inappropriate in terms of their tone of voice with the nurse or what have you; they are not middle class, traditional parents and so the nurses immediately feel maybe that the children are at risk.

Biases in the ways inferences are drawn from the patient’s appearance and behaviour may be overlooked. For example, one day during field work, I was greeted in the unit with several of the staff telling me that they “had one for me”. The situation they referred to was a young “non-white” woman who was in with paralysis and aphasia. She had been admitted before, and both
organic and psychiatric explanations for her paralysis and aphasia were ruled out. The staff suspected her husband was violent.

Bo also tells me about the woman in bed #1. She has also recognized her from a previous admission, and apparently last time [the psych. nurse] tried to talk to them and the husband became very angry, shouting and abusive toward [the psych. nurse]. (Field Notes, September, 1996)

As I talked to various staff members, the apparent reason for suspecting abuse in this woman’s situation was the husband’s anger and hostility toward the staff. When I spoke to the woman’s brother later, he was very frustrated with the staff for not having any explanations for his sister’s condition and for assuming violence was an issue.

A man is now standing at bed #1, and catches my eye. He comes over and we start to talk about what is going on. I ask him what he thinks is the problem. I have a little difficulty following his English and understanding him through his accent. He is telling me that it (the paralysis and not talking) has happened before, and that the woman (who is his sister-in-law) says that she is afraid of ghosts. Lenore joins us, and asks him if anything happens at home prior to her becoming paralyzed etc. A wary light shines in his eyes, and he says, “It has never happened. No fighting.” I ask what he means, and he says, pointing to Lenore “that’s what she means, fighting at home”. While it is true that this has been part of Lenore’s conjecture, he has obviously jumped on this for a reason. He goes on to explain that the last time they were here, his brother (the woman’s husband) became very angry, and now everyone thinks that it is fighting that causes her behaviour. (I perceive that this is exactly what everyone has told me to date). (Field Notes, September, 1997)

A social worker at one of the study sites thought that the referrals she received regarding abuse tended to be about poorer and racialized people. She said “I’m more likely to get a referral for someone who is in a low income situation... than I am to get one from a spousal abuse from [a wealthy area]. Similarly the referrals she received about child abuse tended to be regarding either First Nations or poor people.

There has always been a large First Nations population [here] and yet they are still the identified patient [for abuse] a lot of the time when they come in here... On the other hand a lot of the families that I have referred [to me] aren’t First Nations they are Caucasian families who are poor and the mother is stressed, probably somewhat immature, coping not as well as she should because there is no privilege and they are abrupt with the nursing staff and then I will get a call. So if they are weepy, anxious and demanding, or grouchy sometimes I get “I’m not so sure about their parenting ability”. That is kind of a human
nature thing and maybe their parenting ability isn’t superb but then neither is the guy who
sits there on his cell phone and looks at his kid twice but I don’t get called on him, I get
muttered at about him “I’m glad he’s not my husband” kind of thing, but that kid isn’t
necessarily reported. There is a sense of the parochial privilege.

The possibility that such assumptions might lead to a lack of recognition of abuse among
dominant groups was sometimes recognized when discussed during interviews and
conversations. For example, Yvette talked extensively about the differential recognition that
might follow assumptions about people who appear to be wealthy. Dr. Morgan discussed the
consequences of assuming that violence occurs more among certain people, saying “I think they
[First Nations people] are easily labeled for your topic but I think what worries me is that your
typical upper class housewife in the nice house and the nice neighbourhood is going to get
missed.” However, the consequences of such assumptions about violence for members of less
dominant groups were rarely explored by participants in this study.

Making inferences about violence from the patient’s appearance and behaviour along the
lines of class and “race” is clearly not in the interests of patients, regardless of whether they are
wealthy or poor, white, or not. However, the tendency among health care providers to see
violence as a problem of “others” seems to serve the providers themselves. If violence can be
seen as a problem “they” experience, then violence can be kept at a distance from “us”. Thus the
differential neglect of violence among groups of people according to class and “race” serves the
interests of white and non-poor people in maintaining class and “race” superiority and freedom
from scrutiny, and designating violence as a problem of poor and racialized people serves the
dominant interests of the wealthy and white.

Information Provided by the Patient: Disclosure and Non-disclosure of Abuse

Building on the presenting complaint, and inferences from the appearance and behaviour of
the patient, nurses use information provided by the patient to further identify the problem and
associated level of acuity, and to determine nursing actions. The information provided by the patient varies with what the patient is willing to say, how the patient sees and frames the problem, the nurses’ behaviour, and the patients’ perception of the nurse’s behaviour.

From the perspective of many nurses and health care providers I interviewed and with whom I spoke, what patients are willing to tell was the most critical determinant of whether or not violence and abuse is recognized. Nurses repeatedly told me that women are reluctant to disclose abuse, and that getting information from the patient depended on the nurse “digging deeper”.

I don’t find anyway, they don’t come in saying “I’ve been abused” in whatever way, they come in with something else - a cut - and you have to dig to find out how they got the cut or why they got the cut and a lot of times it depends if they have any alcohol in their system whether you get the right story or not or maybe that is the only way you’ll get the right story, or it depends on who comes with them, if they come with certain people. (Palen, Emergency Nurse)

Monica captured the analysis of the situation offered by many nurses, that is, that women are reluctant to disclose abuse, and if abuse is not obvious, nurses don’t have time to dig deeper.

Usually, one, it is not obvious, and the other thing would be that we are busy. We don’t have time to ferret into what is going on. Also, a lot of it is the victims themselves are very reluctant to come out and say anything about the situation.

Lulu agreed that women are reluctant to disclose abuse, and thought that the likelihood of “digging deeper” depended on the individual nurse.

Again it would be how passive the woman is, and they have the right to be passive. At the time they are here they have been hurt in [some] way, shape or form. I’m not sure what we would do because there is nothing in place. There is nothing in place to help pick up on issues unless the woman says to us, “this is what’s happened, somebody just pushed me down the stairs”, or “I was just hit” or whatever. Depending on who was on, depending on what kind of questions were asked.

Thus “digging deeper” is not in the interests of the efficiency of the unit, and may or may not be in the interest of the health care provider. Willingness to “dig deeper” appears to depend,
at least in part, on how the health care provider understands the woman’s reluctance to disclose.

Explanations for women’s reluctance to disclose abuse included the woman being fearful, the woman’s life pattern, the woman’s “culture”, and the woman not wanting help. Most health care providers saw non-disclosure as a choice that the woman made and most were frustrated by that choice. As the following examples illustrate, health care providers held a variety of ideas about choice, including the idea that a woman’s choice may be limited by fear, and the idea that some women “want” abuse, and the target of frustration varied with the extent to which the provider saw the woman as having choices.

A lot of them are reluctant, either out of fear or just their pattern, their life pattern (Faye, Emergency Nurse)

I think there is a certain amount of fear but with the people that have never had to depend on anybody but this person, for instance, and their family, they are afraid, they are afraid that if they tell someone else he will find out before anything happens and then he will do what he says if you ever tell. (Yvette, Emergency Nurse)

I don’t know what we do with the people that can’t tell you, and they honestly believe they can’t tell you because they believe they are protecting themselves by keeping quiet. I don’t know how you would reach that, I have no idea. (Lulu, Emergency Nurse)

You know the woman might have a bit of Alzheimer’s Disease and her husband or her caregiver has total control over her so this woman is almost being held in position by the controller, that she can’t say anything to anyone because she is afraid that he or she will really restrict whatever access she has to the world. (Monica, Emergency Nurse)

...if she wants to get sluged every Friday night and carry on in that relationship that’s who you are dealing with. You’ve got to want help. You’ve got to be suspicious of the people who may want help and are afraid to ask for it and try and initiate the request for help but if they deny it at that visit then that’s all you can do, you can’t spend half an hour trying to suck it out of them. (Morgan, Emergency Physician)

The racialization of violence also influenced the way health care providers interpreted women’s reluctance to disclose abuse, and “culture” was often used as an explanation in the following way:

Theresa told me about an “Asian” woman who she had looked after, and said that “its their culture not to say anything”. She said that women do not speak up because in their culture
it is shameful to be beaten by your husband, and said that maybe there [in the woman’s country of origin] its OK, but here in Canada, its not.

“Culture” is conflated with “race” so that the culture of violence and tolerance of violence is associated more readily with people of colour. The ideas that certain “cultures” tolerate more violence toward women was often supported by women of colour that I spoke to during this study, which, in turn, can support ideas about “race” and violence. For example, a woman who identifies herself as “Japanese” told me that in her culture you don’t talk about what goes on in the home, and you certainly don’t talk about abuse. I asked her if she knew of any cultures that do, and she laughed and said she had not thought of it that way. Nurses reported various women of colour who similarly associated culture and violence in ways that conflated “race”, culture and violence. For instance, Nicole was told by the friend of a Chinese woman “it’s against their custom, to report.” In another example, Shelby told me about a woman she had seen.

...she ended up divulging that she was in an abusive relationship. And I said... I asked her some questions. To me, what stood out in my mind, was she said, “well....” (She was Fijian or Filipino, something like that. I don’t think she was East Indian. She may have been, but I don’t think she was) but she said to me when she told me about the... her partner, “well he’s East Indian.” And the way she said it, I honestly didn’t know what she was talking about. And I mean, I wasn’t aware of any great difference in our cultures in terms of abuse or anything like that, and I said, “And does that make a difference?” I was quite surprised at how well I had phrased the question, when I thought of what was going through my mind when she said this. And I said, “I’m not sure I understand - is that somehow different - does that change things?” or something like that. And she said, “oh, yeah!” She said, “East Indian men are terrible.” She said, “they’ll kill you.” And I sort of looked at her and she said... she looked at me like convincingly saying, “they will... they don’t care about who you are or what...” I wish I could remember how she put it... She referred to her being not worth anything. “It doesn’t matter, it’s not like I’m worth anything or not to him... meaning, “like it’s no skin off his back, he’ll kill me...” You know, like “it’s no big deal.” And the way she said it so matter of factly, it made me think, “oh my gosh, is this a real terrible problem in their culture that I just really was unaware of - that I’m not recognizing?”

Missing from discussions by health care providers about the willingness of “non-white” women to disclose abuse were understandings of racism, and missing from discussions about
immigrant women and non-English speaking women were understandings of how these variables might affect disclosure. For example, Dosanjh, Deo, and Sidhu (1996) interviewed 15 South Asian Canadian women (all of whom were abused by partners, and sometimes also by other family members, and most of whom were sponsored to Canada by their husbands) who cited language barriers, lack of knowledge about services, fear of deportation, lack of anyone to turn to, fears for children, and so on, as preventing disclosure.

The health care providers I talked to and interviewed in this study often felt that they did not have the time nor the obligation to “dig deeper” and relied on the patient to disclose abuse. Not digging deeper served their interests in getting their work done, and limited the emotional cost engendered by the recognition of violence. Differentially overlooking violence may also allow health care providers to maintain their ideas about themselves as white and non-poor people, interests that health care providers saw as also being pursued by patients.

Willingness to Disclose Abuse: Health Care Provider’s Perspectives

Health care providers thought that people are more or less willing to disclose abuse based on class and “race”. Faye, who worked in a hospital that served a wealthy community, contrasted the extent to which she thought people of different levels of affluence would be willing to disclose abuse.

I think because it is a predominantly probably wealthier, as you said, area I think back to the time that I said that people are more reluctant to identify that they are having a problem. I think that kind of an attitude is almost embarrassing to them, there is this pride, sort of an upper crust kind of pride thing. The more educated we are I think the more tools we have to stuff it in an area where nobody can see it. Whereas people that don’t have those tools will often, they are very open about “yeah my old man beats me all the time” kind of thing.

Further, she thought that wealthier people used other sources of health care, and thus were even less open to scrutiny.

I think the community we live in tends to cover up a lot of their indiscretions and problems and tend to probably be a lot more private about it and probably have the money to go and
see somebody outside of the general public resources rather than come to the hospital with the problem.

Similarly, Yvette contrasted her current experience with wealthy patients with her previous experience of working in an inner city hospital. She said “The clientele there were more transient, less affluent and more used to sharing with outsiders and thus would readily come to tell you that ‘my common-law beat me up again’”. She talked about the differences in presentation, privacy, and scrutiny between women of wealth and poverty.

Y: Well probably in some ways it is a more influential area if you take specifically [one area rather] than downtown skids and I think there is probably the shame factor, they hide more. I don’t think they are as liable to be open, “I don’t need to tell an outsider, we can deal with this within the context of the family”, I think is probably stronger as your economic bracket goes up than the woman living in a common-law relationship in a run down apartment in [a poor neighbourhood] who I think might be more likely to reach out for help.

C: Or, and/or, is maybe more open to our scrutiny.

Y: Well that’s right. “I’m not going to have any of those people judging me”, I think is more an attitude [here]. So I think the guards are up and I think even if you suspect it you would, I think it would be harder in that kind of woman, in the kind of woman who is married to a well-known, for instance, business man, very well dressed the whole bit, it is still happening but I think they are going to keep up more of a front than this woman in this apartment downtown.

C: How is that for you? How does that affect you?

Y: I just think they are less open to talking, less open to sharing anything. They will answer your questions, they make it very clear, probably as clear as we do, in that with their verbal and their non-verbal communication that “I’m in solely about this problem and none of the rest of my life pertains to it and just get on with it”. It is hard to even ask them the [alcohol and drug screening] because they are clearly here about this and “just do it dear”. I think it would be harder to out and out ask them even if you suspected [abuse].

C: Whereas with the other...

Y: They are more open, and like you said, I think it is the scrutiny. They also I think had more, probably anyway, had more interaction with Social Workers, health care workers than the well-to-do lady living in [a wealthy area] has, she has probably never needed a Social Worker, she is not used to discussing her personal life with anybody but family, if even family. Whereas the people downtown, they need help more just as an example of where they live and so they are used to “If I need money from Welfare or Social Assistance or whatever then I do have to divulge certain parts of my life, such as my income, my social situation”, whereas these [wealthy] people have never had to and it’s nobody else’s business. “It might be right, it might be wrong, you might be very unhappy but it is nobody else’s business”, whereas a lower economic group I think are more used to the fact that they are depending on society.
as a whole and they know that certain things are... I think they are more apt to either ask for help or certainly to be open if you indicate that you have a concern.

These health care providers thought that wealthier people would be less likely to disclose abuse than poorer people, would less open and more private, and some thought that wealthy women had 'more to lose' financially. In addition, nurses often associated poverty and common-law relationships, and some associated common-law relationships with violence.

Many health care providers discussed differences in people’s willingness to disclose abuse, and some talked about how they were more or less willing to question patients about abuse. Yvette, as cited above, thought that it would be harder to ask wealthy people, and Monica said that the presentation of the wealthy “is that you wouldn’t dare question that there would be anything going on”. Anne was quite clear that she had a different level of willingness to pursue information depending on the status of the patient.

But I think across the board it is not, as I say it doesn’t matter what level I’m dealing with, of the person, it’s whether I’ll pursue it or I’ll just say “maybe this could be”, rather than really “look let’s deal with this, I think there is some violence here”. Which I would do with the Indian women, which I probably wouldn’t do with the (wealthier) ladies. That’s where I’m at.

Thus assumptions about violence occurring less among the more privileged are reinforced by health care provider’s perceptions of privilege limiting their willingness to suspect and address abuse. The wealthy are thought to be less likely to experience abuse, and are less likely to be suspected of abuse. Consequently it is not surprising that nurses recall recognizing abuse among poor people more often.

C: So in that time [12 years] have you dealt with a lot of instances of abuse that you’ve known about?

Y: Probably mostly at [an inner city hospital] interestingly enough...The clientele there were more transient, less affluent and more used to sharing with outsiders and so they would readily come to tell you that my common-law beat me up again. They may not want to charge him, they may not give you a name, they may not really want to talk about it, it may be just something that they’ve come to feel they deserve or whatever but they are very open about it. Or if you ask “did someone you know do
Willingness to Disclose Abuse: Women’s Perspectives

Interestingly, I found both wealthy women and poor women to whom I spoke open about their experiences of abuse. I met poor and middle class women in one hospital, and poor, middle class, and wealthy women in the other hospital, and throughout various community contacts. Women of all levels of affluence offered to help and/or to be interviewed. While wealthy women concurred that pride, fear of humiliation and finances figured in their decisions not to disclose abuse, these reasons were only partial explanations, and poor women also had similar reasons for not disclosing abuse. The women I interviewed also did not disclose abuse because they did not necessarily think of their experiences as abuse and some did not think they had choices. They also thought that the approach of the health care provider was important.

One woman talked about the reasons she thought poorer people don’t disclose abuse. She had said earlier that people “tell the same lie consistently” When I asked why she thought people did that, she replied
Because of the social stigma.... When I was on my own with [my child] I remember going in to Human Resources and applying for a subsidy for daycare and there was another woman in there with her three young kids and she was stressed out. I was just talking to her and she said “I can’t handle this, my husband is an alcoholic and he has been hitting me” and I was like why are you telling me, why aren’t you telling somebody who can do something for you and I said to her “have you thought about getting help?” “Well where am I going to go? What am I going to do with three young boys on my own?”.

During field work, I met several women who saw no point in disclosing abuse because they thought there were no choices other than living with violence. For example,

I went behind the curtains where Shelby was assessing an 83 year old woman who had come in with a supraventricular tachycardia. As Shelby was doing the woman’s vital signs, I explained my study. The woman said “well, that’s the problem, isn’t it? This happens (gesturing to her heart) every time he gets like this. (pause) But what can I do?” she says. “What can I do? I am 83 years old... I only have my old age pension now, and a rented apartment. I even had to sign my car over to him.” (Field Notes, July, 1996)

Through field work I also met a number of wealthy women who had experienced violence or were currently living in violence. The following example illustrates one woman’s ideas about violence as a private matter.

The woman in the far stretcher... is staring at the ceiling. She sits up on her elbows and looks at me and then flops back down. “Are you bored?” I ask. She tells me that she is just waiting to have her knee seen to, as she twisted it and hurt it five weeks ago, and it has not got any better. She tells me that she is 82, and I marvel at her age, as she is very youthful in appearance (I would have guessed mid sixties). She is thin, very elegant, well (and expensively) dressed (above the waist, as she is undressed below the waist, except for underwear) and speaks with a trace of a British accent. I tell her who I am and that I am doing a study to help nurses do a better job of identifying and looking after women who have been battered. “Don’t you just put up with it? That’s what I did” she says. I guess that I have heard so many joking responses to my topic, that I am unsure if this is another one. “Are you serious?” I ask. “Oh, yes” she says, “I just didn’t know what else to do”. I stop her and clarify that she knows that I am doing research, tell her that what she is telling me is very important to me and that I want to know if it is OK if I make note of what she is saying. She says that it is fine. She tells me her story, not in a chronological order, and not just focused on the violence she experienced, but as part of her overall life. She tells me about coming to Canada with her first husband, and how he died at a very young age. She says that she had a hard time deciding if she should go back to England, as she had three school age children, but no other family here at the time. I mistakenly think that this was the abusive husband, but she says “Oh, no, they broke the mold when they made that one, he was perfect.” She tells me that it was her second husband who was an alcoholic and who beat her.
She says that the first time it happened she was shocked. She couldn't believe it. Her husband was soft spoken and otherwise very gentle. He got drunk and threw her against the wall. "I didn't even know why, I didn't even know what I had done" she said, her voice still full of disbelief and searching for comprehension. At the time they were not in Canada, as she and her second husband lived in various other countries due to his job. She said that when they got married she didn't realize that he drank; that her first husband had not drunk at all, and that she really didn't think anything of a man having a couple of beers. She told me of another beating where a neighbor found her “where I had crawled.” She said “there is nothing you can do, except tell the family, and you don't want to air your dirty laundry.” (Field Notes, June, 1996)

This woman remained married to this man for 25 years. She saw the physical violence as something to be tolerated, and told no one other than her family physician who was a well known physician in the affluent area in which she lived.

She told me about telling her physician. “He said ‘what happened to you, did you walk into a door?’, and I just said ‘yes’”. I asked ”and did he believe you?” She shrugged and said, “well, he didn't ask me any more questions”. I asked her what she would have done if he had told her he didn't believe her, and she said “I would have told him.” (Field Notes, June 1996)

As this woman’s story suggests, it is not only the patient’s willingness to tell that determines disclosure of abuse, it is also the way in which the woman frames the problem, the willingness of health care providers to ask, the way in which they ask, and their behaviour and responses.

The women I interviewed and spoke to in this study did not necessarily label their experiences as “abuse” or themselves as abused or battered women. The woman in the preceding story saw her husband’s violence as something “you just put up with”. Lisa endured years of belittling and emotional and mental abuse before her husband began beating her, and did not think of the treatment as “abuse”.

L: But, there probably was a lot of verbal abuse that I wasn't even aware of and emotional abuse and all sorts of kinds of abuses that I hadn't even, you know, I didn't even recognize you know
C: Did...did you label it as abuse at that point?
L: No, no, it wouldn't even have occurred to me
Alicia said that when she was asked if she was “a victim of violence” at an Emergency that had a screening program, she said “no”, because she was not at that time, and because she had come to the Emergency for other reasons. As these various examples illustrate, women do not necessarily frame their experiences as “abuse” and therefore “disclosure” is not an issue to them.

In addition, the women I interviewed got the message that nurses did not have time to listen to them. For example, Nadia said “Most of the time the feeling I get when I am in Emergency is that people are too busy, they don’t want to be bothered with something else.” The women I talked to recommended listening, and framing questions and responding with empathy.

At least saying “I am here to hear you and I think I could understand if you do want to talk” and just the way you framed your questions.....I think if someone came into the hospital and you had any suspicions it would be the way of asking that would be important, if you sensed that there was something else happening for that person. (Louise)

I don’t think it works if they just say “ahum”... Listening and just the fact that somebody is there and tells you that you are okay now, we are going to take care of you and if they state that “I understand that it is painful, I understand that you are not feeling good, it may not be a big deal but don’t worry but it is a big deal for you and we are here to help”. Little things like that, just a kind word here and there and I am, again, talking from my experience but I would do anything for a kind word like that. (Nadia)

The women I spoke to did not necessarily expect understanding, but they did expect nurses to listen to them respectfully. Lana said “It is hard to say they [nurses] could be understanding because maybe they’ve never been in that situation so you can’t expect them to understand”.

Nadia said

They [nurses] get angry. I get angry, I notice that. I get angry because I expect people to listen to me because I am being abused. “You listen to me, don’t do it [get angry], how can you be so stupid to do it [get angry] when I am just telling you what I am going through”.

From the perspective of the women I interviewed who had experience abuse as a wife, willingness to disclose depended partly on the opportunity to disclose, and, importantly, the
opportunity to disclose depended on the way questions were asked, and the behaviour and
responses of the health provider.

Asking Questions: Perspectives of Health Care Providers

Nurses generally told me that they do not ask women about violence even when there are
cues that violence and abuse may be problems with which the woman is dealing.

I think a lot of it too is the way we phrase things, that we are probably busy with our
blinders looking at whatever the complaint is and we don’t go in and encourage the woman
to talk. I think that is probably what I would assess the situation to be. (Monica, Emergency
Nurse)

During interviews nurses thought about the importance of asking questions and the importance of
how they phrased questions, but cited a lack of time, focus, and preparation and not knowing
what to do as reasons for not asking. Monica went on to say:

Maybe we need to be a little more forceful, “how exactly did this happen”, but a lot of it is
facilitating the woman to come out, encouraging her to talk about the situation. It is very
difficult because I am just thinking that often it must be the way we phrase questions that
would encourage the woman to come out and say more about what was going on. Part of it
is our responsibility in putting things in such a way that the woman will confide in us and a
lot of the time, as I say, we are just so busy and we are not tuned to that sort of thing that we
just don’t do anything about it. (Monica, Emergency Nurse)

Asking questions about violence takes time, both to ask and to listen, and creates
discomfort. Nurses do not perceive that they have the time, and many are struggling to protect
themselves from discomfort. Recall Bo’s words about limiting and manipulating patient’s
answers to question.

...Open ended questions, all this kind of stuff we took years ago, that we don’t have to do
now because we can manipulate answers out of patients. One word answers like you’ve
never seen. But feelings, senses, that’s another story, ‘cause that involves time and it
involves an investment on your part. It involves an investment and I think that as an
Emergency nurse I have learned, finally, as I’ve just said to you, I am protective now of
myself. I am not prepared to give as much as I used to, and I’m certainly not proud of it, but
it is safer...I’m not prepared to be bitten, for a little while. I may never be prepared.
Further, reading a draft of this study, Dorothy pointed out that “we are not taught to listen” and brought to my attention a report on research (Crossen, 1997) regarding the pervasive influences in modern society that make North Americans in general poor listeners. Dorothy said that the quip “we aren’t listening, we’re waiting to speak” applies to Emergency practice too.

Stereotypical thinking about violence in relation to “race”, class, gender, sexual orientation and so on can influence levels of discomfort in asking questions. For example, Susanna recounted incidents from the first months of universal screening in her unit. She told me about a nurse reluctant to question an elderly man with hemorrhoids about abuse.

S: He was fairly wealthy, this guy, a well dressed man. Very articulate. He was white, and she said, “I can’t ask him this question.” “Why not? – what says because he’s got... he’s 71 and he’s probably worked all his life, that he’s not an alcoholic or he hasn’t been abused – maybe his wife beats him over the head with a frying pan, who knows if you don’t ask the question.” But yes, that came up yesterday, all day long, but it wasn’t just once, it was all day long, and the question did not get asked the majority of times.

C: you’ve said that he was well dressed and he was white...

S: And they don’t ask that to white people. She came in and said that [he’s white]. So I kind of peeked outside and said, “yeah, you’re right, he is... He’s white. So what, it doesn’t mean anything.”

Further, as Kathy pointed out, the response to questions is as important as asking the questions themselves. Kathy said that in order for a woman to disclose abuse the woman would have to feel that the nurse is a safe person, and went on to describe what she would consider a safe person.

You have to let the people know that you hear what they are saying and quite often they will open up if they feel you are a safe person. There’s lots of clues you can pick up and if you give them that option to explore that area quite often they will open up to you because that is why they are in Emerg, sometimes they need to unload.... [A safe person is] someone that is willing to listen, someone who is non-judgmental, who doesn’t offer comments like “he’s jerk” or whatever, “what are you doing with him, he’s a jerk”. Right there you are going to shut someone down, you have to be very non-judgmental. Their situation is unique to them and you have to just let them. I think if they feel safe in telling you things and you are not going to react, you are not going to say “wow that’s amazing, why haven’t you left”, that they will be more apt to discuss. I think the big thing is empathy, active listening and being non-judgmental. I think if you make
someone uncomfortable, if someone is telling you their story and you are looking at them like "you are a real goof for being there", they aren’t going to want to tell you their story any longer.

In general, nurses in this study said that they did not ask questions about abuse and that they were not comfortable asking questions. However, one nurse who had worked in a setting where routine screening was in place recounted the advantages of asking direct questions.

At least these nurses then ask a question, and are supportive one way or the other, then they’re getting a message across to that woman that they’re aware of domestic violence, they know about it, they’re not hiding it, they are coming out and asking a direct question, and I think that that is a big plus.

**Asking Questions: Perspectives of Patients**

Although I was not directly asking patients about their experiences of abuse, my quest for informed consent from patients acted as a screening device for abuse. I told each patient that I came in contact with that I was studying how nurses could do a better job of recognizing and responding to women that had been battered. The initial response of every patient, male or female, was within one of three types: reassurance, disclosure, or detachment. The first type of response was open reassurance that violence was not a problem for them. Both men and women said something such as "well, I’m not battered", and most men said it in a joking manner. The second type of response was disclosure. One man and over 20 women indicated that abuse was currently or previously an issue for them. In most cases, disclosure did not occur in the presence of the nurse. In at least two instances I told the patient about my study in the presence of the nurse, and the patient’s non-verbal behaviour prompted me to return to the patient later, and they told me about the abuse in private. Almost all of the patients who responded with reassurance or disclosure commented on the importance of my study, even those who were quite ill. Some, especially those who were not particularly ill, were very effusive about the importance of dealing with violence and abuse. The third type of response was only apparent to me in contrast to these
other two types of responses. Although without exception every patient was willing to be observed, this third group of patients were markedly detached in response to my “informed consent speech”, and gave consent to be observed with silence about their own status regarding experiences of abuse, and without comment regarding the importance of dealing with violence. Often the non-verbal behaviour of these patients (appearance of discomfort, limiting conversation, lack of eye contact) suggested that they were uncomfortable discussing abuse. These responses may have been due to general discomfort with the topic, or these people may have had personal experience with abuse as victims or perpetrators.

Regardless of their personal responses, all of the patients were willing to be observed, none objected in any way, and most were willing to talk to me. Of the women who disclosed abuse, most offered to help in whatever way they could. Five women agreed to interviews, and one woman, the 83 year old who was still living with her abusive husband, tried to write me a cheque for my study.

The women I talked to and interviewed said that asking them about abuse was important, but that the way questions were asked and responded to, was critical. Alicia had been repeatedly “screened” at one hospital. She said

When I first walked in there, the first thing they say to you is, “are you a victim of violence?” I didn’t deny I was not a victim, I said, “yes I am.” But I also didn’t like their attitude. “I’m here because I’m going to have a seizure at your front desk.” Once I was admitted, I wouldn’t mind them asking those questions, but it seems to be like three times (pause) on three occasions at [the hospital], they have asked me, “are you a victim of violence?” I don’t know what the reasons are. They sees I’m having a seizure in there, let me have the seizure, and then ask me if I’m a victim of violence.

Nadia said that asking questions had to be accompanied by a willingness to listen.

By not talking about it and not allowing people to talk about it also makes them [women] feel guilty, not giving them the courage because it is like a taboo and if nurses do that they are not going to help, they are going to do the opposite. It’s funny, when somebody goes in bleeding they know what to do and that is way more complicated than listening to somebody.
The Influence of the Context on Recognizing Abuse: Toward Congruence

Nurses' ideas about violence and the way in which nurses behave combine with women's ideas about violence and ideas about health care providers to limit the information that nurses are likely to get from patients about violence and abuse. The context of practice supports these limiting dynamics by 1) privileging the physical aspects of health concerns, 2) limiting opportunities for privacy, 3) limiting the time available for each patient, and further limiting the time spent on non-physical aspects of care, and 4) limiting continuity and opportunities to build trust and to allow follow through with care. These influences support practices in relation to violence and abuse congruent with the predominant pattern of practice.

The focus on physical aspects of health concerns is a predominant feature of Emergency nursing, and is congruent with the mandate of the Emergency unit. This focus means that physical cues of abuse are most likely to be recognized, but because women who have experienced abuse rarely present with a complaint of "abuse", and often do not present with "blatantly obvious" evidence of physical abuse, even physical indicators can be ignored, and less obvious and non-physical indicators can be over looked. Furthermore, the Emergency is structured to deal with the presenting complaint rather than with the root cause of the complaint. Cardiac pain is treated, but counseling about risk factors is beyond the mandate of Emergency (and the resources of the health care system, as currently allocated). Constipation is treated, but prevention of recurrence is not necessarily addressed. Similarly, broken bones are set, but the cause of the fracture, whether it be risky sports or assault by a partner, is not confronted.

Women who had been abused talked in their interviews about their perceptions of the focus on the physical in Emergency units. Nadia said "I don’t see too much support in the emergency room." Louise said
You can attend to the wounds or make sure that they have gotten the x-ray or done whatever they need to do but the emotional sometimes isn’t addressed at all and then the person is left lying there. I don’t know if this is a fair term to use, but feeling emotionally raped...

She described how treatment in the hospital can replicate the abuse a woman experiences at home. She described how powerless she had felt saying “...and then you go in the hospital and somebody just cleans you up but doesn’t address any of those inner wounds. That is devastating.”

The issue of privacy continues to influence the nurse-patient relationship throughout the Emergency visit. Almost every nurse interviewed cited the lack of privacy as a deterrent to discussing violence and abuse, although this concern was not mentioned by the women that had experienced violence. The modicum of privacy afforded by thin curtains between stretchers insures that one patient’s information is shared with others.

You know some nurse that they have never seen before that is half their age, why would I tell her anything like that? Especially in an open environment like Emergency where they can see us talking and possibly overhear us talking about bed 12, why would bed 8 speak up?

Further, the presence of family members, who in the case of abuse may include the abuser, may constrain the patient from sharing information. This was especially problematic in one hospital where family members were encouraged to be with patients as much as possible. Monica said “Often it is very hard to keep the relatives out and I guess in the case of an abuser they definitely would want to be in control of the situation.” Yvette told of an instance when she suspected abuse.

And I said “would you like to be alone for a little while and your husband could wait in the waiting room until you are undressed and we’ve finished”, she looks at him, he looks at her and she says “no, he can stay” and I just had this feeling that she was afraid to let him go and he wasn’t going to go… you sort of wonder, especially if you can smell alcohol and especially depending on the injury, “no, I’ll stay with my dear wife” because they are afraid of what their dear wife will say.
Most nurses also thought that the issues of brevity and discontinuity in the nurse-patient relationship limit disclosure and recognition of violence. Seeing time as a scarce resource, nurses did not think that they had enough time to identify women as abused.

I feel that (the Emergency unit) is lacking sufficient numbers of staff to be able to spend with the person and as a result people with problems like these women could often have, could probably have better results out of the department. Sometimes you don’t even have time to identify, sometimes you realize that there is a problem but there is just so much going on that you just have to keep moving around. Hopefully you will get back to the person, but in that situation they can fall through the cracks. That department needs a whole new revamping. (Faye, Emergency Nurse)

We don’t have enough staff to give that kind of time. I think that is why if we suddenly, if we added to our chart, for instance one little line about abuse or battering or anything like that, it would be hard to ask sometimes if you are running, because what if they say yes? and they want to talk about it? I hadn’t really thought about that ... I thought “yeah, what if they say ‘yes’? and, ‘can I tell you about it’?”, NOW? You want to do it NOW? Right NOW? HERE? (Yvette, Emergency Nurse)

Many nurses also felt that they are unable to have a lengthy enough relationship with patients to develop a sense of trust.

I think you have to give in order to get from them, they need to trust you, they need to know that you actually care about them, that you are not just doing acts, you are not just doing A, B, and C; blood pressure, pulse, respirations, et cetera.... If I was able to take her away and maybe have her on a one-on-one outside of the department, where I wouldn’t have to say “excuse but I have to go”, or “I’ll be right there, there is a call light”, or “excuse me there is an ambulance that has come in”, it seems to be so disjointed when they are really feeling with you, it probably takes me six or seven hours to really get a rapport with a patient that they are going to cough up information like that. (Bo, Emergency Nurse)

There are shifts where people just keep rolling in and rolling out. You just don’t have the time. It just boils back down to time. You need the time to build up the rapport for the person to trust you in the first place to be able to unload all this stuff. You can’t do that in 5 or 10 minutes, not even in 1/2 hour (Faye, Emergency Nurse).

Other health care providers often concurred with nurses regarding the challenges of insufficient time to build trust. For example, one social worker said “the nursing staff don’t have time to spend more than 3 hot minutes with someone and you can’t get anything like a trust
factor going with most people in dangerous situation that quickly”. Fran, a psychiatric 
Emergency nurse said

These guys [Emergency nurses] are so busy they don’t have time for that, that’s why they 
single out the Psych Emerg Nurses. It is not because they don’t care but because they 
haven’t time. I have time, I can sit and spend three hours, like I did with this lady, 
sometimes.

The context of practice and the predominant practice pattern in Emergency promotes the 
non-recognition of abuse. Limited time, privacy and continuity, combined with emphasis on 
 immediate physical problems make the neglect of violence highly probable. However, there are 
also interests within the context that counter these dynamics and challenge dominant interests, 
including nurses’ concern for patients and desire to make a difference, and, in some settings, 
institutional commitment to recognizing violence.

The Influence of Individuals on Recognizing Abuse: Toward Resistance

Nurses do not merely accept the constraints to practice imposed by the context. Rather, 
many find ways to weave their concern for patients with the physiological focus and the demands 
for processing patients efficiently. As these resistances to the influences of the context extend to 
all patients, women who have experienced abuse may also experience nurses’ attempts to go 
beyond physiological concerns and efficiency. When that happens, the experience may be 
profound. During field work, I joined Bo for a shift a few days after I had interviewed her.

I find Bo in the dungeon (her term for the stretchers in the less acute area). She is assessing 
a woman, briefly says "hi" and carries on with her assessment. I simply stand at the bedside 
and listen. The woman briefly looks at my name tag and smiles, but there is no break for 
me to explain what and who I am. The woman is in her ?late 30's, very pretty, blonde, 
beautifully dressed, and speaks with a Scandinavian accent. I gather from the questioning 
that this woman has renal colic. She has passed stones before and has the same sort of pain. 
I also gather that she is in quite a bit of pain and that she is frustrated at having been in pain 
for about three weeks with no resolution of the problem. Bo tells her she has a lot on her 
plate. The woman has had Demerol already and is a bit teary. Bo goes over the pain in 
detail, and then asks her about medications. The woman tells her that she is on a medication 
for depression and says that she has been diagnosed as manic-depressive for about 9 years. 
Bo asks her if it is under control and how she feels when she is getting depressed or having
an episode. Bo also starts to ask her if she is under a lot of stress. The woman gets defensive? angry. She straightens up (she has been hunched over with pain) and says “oh, no, I’m a very strong person.. and...” Bo immediately figures out what is wrong. Bo explains that she needs to know about her as a whole person, not just about her pain, so she can look after her. The woman is a bit mollified and says "do you think this (the pain) is a stress-related thing? Bo says "well I think all illnesses have a stress related component, but stress doesn't cause kidney stones. I just want to know how I can help you the best."

A few minutes later Bo is nearly done her assessment, and says "when your pain gets like this is your home environment safe and supportive?" This is especially significant because Bo and I talked about this as a possible question instead of asking directly about violence (with which she felt uncomfortable). The woman responds emphatically "NO", and begins to cry. She says that if she had a supportive environment her husband would not have made her drive here by herself. He offered to call her a taxi. (Field Notes, May 1996)

This woman (Nadia) did not tell Bo that her husband was mentally and physically abusive, but told me a few minutes later when I asked for her consent. However, the experience for Nadia was profound. She asked me if she could help with my study, and in an interview a few months later said:

I don’t know exactly what to do next time. I was lucky with my experience because you two were really good around me. It is like “wow, it is Hollywood, it is Las Vegas, it’s a Bingo, I am respected here”. I didn't feel like just to go hiding in a corner, I want to close everything, leave me alone.

The encounter with Bo did not lead to Nadia leaving her husband, but she saw it as a step forward for her. Later in the interview she said

By talking to you right now I am getting major, major pain in my stomach. Now don’t take it the wrong way, I am getting the knots in my throat, it is nothing new, but also it makes me realize how much I have grown since the last time you and I talked in the hospital. So you see, every time you talk about it, it is a step forward and I didn’t know. It is a good step forward when you realize that these pains are because you are stepping on hidden territories that are really painful but this is how your body reacts, that is what those people [who don’t listen] don’t know.

The nurses in this study who told me about caring for women who had been abused, told the stories with great compassion for the women, and with distress over the nurses’ perceived inability to “do anything”. In the same way that nurses experienced distress in relation to all patients over the discrepancy between the level and type of care they value and would like to
give, and level and type of care demanded by the nature of the Emergency unit, nurses expressed this distress in relation to women who have been abused. In regard to recognizing violence, the nurses I interviewed were dismayed at the thought that they “missed” recognizing women who had been abused. They said “its not right”, “it’s not good enough”, “it’s unfortunate”. One nurse dismissed the “reasons” for non-recognition of abuse as “excuses”. She said

I hate making those excuses though. We really shouldn’t. I think it all boils down - would more staff help - possibly, but I think we have to be trained to be sensitive, I think that is a role that needs to be put into nursing, more emphasis on it. Yes, you need to know the physiological, but there is another component to nursing.

In order to recognize violence and abuse, nurses and other health care providers depended on women to disclose abuse as part of the presenting complaint, or as part of the information they provide during the Emergency visit. Conversely, women depended on health care providers to create the opportunities for disclosure. As the context and patterns of practice are not conducive to such disclosure, recognition of abuse depended on the nurse having and pursuing suspicions of abuse, and those suspicions depended on individual nurses thinking and acting in ways counter to the predominant practice pattern. Thus varying levels of suspicion for abuse can be seen as encompassing practices of both congruence with and resistance to predominant practice patterns and the neglect of abuse.

Congruence and Resistance: “Index of Suspicion” For Abuse

Unless the patient discloses abuse as part of the presenting problem, recognition of violence and abuse depends on nurses or other health care providers having some level of suspicion that violence and abuse may be issues for the patient. The “index of suspicion” for violence and abuse tends to be low among Emergency Nurses and other emergency health care providers for complex reasons. First, the nurses and others in this study tended to practice with little awareness of violence as an issue, and limited knowledge about who experiences violence and
how violence might present. Second, nurses said that they did not want to see, hear or know about abuse for several reasons. These reasons included not wanting to acknowledge violence as a problem, not having the time to "get into it" and discomfort dealing with violence and abuse, and not knowing what to do. The context of practice supported these reasons because the Emergency unit is structured to deal with physical problems and process patients quickly. However, importantly, the nurses who participated in this study were dissatisfied with practice in relation to recognizing abuse and critical of the explanations they gave for such practice.

Oblivious to Violence and Abuse

Four of the seventeen Emergency nurses interviewed in the primary study sites were quite clear that they had very little awareness of violence and abuse, with several saying that abuse had never "entered my mind". Most others thought they were aware, but could recall very few examples of dealing with violence. Only six of these 17 nurses thought they had a high level of awareness of violence and abuse and could recall more than a few instances, and four of these had spent a number of years in leadership positions in which they were referred most instances of violence that came to the attention of other nurses.

Being oblivious to violence is congruent with the demands of the context of practice. Repeatedly nurses told me that they did not recognize violence and abuse because they were not focused on non-physical aspects of patients concerns, and that they did not have the time to attend to non-physical issues. When I asked Faye about her contention that nurses do not have time to question women's stories that don't sound quite right, she said "Funny, you get so wrapped up in coming to work and dealing with mostly the physical aspects of the job you don't often have time, or even concerns." Monica echoed her ideas.

I think part of it is we just don't think about it all the time, we just go on and as I say look at the physical problems and sort out the immediate problem for right now but don't go into
the reason why, “why did you come here, why have you been here repeatedly, what has been going on?”

Bo argued that recognition of violence is not seen as appropriate for the Emergency unit because of time, the emphasis on acuity and because nurses get “burned out”. However, she also thought that nurses could potentially find the time.

I think they [other nurses] see it is not a priority, it is not acute. It is not one of the top ten things we would put on a “do list”. Because I think that we don’t think it is appropriate. Once their airway is fine, and they are breathing all right and the circulation and the disability, then we might think of the emotional component, and not all nurses are into that, that we have done our job because now we are going on to the next patient. But in actual fact I have found from my practice of dealing with [other situations] it takes about 5 more minutes of talking to them, so 5 more minutes we could also add when we are trying to investigate a client that is having a challenging situation. It could be there.

Levels of awareness of violence may be variable depending on the class and “race” of the patient. As noted earlier, nurses and other health providers who associate violence differentially with class and “race” may have a higher “index of suspicion” for violence with people of colour and poverty, and be more oblivious to violence with dealing with white and wealthy people.

**Limited Knowledge of Indicators of Violence and Abuse**

The demographics of violence and abuse did not seem to be well understood among health care providers in this study, or were known, but denied. In addition, not surprisingly, most nurse’s ideas about when to suspect abuse were confined to physical cues associated with trauma. Nurses primarily looked for physical problems, a practice which was abetted by the nature of the Emergency and the documentation practices. Several nurses said that they wanted more education and understanding regarding what they should be looking for.

Also to be schooled on what might be some trigger points that would tell me that is a woman that is in a difficult situation. I honestly don’t know, physically yes. They might tell me, repeated visits, anger towards family members or fearfulness or apprehension, closed mouthed, not talking, I don’t know.
At least some physicians in this study also tended to associate violence primarily with trauma.

For example, during field work, several physicians kept directing me to the first aid areas.

Dr. R. suggested that I look at an elderly woman in first aid, and tells me I could spend days in the [more acute] areas and never see “anything” (meaning the consequences of violence). (Field Notes, April, 1996)

Thus nurses tend to recognize obvious physical abuse, if and when violence and abuse are recognized at all, and may think that a higher “index of suspicion” for violence and abuse is warranted among certain people.

**Not Wanting to Know**

Many nurses and other health care providers said that they or others did not want to see, hear or know about abuse for several reasons. Some of these reasons included not wanting to acknowledge violence as a problem in their community, not having the time to “get into it”, discomfort dealing with violence and abuse, and not knowing what to do. Several nurses identified wanting to preserve their ideas about their community as a reason for not wanting to see violence and abuse. Lulu noted

The other issue that is difficult, because of the community that we live in, is that violence is not upper most, people ignore it, but it happens and it is here ... it is right here in the community and yet we as a group, [most] of the staff that work in this hospital live in this community and we believe that it is a good community, that bad things don’t happen. So I think that we also ignore obvious signs of people that have had some violence happen in their lives because we don’t think that it is going to happen in this community. So I find that difficult as well. We don’t pick up on some cues that maybe we should be picking up on because it is not going to happen here.

Similarly, Lenore said

I would say a lot of times we don’t want to see it so we [don’t]. You have a false sense of security working [here] because you keep getting told over and over again what a nice place it is, what a nice community it is, I mean the patients are so nice they bring you flowers. So, when you do get something that is really obvious it has to hit you in the face before you say “damn I guess this stuff does happen here” but you are not actively seeking it out. It is unfortunate.
These words support the idea that ignoring violence is in the interests of health care providers in that it limits emotional involvement, and preserves ideas about the community.

Lenore, who was very clear that at times she intentionally silenced patients because she could not deal with them due to time or other constraints, wondered if health care providers unintentionally silence women who have experienced violence and abuse, and further wondered if unexamined attitudes, beliefs and assumptions underlie such silencing.

I mean we do intentionally send messages like that [we don’t have time to hear] but are there times when we are unintentionally sending it? So, with abused women I wonder if we are doing it, I wonder if we send that message. When I was at [another hospital], years ago, somebody was doing research on rape victims and how we handle rape victims and our attitudes towards them and the results that came back were really surprising, the results came back that we as Emergency Nurses are the most bigoted, we are the biggest ones to question whether a woman is truly sexually assaulted, or truly, you know.

Faye explained that the combination of discomfort about violence and the pressures of workload and time meant that she did not pursue her suspicions unless violence and abuse were blatantly obvious.

I think a lot of it is just uncomfortable and you suspect some people that you see come in, you suspect it might be as a result of say a battered situation but their story is different from what you gut feeling is going on, and you don’t really have the time, because of the busyness of the department, you don’t have time to sit down and say “really, what really happened”. Unless it’s really blatant or the injuries are that horrendous, which I’ve never really seen anything like.

Kathy, a nurse who was new to Emergency, had similar ideas.

I think given the push to get people in and out maybe people don’t want, may see the warning signals, but don’t feel they have developed enough of a relationship or maybe they are going to have a tough time dealing with that problem so it may be ignored. Not consciously, but I think sometimes if we are afraid of a situation we hope that it is not there, so that we don’t have to deal with it, or maybe we don’t know how to deal with it so we hope it is not there.

For some nurses, avoiding discomfort was essential to their emotional survival. The emotional toll of dealing with violence is but a component of the stress experienced by
Emergency nurses hourly, as they deal with the most grievous of injuries under conditions of uncertainty, and often with limited resources. Most nurses talked about the emotional expense of working in Emergency.

Nurses who have experienced caring for victims of severe violence at work found knowing about violence and abuse that other patients experience particularly difficult. For example, when I initially interviewed one nurse, she had not recovered from caring for a child who had been brutally murdered a year earlier. As discussed earlier, nurses who have experienced violence in their families and have not been willing or able to think about that violence may be particularly unwilling to know about the violence and abuse. As cited earlier, Anne told me in her second interview that she had not been able to face the violence and abuse in her family prior to our first interview, and thought that this reluctance led her to ignore cues in patients. Thus, not wanting to know about violence and abuse may be part of the way in which nurses protect themselves from the emotional toll of their jobs, and from the emotional toll of their own personal experiences of violence. However, it is critical to emphasize that this is not what the nurses I interviewed wanted for their practice. When I suggested to Anne that perhaps she had been protecting herself, she was adamant that her self preservation should not interfere with her care of her patients. Similarly, Bo said

If I found out, if I was able, if somebody shared that information with me, I would go out of my way to support them and do whatever I could on any given time and I would go out of my way to find it.

Not Knowing What To Do

Finally, not knowing what to do inhibits nurses from digging deeper. Nadia said “Mostly I remember when I go in and I am crying I feel embarrassed, of course, and the nurse doesn’t know what to do so therefore they don’t do anything”. Most nurses were unsure what they
should do if and when they recognized a situation of violence and abuse. Anne said “But quite honestly as far as a lot of options I don’t feel that we have a lot in my bag”. Another nurse who worked in a hospital that was initiating a screening program for violence said:

I think one of the most frustrating things for everybody has been, we want to do more than send them out the door and this and that, but what do we do? Like, what’s our role, what resources are available, do we really even know what’s out there? (Shelby, Emergency Nurse)

A nurse from another hospital said

We are missing it, probably several times a week, we are missing cues because people are looking at us, they are going “they don’t have time” or they are looking at the whole way of the Emergency working and going “this is not my comfortable space to do this, I might be ready but I’m not doing it now, I’m not doing it here.” But I also think that if you increase our level of awareness and get us to incorporate it somehow into our assessments I still think the ball is going to be dropped. ...so I think that at the same time as trying to pick it up we have to figure out what we are going to do with it. (Yvette, Emergency Nurse)

Not knowing what to do may contribute to not wanting to know, and to doing nothing, a situation that caused Louise great disappointment as, over years of beatings and verbal abuse the “helping professions” failed to help.

I think I felt the most alienation from the nurses and the doctors because they are in the helping professions and not one of them ever asked me “is there something we could do” or “have you told anybody about this”, they all just looked the other way.

**Routine Questioning**

An alternative to recognizing cues and acting on an “index of suspicion” for abuse is to ask all patients questions about abuse. In one of the primary study sites, such a universal screening program had already been implemented for alcohol and drug abuse. As alcohol and drug abuse are like wife abuse in that both are socially stigmatizing, both are denied, both are hidden, and both cause discomfort, this program served as a model for examining the possible impact of such screening for abuse. In considering the idea of routine screening for abuse, nurses drew on their experiences of screening for alcohol and drug abuse. In fact, alcoholism was used as a metaphor
by both health care providers and women who experienced abuse to explore various issues related to abuse. In the other primary study site, toward the end of my study, a screening program for abuse was being planned. In this second site, alcohol and drug screening was done, but only when clinical indicators suggested such screening was appropriate. Thus different approaches to screening for alcohol and drug abuse served as models for different approaches to screening for abuse. Further, I interviewed several nurses and women who had experienced abuse who had direct experience with screening programs for abuse in other hospitals.

Screening for alcohol and drug abuse was a highly contentious issue in the study site which had implemented routine questioning. Nurses' concerns about the screening were related to 1) the imposition of the practice by non-nurses, or by non-Emergency nurses, 2) the incongruence of the practice with the demands of the context, 3) the imposition of a practice for which many nurses felt ill-prepared, 4) the lack of organizational commitment to, and opportunity and resources for follow up, and 5) evaluation of compliance to documentation rather than evaluation of patient outcomes.

In field work, I talked to nurses about the possibility of routine screening for abuse, as I thought it was a promising approach. However, in the site that had implemented routine alcohol and drug screening, I was repeatedly met with objections based on the nurses' experience.

We talked a bit more about the idea of universal screening and they [the nurses] talked about doing the [alcohol and drug] questions. They said that there is no follow up. “We ask all these questions, and then what? We ask these questions for nothing.” (Field Notes, April 9, 1996)

The lack of follow up was blatantly obvious in regard to alcohol and drug abuse. One of the first times I saw a nurse ask the screening questions, the patient, who had come to Emergency because of chest pain, told us that he drank half a bottle of rum every day, that he had tried and wanted to quit, and that he felt guilty about drinking. A few minutes later the man was
discharged by the physician, his chest pain having been diagnosed as chest muscle strain. He
was not offered any referral, advice, or assistance.

There was also considerable resentment about the questioning because the practice was
mandated from outside of the Emergency staff. Lenore’s resentment stemmed from the fact that
there was no follow up, that she saw the practice as imposed, and that the practice of routine
screening was sometimes against her judgment.

L: ...sometimes when I am doing those [alcohol and drug] questions I get really choked
at doing them because I know this information isn’t going anywhere. I know that
nothing is being done, absolutely nothing so I just think “what is the point?”
C: So why do you do that?
L: Because we are held negligent if we do not. I am sure somewhere down the line,
somewhere in the hospital they got sued when somebody came in and the questions
weren’t asked and they went into DT’s and they weren’t given the right medication,
I don’t know if they died, I don’t know what happened, but I am pretty sure it is the
result of a court case somewhere in the hospital and they have come up with this. I
am not sure who it was that came and spoke to us about the alcohol abuse [in our
community], anyway they came up with these [alcohol and drug] questions and we
have to ask them, we have to ask them on every patient we do an [nursing
assessment] on. Quite often, if it is not appropriate, I figure “I’m a highly training
health care professional I’ll go use my judgment”, but they tell me they haven’t had
a drink in three months and I believe them, I’m not going to ask the [alcohol and
drug] questions, I don’t see any point in them.
C: You have a bit of defiance in that.
L: I do. Because they are telling me. They are taking away my judgment call, my
professional judgment on whether I think this is appropriate or not. I mean they
[patients] could come in and they are screaming and writhing in pain, it is not
appropriate to ask these questions. I don’t care if Administration is saying those
questions have to be asked, if they have to be asked before they go up to the unit,
maybe I’ll wait until they are on their way up to the unit, but right now it is not
appropriate and I resent them telling me that this is the priority when I don’t think
that it is the priority. Anyway that is why I am defiant about it and I tend to feel that
having standard questions that we ask about abuse would tend to go that same way if
there were standard questions that you had to ask everybody that walked through the
door. Actually the woman last night with the Dilantin, she hit on it because she said
at [another hospital] that is the first question they ask you when you walk through
the door, whether it is appropriate or not. Now that would be the way of getting
around missing that 25% or whatever it is that aren’t being identified, but there has
got to be a better way of identifying it than just doing a standard.
Susan thought that screening for abuse would be ineffective because of her experience with drug and alcohol screening.

I don’t necessarily think screening is going to work or is effective. I have absolute faith that they will be measuring the wrong things at the other end, for example with the [drug and alcohol] questionnaire they don’t measure the outcomes for the patient, they measure the compliance rate in filling the tool out. I would hope that when something goes forward on this topic [violence and abuse] or when social awareness is high enough that we push it to the forefront and say “right we need to do something about this, we need to act on it, we need to incorporate it into our practice”, that there is a more pervasive and concerted effort than the [drug and alcohol] questionnaire has been, which has gone really far astray from what it was intended to do.

Resentment about asking questions was not just specific to alcohol and drug abuse nor to asking questions about violence. Several nurses expressed resentment about asking questions prescribed by a form; questions that were not always appropriate to the situation nor suitable to ask in the nurses’ judgment. Bo saw the practice of routine questioning as one of the reasons that nurses had lost their ability to “dig deeper”.

I sometimes think that when you become an Emergency Nurse you learn, you lose the ability to dig deeper. All you do is you ask all the questions on the nurses notes and we resent all of the questions, “when was your last BM, do you have difficulty swallowing, do you have bladder problems”. Here they are having an anterior MI and you are asking these questions which at the time seem to be [inappropriate], whereas, going even deeper into looking at their stress level, which is really a basis as to why they are there in the first place, is a little more [appropriate].

The discord that nurses expressed in regard to screening, read in relation to the conflict between efficient processing and the care that nurses value, can be seen as a practice that, from the perspective of Emergency nurses, neither improved the care of patients nor fostered efficiency. During field work I observed nurses asking assessment questions in a manner that conveyed that some of the questions were only being asked as a matter of routine, and that the answers were not really important. Nurses often asked all questions on the forms, but through body language, verbal emphasis and so on, communicated which questions they really wanted
answers to, and which questions they asked only as part of the routine. This was particularly
evident in relation to questions about alcohol and drug questioning, perhaps because some nurses
felt uncomfortable with the subject matter. The head nurse told me that the program had been
very difficult to implement due to many nurses feeling uncomfortable.

It was extremely difficult to enact that [drug and alcohol screening] in this particular
Emergency. The nurses had such a difficult time with asking what they felt were very
personal questions to patients with a curtain between them and the rest of the world.

Some nurses had received more intensive training in preparation for alcohol and drug abuse
screening, and felt comfortable with asking questions. However, they watched their colleagues’
screening practices with dismay. Susan, who was supportive of the alcohol and drug screening
program initially, and comfortably incorporated the screening within her own practice, wished
the program had not been introduced because of the way she saw her colleagues enact the
practice, and because of the way in which the screening isolated the issue from the patient as a
person, and the person’s health concerns.

It is awful to watch them do it, it really is. You can watch one nurse ask those questions and
it is like they have completely switched off and they are not even in the room with the
patient anymore. They are just ticking, and you can watch another nurse where every single
experience that she has ever had is right out there on the table and you know that she is
agonizing over these questions and the patient feels the pressure to answer. It is just awful, I
wish they had not introduced it at the Emergency Room level, especially since we pick it
out as a [separate issue], so we do this whole thing on their abdo pain and then we pick out
alcohol and substance abuse, or violence, what about the entire person? The person must
lay in the bed thinking “omigod where did that come from? One minute we are talking
about my allergies and the next minute how much I drink every night and whether I
perceive that to be a problem”.

Indeed, Nadia had a similar reaction to the one Susan is imagining. Referring to her experience
of being asked about her home life being safe and supportive, she said “I find it kind of strange
when she asked it and the very first thing I wanted to see was a mirror, does it really show this
bad? I wondered why she asked that.”
Some nurses resisted the requirement to ask screening questions by asking the questions in a way that disassociated themselves from the questions. Some simply did not ask the questions, or only asked the questions with certain patients. Although the nurses were required to ask the questions of all patients on whom they completed a full assessment form, they could get away with asking the questions of only those patients that they predicted would be admitted, because monitoring of compliance was carried out only for admitted patients. Further, it seemed that in the same way that nurses felt more comfortable asking questions about violence of certain patients, they felt more comfortable asking questions about alcohol and drugs, and questions in general, of certain patients than of others. Several nurses specifically said that they felt less comfortable asking the alcohol and drug questions of wealthy people.

In contrast to the experience in the hospital in which routine screening for alcohol and drug abuse was mandated by the administration, the other hospital had implemented a program of alcohol and drug screening that relied on the health care providers to do a clinical screen and then make a judgment regarding whether or not to do an assessment regarding possible alcohol and drug withdrawal. The attitudes of the nurses towards this program was dramatically different from the attitudes of nurses in the first site. Nurses explained the program with pride, told me that they found it useful, and communicated a sense of ownership for this program which depended on their clinical judgment. Important differences in this approach were that the staff had been involved in the development of the program, the purpose of the program was very clear (prevention and management of withdrawal symptoms) and the process for follow up was clear (there are accompanying "doctor's directives") and seemed to be followed.

In terms of considering routine questioning about abuse, many of the problems and concerns associated with alcohol and drug screening were raised in regard to screening for abuse. Some
health care providers expressed concern over the invasiveness of questioning. For example, Bo talked about her limited ability to establish rapport and trust with her patients and went on to say:

I mean I'm a very private person. I'm not sure if, Colleen, if you said "well have you been physically abused at home, I've noticed some bruises on your arm and you've been in here several times, is that a problem" I might become very defensive.

Many health care providers did not see screening for abuse as part of the mandate of the Emergency unit. Dr. Morgan, an Emergency physician, saw routine screening for abuse as beyond the mandate of the Emergency.

I think that we are not searching for secondary or incidental abuse relationships when the patient is there because of some other, because of another problem. I think the question mark is whether the Emergency Department should even be involved in that assessment. Is the Emergency Department everything for all things? I don't think so.

Emma, the manager of a unit which had a screening program, was also unsure whether routine screening for abuse ought to be part of Emergency practice.

I probably had much firmer beliefs about it initially and may be less firm now, and that is thinking about what is in fact the mandate of the Emergency department and does it fall within the mandate, and I don't know the answer to that. Off the top of my head, I would say, "no it doesn't". That's not the mandate of the Emerg. Department to do screening... We currently don't screen for drug and alcohol abuse which is just as big a society problem, may be bigger. We don't screen for breast cancer, we don't screen for infectious diseases such as TB or whatever, which are also major health issues for our society and our community.

Examination of approaches to screening for alcohol and drug abuse suggests that routine questioning for abuse will not be done simply because it has been mandated by administration or because questions have been added to an admission chart. Further, some nurses are less willing to screen certain patients than others for both abuse and drug and alcohol abuse regardless of whether screening is mandated as routine. Given that many health care providers associate violence with poverty and people of colour, "universal" screening may be implemented differentially. What is of greatest importance in determining the recognition of violence and
abuse is the knowledge and commitment of the health care provider, and a willingness to listen that is more than a requirement to question, and the time and resources to do so.

I think unless people are actually tuned in to, it just becomes another question and they aren’t looking at the response. If I’m asking the questions then I’m just ticking it off, I’m not looking at her, this woman could be saying “no, no, no, no” whereas if I was actually into it and looking at her body would be telling me “yes, yes, yes, yes”. I really do think that just another tick-off list is not the way to go, it really isn’t. I don’t know whether we can actually even standardize it so everybody does, but I think it just comes from an awareness and caring and a wanting to identify. (Lenore, Emergency Nurse)

Screening practices driven by an ideology of scarcity, and within a context predominated by “efficient processing” will merely lead to reproduction of dominant interests. Refusal of the predominant practice pattern and the dominant ideologies that support the pattern are required if screening practices are to contribute to meaningful recognition and responses to violence.

Summary

Violence and abuse are rarely recognized, and are only recognized if 1) the presenting complaint is obviously a direct consequence of physical violence; or 2) the nurse (or other health care provider) infers from the patient’s appearance and behaviour, or physical findings that violence and abuse have occurred, or 3) the patient discloses violence and abuse. The likelihood of any of the above occurring is influenced by a multitude of complex and interrelated factors. Reliance on the presenting complaint means that only obvious physical violence is recognized. Nurses said they were limited in their skill at recognizing abuse based on inferences from the patient’s behaviour and appearance. Nurses and other health care providers who associate violence with poverty and people of colour may be inclined to differentially infer violence from the patient’s apparent financial status and skin colour.

The patient’s willingness to disclose abuse was held by health care providers in this study to be the most important factor in recognizing abuse. Conversely, the health care provider’s
willingness to listen was held by women who experienced abuse to be the most important factor in health care providers being able to recognize abuse. Nurses said that they do not have the time to listen to patients (not just with regard to abuse), nor to dig deeper. Some nurses also think that they do not really want to know about abuse because abuse makes them uncomfortable, and because they do not know what to do. Nurse-patient relationships in this study were enacted within a practice context that inhibited disclosure of abuse due to time constraints, lack of privacy, and a drive for efficiency, and were enacted within a larger social context which supports “race” and class assumptions and sanctions silence about violence and abuse.

Health care providers in this study reported avoiding recognition of violence and abuse by ignoring cues and acting in ways which limit disclosure. Avoiding recognition serves the interests of individual health care providers in that they can avoid the emotional cost of recognizing abuse and they can avoid the time commitment involved in dealing with abuse. Avoiding recognition serves the interests of the health care system in that the patient can be processed more quickly than if abuse was recognized and addressed. However, the lack of recognition was not seen by nurses as acceptable.
Ode to Lung Cancer

Long grey fingers curl
toward the ceiling
a cry for help unheard
but leaving
me with hope

that I may unclench
my own despairing
rage, tangled, twisted
frayed, knotted
like the rope

for which I yearn and
cry, to which I turn
stumble, run, escape
breathing deep
of the grey

which you say will kill
me deader than I
am. now, here, living
with the dark
in my soul

where I take one more
drag thinking this is
softer than the knife
that slices
sets me free

leaves me bleeding out
the hope of finding
peace among the ash
now settling
in my heart

where ruby fingers curl
to the grey, twining
grasping, pulling, up
to the pearl
of the dawn
CHAPTER EIGHT

INTERPRETATION: DEALING WITH VIOLENCE

For the most part, the health care providers in this study reported that they recognized only violence and abuse that was blatantly obvious, that is, they recognized violence and abuse only when recognition was unavoidable. When abuse is recognized, the response of health care providers can be thought of in terms of three overlapping patterns: doing nothing, influencing choices, or offering choices. These patterns of practice are overlapping, and are not mutually exclusive. Individuals in this study did not use only one of these patterns of practice, although one or two patterns tended to predominate in individual’s accounts of their practice, and during interviews, nurses struggled with the ideas represented by these three patterns.

The context of practice promotes the neglect of violence as health care providers are impelled to “do nothing”, which includes dealing only with the immediate physical consequences of violence and/or shifting responsibility to others. In the same way that nurses feel they “do nothing” because of time constraints in relation to non-physical needs of patients, those same constraints, abetted by practice patterns and an ideology of scarcity maintain a focus on dealing with the physical in regard to abuse. The unpredictability, temporariness, and discontinuity which characterize practice in general also limit nurses in their practice with women who have been abused. “Doing nothing” is justified and supported by ideas about the woman as an undeserving victim, and serves the interests of maintaining efficiency and is congruent with the mandate and serves the interests of the Emergency unit and hospital in maintaining efficiency. “Doing nothing” may allow health care providers to avoid some of the emotional cost of dealing with abuse, but, to the extent that the health care provider sees “doing nothing” as insufficient, it may create feelings of inadequacy. “Doing nothing” overlaps with other forms of intervention at
the point at which health care providers challenge the adequacy of not pursuing cues, dealing with only the physical consequences of abuse, or shifting responsibility.

Health care providers may attend to the abuse in two ways: intervention as influencing choices and/or intervention as offering choices. These modes of intervention are not entirely distinct patterns, but will be discussed separately for ease of analysis and discussion.

"Influencing choices" is justified and supported by ideas of the woman as primarily a victim who is deserving of care. In this mode of intervention, health care providers seek to influence the woman to decide to disclose abuse, call the police, and leave the relationship. Influencing choices serves the interests of the hospital and health care system to the extent that women are influenced toward existing solutions and resources, and is congruent with the predominant practice pattern in that women can be processed efficiently if they accept the choices offered. Influencing the woman's choices serves the health care provider's interests in that doing "something" generates less of a sense of inadequacy than doing "nothing". However, to the extent that the woman is unwilling to be influenced, the health care provider may become frustrated with the woman. Such frustration is related to health care providers disagreeing with the woman's decisions regarding what the health care provider sees as her choices, and often leads to seeing the woman as less deserving, and thus to the justification of "doing nothing" (further). The two patterns of intervention overlap at the point at which health care providers question the efficacy of influencing choices, shift their focus of frustration to the "system" and examine the limits to women's choices.

While choices may be offered during the process of influencing the woman, "offering choices" is distinguished from "influencing choices" by ideas about the woman as a person with agency, and the provider's intention to leave decisions to the woman. Offering choices can be
counter to the interests of the health care provider because it requires an emotional commitment and a time commitment, and can be counter to the interests of the organization and the predominant practice pattern because it may reduce efficiency. However, offering choices may be in the health care provider’s interests depending on how he/she frames his/her interests. Health care providers may be frustrated when offering choices, but such frustration is directed more toward the “system” than the woman, as the health care provider encounters limitations to choice. Similarly, offering choices may be in the interests of the organization depending on how the interests are framed.

Doing Nothing: The Undeserving Victim

Nurses categorized recognizing cues and not pursuing them, and dealing with obvious physical injuries, but doing nothing further, as “doing nothing”. The reasons given for doing nothing were the same as the reasons given for not recognizing abuse: focusing on the physical problem, not knowing what to do, not having the resources, and so on. However, embedded in each account are reasons why “doing nothing” serves the interests of the health care providers. In the following story, Monica told me about “doing nothing” for an elderly woman whose son had apparently broken her nose.

I just remembered another case of a woman who was brought in by her son and I could swear on a stack of Bibles that he had been abusing her. We really didn’t do anything about the situation, we sent them right back out, with the son with the mother because again, we were so busy treating the situation we didn’t, nobody did anything about it and the only person who really said a lot was the unit clerk who said “I hope somebody is going to do something about that”. The husband was raising Cain and being difficult, saying his mother had a broken nose and the Plastic Surgeon said “no she doesn’t”, he said “yes she does” and the idea was “just get this guy out of here”, “he is just being unreasonable that he thinks that his mother has a broken nose and we are telling him she doesn’t”. So the idea was to get him out of the place but I’m sure he had been abusing her. The way he told the tale, he was waiting for someone to say “what happened, are you having problems?”, his mother was senile. At the time I didn’t know how, who we went to or who we spoke to I guess and at that stage we didn’t have a social worker in the department.
Although Monica points out that she did not “know how”, that the staff were “busy dealing with the situation”, and that they “didn’t have a social worker”, the idea to “just get this guy out of here” arose from the fact that the son was a problem for the health care providers. Getting rid of the son was in the interests of the health care providers.

Stories about “doing nothing” were often associated with a sense of the extent to which the “victim” was considered deserving. Nurses and other health care providers in this study routinely made judgments about the extent to which patients deserve the level of care nurses value, and women who have been abused are no exception. In fact, several of the factors which are commonly interpreted by nurses as signifying an undeserving status (perceived to be abusing alcohol, using Emergency services frequently, using the Emergency inappropriately, and failing to take steps to improve one’s life) may be part of the interpretation of the situation of a woman who has been abused. In the above story, the elderly woman is not portrayed as an active player, and her senility may have been perceived by the health care providers as making her less deserving of intervention than if she had been mentally competent. In the story below, the physician appears to have drawn on his attitudes toward alcohol abuse, First Nations people and women, to judge the woman as undeserving of care.

What happened one night was a young Native Canadian woman who was found with her pants down in the park and she was extremely drunk. She was brought in to the hospital, so there is a strong possibility that she had been assaulted. He [the physician] walked into the room.... and in front of the patient and two nurses, he said “this is a societal derelict and I am too embarrassed to even call [the sexual assault team] over an issue like this”. He said “put her to bed and let her sober up and then she can go home”.

In this case doing nothing served to limit the embarrassment of the physician, and was seemingly justified by the undeserving status of the woman. As alcohol and drug abuse were important in determining whether any patient was judged as deserving in Emergency, alcohol and drug abuse were also frequently cited in stories about women who had been abused who were judged as
undeserving. One social worker told me about a woman repeatedly beaten by her partner, and dealing with drug abuse.

She had been in a transition house, left the house to go and try to reconnect with this partner, been badly beaten again and was now in Emerg awaiting some repair surgery on her nose and a huge laceration on her neck and was going back to the transition house that night and so at that point my role was to confirm that she was going to be safe because her situation was quite appalling to some of the nurses, but also dealing with the judgment that she was the undeserving patient because of the drug addiction.

In other cases, the status of the apparent abuser being greater than the status of the victim appears to justify doing nothing. In the story of the woman whose husband was “in a suit”, and “on his way to work”, the husband’s apparent status apparently precluded action. In the following story, the status of the mother apparently justifies inaction.

I can tell you about one instance here where a young boy, 12 years old, and his mother threw a cup of hot water in his face. He was sitting at the kitchen table, lipping off, she had had a bad day and she tossed the boiling hot water in his face. He came, was treated for his burns, and what did we do, discharged him with his mother who had just thrown the hot water in his face. The physician knew the mother from [a particular business] because she [worked at that business] and he thought everything was fine, “I know her, she was just having a bad day”, and off they went. Again, it’s not that we don’t know what to do, it’s that our own values and beliefs and attitudes get in the way of, sometimes, helping people. Now that’s not to say that the boy shouldn’t have been in the home with his mother, my point is that it is not up to us to decide because we might know his mother from [a particular business].

The extent to which women are judged as deserving combines with the demands of the context to influence how nurses expend their limited available time. In the following story, Lenore describes an instance in which two women who had been sexually assaulted came to the Emergency at the same time, and her judgments about the women.

L: I had a woman that was sitting in the waiting room, and she was just sitting in the waiting room. It was quite busy, it was an evening shift and then she was just sitting there and sitting there and I remembered seeing her but not thinking too much about it, I thought she was waiting for somebody or something. Well then the Police bring in this sexual assault and she was drunk and she was really enjoying the whole attention and everything, I mean she had written out on foolscap, you know the big long Police reports, she had written out four pages and as it turns out she was abused but she was getting back at her husband or her boyfriend, like that was more what was coming out of it. Anyway,
we spent three hours with her and when I came out of the room this woman was still sitting in the waiting room but by this time the waiting room had emptied out and I said to her “can I help you, are you waiting for somebody”, like what is going on and she said “I’m waiting for somebody from a Rape Crisis Unit” and she had, it was an actual date rape, she had marks around her neck and I was pissed off. I thought “here I just spent three hours with this woman who is not going to be traumatized by it and as a matter of fact she is enjoying the attention” this is nothing to her and I thought “she has taken away from this poor woman who is really traumatized by it” and that I think is where that attitude sort of stems from. I don’t like to think that I am like that but you do get a little hardened to it...I’m thinking sexual assault is wrong but this first woman that came in, this woman will have forgotten it by the next day, I really don’t think it would have fazed her at all, not even a little bit; whereas this other woman is going to be traumatized for the rest of her life. I can’t help it, my heart goes out to the woman who is going to be traumatized for the rest of her life.

C: And you think that the one woman would be traumatized because she was quiet and internalizing it, whereas the other woman who was dealing with it with bravado and whatever?

L: She was laughing. Well actually maybe it was bravado but, she was drunker than a skunk, I mean even what she remembers the next day is going to be limited. Again, I’m not saying that it should have happened or anything like that, but when I have limited resources I would rather my resources go to the people I see as needing it.

Individual nurses allocate their own time within the specific economic conditions of the health care system and within an ideology of scarcity, and these decisions cause conflict for nurses as their sense of obligation to fiscal responsibility conflict with their sense of responsibility to patients.

It is very complicated and because I have 2 hats, both the consumer hat and the ... who is it, Paddy Rodney? [a well known local nurse ethesist] that talks about the levels of responsibility, so we have the micro, which is me as the Triage Nurse deciding what happens, and then the meso and that’s the hospital and our institution deciding, and then the society, so I would be wearing 2 hats. I’d be saying to admit somebody overnight so she can make a decision, that’s going to cost this society $1000 of our health care dollars and is that the right spot for her versus the availability of a safe house. If she is not physically needing nursing care is there something else in our community that would work for her and buy her that decision making time, rather than the hospital. But then as the Triage Nurse my responsibility is not to the community, my responsibility is not to the Hospital, my responsibility is to that woman at that time.
Whose Interests Are Served?

In each of these cases, the obvious physical injuries were dealt with, but further action was not taken. In general, not taking further action serves the interests of using few immediate resources, and processing patients more quickly and with less emotional and temporal investment by health care providers. Additionally, taking further action in some instances would bring violence and abuse “closer to home” by making it obvious that abuse occurs among people with whom health care providers identify. Mary argued that health care providers will talk about a specific instance of abuse, but are reluctant to examine the larger picture because it makes everyone vulnerable.

People will talk about it around a particular case. I think that the bigger picture actually frightens people a lot and they don’t talk about it. They will talk about “oh, this poor woman”, “gee this is horrible” and “what can we do for her” and “how can we help” [but] ...they don’t talk about the bigger societal picture, that this represents. Because I think life is kind of frightening, and it makes us all vulnerable, and it makes our system imperfect and that’s a frightening thought, to have an imperfect system.

Thus, in the same way that some health care providers thought they limited recognition of abuse in order to preserve ideals about their community, they may also limit their actions because confronting violence and abuse might challenge the health care provider’s sense of safety and security and extend the emotional cost of dealing with abuse beyond the woman’s individual situation to the health providers’ world.

Health care providers said that they were too busy to attend to cues or to “dig deeper”, and expressed concern about the time involvement required if women disclosed abuse. Thus anticipation of a significant time involvement may also be an incentive to do nothing. In the same way as the emotional cost of dealing with abuse may extend beyond the immediate unit and situation, the temporal investment required of health care providers by responding to abuse may extend beyond the immediate shift. Many nurses and other health care providers talked about the
possibility of being embroiled in the woman’s situation by the legal system. Nurses at both primary study sites and nurses from other hospitals told me that they were discouraged from becoming too involved because of the potential legal involvement. Lindsay said:

Sure, we can deal with a rape case or a physically battered case, we can deal with that physically, start the intravenous, give the antibiotics, send the person off to some [transition house] or bring the social worker in, try not to get involved because the Police will try to subpoena you and you will have to go to court. I mean this is ridiculous! You walk into a situation, there is a woman in dire need, waiting for you in a particular room (the pelvic room usually) and everybody is back paddling, “No, no, I don’t want to go in there” and the Doctor is going “yeah I’ll probably have to go to Court and get subpoenaed and lose time and blah, blah” and who loses out but the patient? Then you walk in and somebody, lack of education, somebody in the hierarchy tells you “don’t talk to the person about the situation, don’t get involved, just be there and hand the instruments and do not get involved or you will be subpoenaed”.

Shelby told me that the direction she had received regarding legal involvement led her to try to limit her focus to the physical aspects of care. She said:

I mean I know legally when I go into check in a patient and I find out they’ve been battered or abused that I focus on the physical, I try not to get, I mean, you get them to tell you a little bit, but the less they tell you, the better, in that if it goes to court and they ever call you as a witness, if the stories conflict....it can hamper them, it can hinder them instead of helping them later. But I always find that very awkward to sit there and focus on the physical injuries when you know that there is a lot more hurting than that.

Dealing with only the physical consequences of violence is congruent with the mandate of the Emergency unit, and serves the interests of both health care providers and the health care system in terms of efficiency. Because of the mandate of the Emergency, and the resources available, doing nothing is a pattern of practice which applies to other health concerns, such as alcohol and drug abuse as Monica suggests in the passage below. Thus, doing nothing about abuse is congruent with the predominant pattern of practice, and is a component of the neglect of violence, a specific case of efficient processing.

People move through Emergency; they either go home or I guess if they were going home then really we should be involved in getting somebody, but there isn’t anybody really in particular (unless the poor Social Worker who already is overworked with what she is doing) to check with this person, do they need help with substance abuse, would they be
interested, and what can we do to help them... The same with the battered women, you can’t just ask the question and then leave it hanging, you have to have some follow-up somehow.

Despite the fit (or perhaps, because of the fit) with the goals and resources of the unit and the patterns of practice, doing nothing in relation to violence creates conflict for nurses in the same way that the focus on efficiency and the physical aspects of care generally create conflict. In relation to dealing with violence, the conflict is particularly acute, and most nurses expressed feelings of inadequacy and frustration with themselves and the system. For example, after telling me about a woman for whom she and another nurse “did nothing”, Susan said

I remember, I can still feel how inadequate I felt at the bedside in that situation and I never ever wanted to feel that way again and when I think of the question of violence and abuse and the way that we address it, i.e. by screening, we aren’t even close to being useful, helpful or effective, to me at all.

Doing nothing is not merely an individual pattern of practice, rather, it is a collective pattern of practice which individuals collude with and contest, influence and are influenced by. Monica critiqued the tendency to do nothing in response to recognizing abuse, saying “It’s no good asking a question and then just leaving it, because then the woman is really going to feel betrayed.” Lindsay pointed out that “swarming” occurs in relation to dealing with physical aspects of abuse, but that in the aftermath, both the woman and the nurse are abandoned to deal with their non-physical wounds.

... where I seem to see that the gap falls, is once everything is all done. Like a cardiac arrest, you are in there, you are pumping, you are flying, you are doing everything and the person either makes or they don’t. If they don’t, everybody leaves; if they do, four people leave and one person is left looking after the patient and that seems to be what happens. It is very intense and then it falls off and that is where the cracks in the eggs start. They are all around it and then “pfft” the crisis is over, but it is not for this person. A particular person’s crisis is emotional and could very well be extremely physical. How do people know if they are raped and they are ripped from vag to anus - that is a physical thing, that will heal but it is also extremely painful, but it is nothing compared to what is going on inside. We tend to focus on that “look at how torn she is, we have to stitch this up, we’ve got to deal with this” and the physicians, everybody is uncomfortable with it... you find out very quickly who is comfortable... and who isn’t, because they all fall off and they leave you, and you think to
yourself “in the time of need where is everybody?” I try to think of that with battered situations.

To me, Lindsay’s words resonated with those of the women who had been abused by their husbands and experienced health care professionals “doing nothing” beyond attention to their physical concerns. Recall their words

...by not talking about it and not allowing people to talk about it also makes them feel guilty, not giving them the courage because it is like a taboo and if nurses do that they are not going to help, they are going to do the opposite. (Nadia)

You can attend to the wounds or make sure that they have gotten the x-ray or done whatever they need to do but the emotional sometimes isn’t addressed at all and then the person is left lying there. I don’t know if this is a fair term to use, but feeling emotionally raped...(Louise)

Louise contended that “doing nothing” in the hospital replicated the abuse the woman experienced in her home.

So here you are attending, it would be, (I don’t want to put a woman in a child position because I just said that wasn’t a good thing) but if you attend to a child’s physical needs only that doesn’t help that person grow, the child needs the whole thing and if this person has been treated like a child, like “I can hit you”, “you are smaller than me”, “I can do what I want”, “I can emotionally abuse you because you don’t have any power” and then you go in the hospital and somebody just cleans you up but doesn’t address any of those inner wounds, that is devastating. In fact, many women will say that they would rather have a physical hurt than the emotional stuff that goes on in the relationship, so the hospital just is an extension of all of that it is not helping.

The experiences of the women in this study also resonated with the experiences of women in a phenomenological study of the problems faced by “victims of spouse abuse” in hospital (McMurray & Moore, 1994). These researchers found that the women experienced disengagement from hospital staff and loss of status, disempowerment and lack of control, stigma and social isolation, and a sense of being misunderstood.
Shifting Responsibility

One of the ways the sense of inadequacy associated with “doing nothing” appeared to be ameliorated for health care providers was by shifting responsibility. When I asked what is done when a woman is recognized as having been abused, nurses repeatedly referred me to physicians, social workers, Emergency psychiatric nurses, nurse clinicians or clinical nurse specialists, depending on who was available in the particular hospital. Sometimes reference to other health care providers was made in terms of follow up and referral. For example, Monica said

If you come across somebody and you think “there’s something wrong here”, so you go to the Psych. Emerg. Nurse and you say “listen will you have a talk to this person” and they have the skills of going in if there is more going on there...

Shifting responsibility to others partly seemed to arise from wanting to share the burden of difficult situations with others and the perception that other health care providers have more skill and/or more time to deal with abuse. Monica went on to say “I don’t like to make it [a decision] all myself, I like to get someone else.” More often however, nurses implied that primary responsibility for responding to women lies with others. Nurses repeatedly told me that dealing with violence is someone else’s job. For example, Bo said

I guess I really have to say that I have not been involved with a lot of battered women on a one-to-one basis because generally, because we have the Psych. Emerg... Nurses or the physicians or we have [the transition house] and we have a Social Worker. They are often taken out of our hands, or my hands.

This nurse not only implied that dealing with women who have been battered is someone else’s responsibility, but saying “they are often *taken out of our hands*” (italics and bold added) further implied that other health care providers actively take such responsibility away from nurses.

In addition, shifting responsibility was sometimes something nurses speculated that they might do, but thought that more often nothing was actually done. For example, when I asked Monica if there was any particular way that abuse was dealt with in her hospital she replied
M: No. I supposed we might mention to the physician that we thought something was going on and then wait until he got his opinion of what the situation would be and then I think from that we would probably get on to the Social Worker and see if we could send somebody in to look at the situation.

C: But as in your own personal practice, that rarely happens?

M: No, it doesn’t happen very often at all.

Many nurses were aware of the extent to which they shifted responsibility to others and were critical of doing so. For example, Mary said “I have been somewhere along the line conditioned to believe that social workers did that. ‘oh, family violence, that’s social work’s department’”. Yvette was concerned that shifting responsibility to others would not be in the interests of the woman. She thought that the need for a woman to repeat her story and the increased safety risk incurred by telling another person might be very threatening.

If they’ve looked at your face and thought “okay I can trust her and I’m going to tell her because I am ready for help” and then you say “okay, well, look, I don’t have time to really get into this (or however you want to word it) but I’ll send in someone else” they might clam up and say it is nothing.

Several nurses also pointed out that other health care providers also dealt with violence in a minimum fashion by shifting the responsibility to others. For example, one head nurse said

So if it is a physician that suspects something, right away that physician would consult [the social worker].... that’s it, that’s what they do, they ask for the social worker to get involved and then it’s done, it’s looked after.

The physicians I spoke to agreed that they dealt primarily with the physical aspects of care and then hoped that others would deal with the rest of the issues. For example, one physician said

Well you [the physician] deal with the physical problem like you do any other physical problem and then if it’s, hopefully the Psych. Emerg. Nurse is available to help with the psychological follow-up, counseling, resources aspect to it.
Shifting responsibility is congruent with the work patterns of an Emergency unit. One of the most important goals is to empty the stretchers, and referral to other health care providers is one of the necessary ways in which this goal is accomplished. However, referral can become part of a pattern of avoiding dealing with abuse.

Those who are given the responsibility for dealing with violence often recognize that the shift is occurring, and try to resist the shift of responsibility and shift it back to the nurses. A nurse who previously worked for several years as a Emergency psychiatric nurse told me that she felt that the regular Emergency nurses tried to give her the responsibility. "Oh, no, no, no. I'm happy to help you, but I'm not taking over". She pantomimed dragging me to a bedside and told me that she would go with the nurses, but would not take over. Similarly, Mary told me that in her consultative role she has tried to get other nurses to remain involved.

You know, and I've started to pull the staff nurses in with me when I go in to talk to someone. So we interview this woman together. Because that will pass on...basically help that staff nurse to know what I learned the first time round, that we can do this, and it's basic nursing skills...and that we can all do this, we all should be doing this.

Interestingly, some of the people to whom the nurses and physicians shifted responsibility did not think that they actually received any referrals or were as responsible for responding as nurses thought. While two of the Psychiatric Emergency Nurses that I talked to did think they received referrals regarding abuse, two did not think they saw women who had been abused, and did not think that they got referrals from staff. For example, Scarlet said “I can not think of very many cases where I have been asked to see somebody because she has been battered. Seriously, I have not.”. Scarlet went on to detail the situations she thought might be related to abuse, including depression, alcoholism, and suicide, but said that in each situation the Psychiatric Emergency nurses are not thinking of abuse. For example, in regard to women who are depressed, she said
I guess I was saying that so often when we get depressed women in, and we get a lot of depressed women in, they talk about their husbands or their families and so on, that often what we are saying is things like, well, we are neutralizing it a bit in the sense that the depression is so severe, I mean it is life threatening in some cases. So we are looking at dealing with the acuity, in the sense of not letting them suicide, trying to get the compliance to come in and getting treated and so on. We are looking mainly at... that in the context of the Emerg... saying "we need to get you admitted and we need to get you treated” and “you don’t make decisions about your family when you are so severely depressed” because at that stage, cognitively they are just not functioning and you always encourage them not to make major decisions at this time. So in a sense that is disqualifying some of their experiences.

Scarlet went on to talk about how alcoholism is also focused on, without attention to the possible influences of the women’s life or abuse by a partner.

Certainly we don't look at treating alcoholics on the inpatient unit. Now, so often those are battered people and we never look at it in that context. This is so awful, I'm saying what we don’t look at instead of what we do look at. But I will get somebody in that is battered and bruised from either falling or, and we don’t say “well did someone hit you?”, or “you come in here and you’ve been screaming at your live-in partner, what is happening with that?” Well the issue is gaining detoxing and nothing [else] and so “where can I get you sent for detox?” Again the acuity is needing to be detoxed, we are not going to do that here because that isn’t what our units are set up for, nor is Emerg, so we ship them [elsewhere]. So that is probably another whole area where we are not touching any of that violence because the problem is seen as alcoholism.

As Scarlet’s words suggest, the Psychiatric Emergency Nurses, upon whom the Emergency Nurses rely to recognize and deal with abuse, may also be focused on the most immediate and obvious problem, and may be largely oblivious to related health problems including abuse.

When asked how they responded to women who had been abused, physicians and nurses in this study often referred to the work of various other health care providers and said that they referred the care to these other workers. When I talked to these other health care providers, most were aware of these referrals and tried to shift some of the responsibility back; others did not think that they received referrals. Referral is an important way of intervening, but in shifting the responsibility for care, referral may also function as a way of avoiding responsibility.
Doing nothing was the most common response to violence reported by health care providers in this study, and can be seen as a larger pattern of neglect that begins with the non-recognition of abuse. Doing nothing serves the interests of the health care system in the short term by maintaining efficiency without incurring additional costs, and serves the interests of individual health care providers in maintaining efficiency and limiting emotional involvement. Doing nothing seems predominantly counter to the interests of women who have been abused, as their experiences are not acknowledged and validated, and the abuse continues, but may serve the women’s interests in allowing her to avoid judgment and resist scrutiny and pressure to make unwelcome choices. Doing nothing is counter to the interests of individual health care providers to the extent that they see doing nothing as inadequate, and is counter to the interests of the health care system in that abuse continues unabated, incurring further health care costs over the long term. In order to serve the interests of efficiency and limited emotional involvement, health care providers shift the responsibility for abuse between one another. Although referral is essential to maintaining efficient processing of patients, in the case of dealing with violence, referral may function as a way of avoiding responsibility without the health care provider feeling that he or she has done nothing. Seeing the woman as undeserving supports doing nothing and may serve to minimize health care providers’ feelings of guilt and inadequacy in doing nothing. Women who are seen as undeserving include women of low status; women who are drunk, women who abuse drugs, women who are poor, and women who are not white. In addition, as will be shown, women who have been offered help before, have refused help, or return frequently are seen as undeserving. As ideas regarding who is undeserving are examined, a profile of the deserving victim can be constructed. The deserving victim of abuse is like health care providers in that she is white, not poor, is not drunk or using street drugs. And, as the next section
illustrates, she has been violently and obviously abused, and is receptive to the suggestions that health care providers make.

Influencing Choices: The Deserving Victim

Health care providers in this study gave accounts of going beyond “doing nothing” by dealing with physical injuries and shifting the responsibility to others, to intervening in relation to abuse. One of the ways nurses and others in this study reported intervening was by influencing women toward choices that the health care providers think are best.

Accounts of influencing choices were associated with women who were judged as deserving. In addition to social status, the degree of physical injury seemed to influence the extent to which women were judged as deserving and accounts of influencing choices were associated with women who had been seriously physically abused. For example, the woman Lenore saw as more deserving than the drunk woman, “was an actual date rape” and “had had marks around her neck”. In another example Anne recalled “... one lady who came in with very battered chest and breasts, lots of bruising...” Nicole recounted the story of a woman whom she tried to convince to “press charges and to do something”.

It was a Chinese lady that was beaten up by her husband. Actually she went unconscious for 30 minutes. In actual point he could have killed her. She had no thought left, she had strangulation marks, she had petichiae actually, probably struggling, bruise marks to her back and leg.

Because health care providers tended to only recognize blatantly obvious abuse, and because acuity is routinely judged on the extent of physical injury and risk, it is not surprising that accounts of intervention are associated with serious physical injury. Thus, the severity of physical abuse contributes to health care providers perceiving the woman as deserving, and thus requiring them to “do something”.
The strength of influence that health care providers described exerting ranged from making suggestions, to making the woman’s choice for her. The weaker sense of influence, making suggestions, overlapped with the other mode of intervention which I have called “offering choices”. The choices toward which women were directed were limited, and included disclosing the abuse, calling the police, and leaving the relationship, and nurses saw the influencing of choice as fitting with their views of themselves as “fixing problems”.

**Disclose the Abuse**

Influencing choices begins with trying to influence the woman’s decision to disclose abuse. Many of the nurses and other health care providers in this study described reluctance to disclose abuse as duplicity on the woman’s part. Especially during initial field work at both sites, words such as “hiding” and “lying” were used and several nurses thought that women were in “denial”. Many health care providers thought they should be “more forceful” or “more persistent” in getting women to tell. In some accounts there was a sense of the health care provider trying to extract a confession, and sometimes the words used implied that the woman was the wrong doer.

Elaine told me the story of a woman who had been beaten by her boyfriend, and was brought in. When the woman was transferred to the stretcher, Elaine noticed that the woman did not have any underwear on, despite the fact that she was wearing an extremely short mini-dress. She told me that she asked the woman if the boyfriend had raped her. The woman repeatedly said “I don't want to get any one in trouble”, but eventually, “after repeated questions, she admitted he had raped her”. At this point, Elaine and the physician decided to send the woman to [another hospital] for the sexual assault exam. (Field Notes, July 1996)

In these accounts, the woman who was not telling was often talked about as deficient in some way. For example, in the following passage a physician is telling me what he thinks nurses do in relation to violence. He says that the nurses will not “accuse” the woman, but the implication is that there is an accusation that *could* be made. He says that the nurse would offer
the patient the "ability" to clarify, implying that it is ability rather than opportunity that is required.

They are not forcing them into it but they will be carefully considered, perhaps a bit persistent in saying "well that doesn't seem to fit that", although they will not accuse them and they will not put words in their mouth but they will make it clear that they may not completely understand what happened and offer the patient the ability to clarify. [bold and italics added]

A key decision that health care providers often make for women is which other health care providers should know about the abuse, and who else should talk to the woman. Thus after initial disclosure, further disclosure is taken out of the woman's hands, and intervention is initiated. Most health care providers told me in interviews and conversations that they would "send in" the social worker, the Psych Emerg. Nurse, the physician, or whom ever was available in their hospital, without any suggestion that they would ask the woman first. In addition, in the one study site that began to initiate a "Domestic Violence Protocol" toward the end of my study, the draft protocol document specified that patients "will be referred to social work", and patient confidentiality was only considered an issue in relation to professionals in the community. This practice is totally congruent with the patterns of Emergency practice, as multiple care givers are routinely involved in any individual's care, and as referrals are routinely made to a great variety of people such as lab technicians, IV nurses, Obstetrical Nurses, and specialist physicians, without asking the patient.

The practice of sharing any and all aspects of the patient's history is an apparent norm in the Emergency. Yvette thought that most patients have no idea that this is common practice, and that if they did, they would be much more reluctant to share information.

I think people wouldn't tell you anything if they thought it was going to be discussed at the nursing station. I think that a lot of them think that you quietly tell things to the nurse that is taking over.... but if you knew that your whole story is taped on a report if you are on the ward and said to the whole nursing station if you are down in Emergency you wouldn't say
a bloody word would you... I still think that they think that what they tell the Doctor
doesn’t get mentioned in the nursing station when you go back.

Nurses in Emergency rely extensively on sharing verbal information to accomplish their
work. The sharing of information is partially a safety factor, because nurses cover each other’s
patients and may need to help out in times of crises. Sharing information about abuse may also
allow for staff to support one another. In addition, knowing individual patients helps nurses
recognize when patients might be returning repeatedly. However, the sharing of information
seemed especially extensive in relation to “dramatic” situations such as abuse. I explored this
with a number of nurses. I asked Yvette if there was an element of voyeurism in the sharing of
such information. She mostly disagreed saying “I think on the whole, I mean there is probably a
certain amount of voyeurism but I think on the whole what is passed on is necessary.” Susan
offered an fascinating perspective about the function of sharing sensitive patient information.

I think as nurses in searching for something that excites and is not routine, we tend to latch
on to any detail about a person that is emotional, because it ties us back to our work. We
don’t want that distance. I’m only speaking for myself, so then when someone comes in
and they have lost a child, or have a really seriously ill child, or someone is dying and losing
a parent, or someone is abused, or someone is violent, or anything that instantly makes us
have an emotional reaction, that we tend to glom onto that because it makes that person
unique and then we spread it to everybody else.

From Susan’s perspective; sharing patient information was a way of making the person into an
unique individual, and sharing patient information was not thought of in terms of confidentiality
or the woman’s autonomy.

Women are pressed to disclose abuse in the interests of the health care providers (so that
they can intervene with the abuse), and in the interests of the health care system (so that available
resources can be mobilized). Disclosure is in the woman’s interests if it leads to responses and
interventions which are helpful to her, but is counter to her interests if it invokes responses and
pressure toward decisions that are not helpful to her. The decision to share information and
involve other health care providers is routinely made without the woman’s involvement. This serves the interests of the organization in that work is distributed efficiently among various providers. This may serve the interests of the health care providers in facilitating the efficiency and continuity of care, and in connecting them to the patient. It may also serve the interests of the woman in providing options and in constructing her as an unique individual; however, it may be counter to the woman’s interests in that she may be known and treated as a “victim only”.

**Leave Your Partner**

Beyond disclosure, health care providers reported trying to influence the woman’s decisions about care. The key decision that health care providers wanted women to make was the decision to leave their abusive partners. Leaving the partner was not just a goal that individual nurses thought appropriate. Most health care providers I talked with held leaving the relationship as an implicit goal. An initial draft of a “Domestic Violence Protocol” in one study site specified referral to a transition house as one of two effective techniques (the other being counseling). Absent were techniques such as listening, mobilizing women’s personal resources, creating a safety plan, and so on. In light of efficient processing, referral to a transition house as a main strategy makes sense in that, at least theoretically, women can be discharged and the stretcher emptied. It is not that leaving the relationship and referral to a transition house is not useful, in fact, Ratner (1995) found that shelter stays were one of the contacts that contribute to improving women’s health. However, posing shelter referral as a proscribed option contributes to constructing the nurse-patient relationship in a particular manner, and participates in efficient processing, perhaps at the expense of what would be helpful for a given woman.

“Convincing” the woman to leave is one of the strategies that some nurses described using, as in the passage below.
I said “there’s no need to stay in something like this, no matter what you might have said or done it doesn’t warrant being beaten for it, that’s not necessary”. I had her to the point where she was convinced and I got Social Services involved and they came and talked to her and were all ready to set her up to go to the [transition house] and everything. (Faye, Emergency Nurse)

What the decision ought to be sometimes seems to be made without the woman’s involvement. Monica said that because she was reluctant to make decisions about women on her own, she involved other health care providers in the decision-making.

Well the Psych. Nurse comes by and she is a nurse, she will come, I usually get them to come in, because then the two of us can look at the scenario and say “yeah she can go back”. So that kind of thing happens with her [the psych. nurse] involvement. I don’t like to make it all myself, I like to get someone else, either a physician or...

Similarly, Anne said that at times “the team” made the decision for a woman to leave because the woman had no choice.

C: You said “for her own good” she goes to [the transition house] and she doesn’t have a choice and that’s what I am wondering, what kinds of situations would she not have a choice in?

A: If she’s telling. I think that is something that the team decides at that point. If the scenario is that it is the only place that she has got to go back to is someone who has already wrecked the place and is violent and the Police have been involved, you are not going to send that woman back to that scenario.

Nurses and other health care providers wanted women to leave their partners, and in expressing this goal also talked about how they found women’s refusal to leave their partners incomprehensible. Palen said “I think bewildered is a good expression for myself, it just bewilders me why they go back and why they don’t leave and what is so hard about this decision...” As noted earlier, whereas the women who had experienced abuse in the position of wife talked about why they stayed, nurses and other health care professionals who held leaving as a goal struggled with why women don’t leave.
Another key decision that nurses and some other health care providers wanted women to make was the decision to call the police. This decision was talked about by health care providers in concert with the decision to leave the partner, and was often presented as an uncomplicated decision. An ambulance attendant told me that he and his colleagues routinely call police if they think there has been an assault.

He tells me about his experiences, and tells me that he calls the police if there has been an assault. He says that he will do so even if the women does not want them to. He is very clear that he does it, and says that I will not find an ambulance attendant that does not. (Field Notes, July, 1996)

When I asked him if the ambulance attendants had any legal advice regarding this practice, he said that they didn’t, and glared at me.

He tells me that he doesn't know how many times he has said "why are you here?" to women. He tells me about a “native” woman who was assaulted by her husband, and how he called the police. He said that the woman's jaw was already wired from a previous assault, and the partner had broken her jaw again. He says that "there is often a dance" between the assaultive man and the ambulance attendant. In this case, he got between the husband, who was drunk, and the woman, and gave a meaningful look to his partner, who called the police. Apparently the police did not want to do anything, but he insisted, and they charged the man. (Field Notes, July 1996)

Nurses described a number of instances in which women’s refusal to involve the police led staff to want to call the police themselves.

“Of course the police have to be involved because it was attempted murder”, and “how were we going to help her?”. Our vision was, if we phone the police we will be helping her so let’s do that. (Lulu, Emergency Nurse)

But, the Head Nurse is concerned because it was the point where she was battered that he could have killed her... do we go against the patient’s will to report it?... But, you don’t really want to do that either because of the trust of the patient. She’s not going to come back if she knows that this is going to be done behind her back. Then I see the Head Nurse [is] saying, “well if she’s going home and gets killed and I’m going to feel guilty that I didn’t report it to the police.” (Nicole, Emergency Nurse)
Calling the police was an especially appealing option, partly because calling the Police seems like a concrete, effective option that would shift responsibility, partly because Emergency Units typically have extensive relationships with the police, and partly because the Police often think that they should be called. During my study, I talked to a number of Police officers, who, because of their legal mandate to charge assaultive men regardless of the woman’s wishes, thought that nurses ought to call them when an assault has occurred. For example, one Police officer who was guarding a patient during one of my shifts expressed his frustration and incomprehension regarding why nurses would not call police. In another example, during a community forum, four social workers and nurses (myself included) explained repeatedly and publicly to the hospital liaison police officer that confidentiality would not permit nurses to call the police when an assault was suspected, and he remained unconvinced.

During my study there was considerable discussion in both study sites regarding whether or not the police could be called against a woman’s wishes. Some nurses at both sites found it difficult to accept that calling the police was not their decision. For example, one head nurse described her follow up to a particular case and the response of the staff involved.

I did follow up with the lawyers and asked what is the law, what are her rights versus what are our responsibilities; it was laid out very, very clearly to me that her rights are upper most and it is her that has to decide when to call the police, that it is not a decision that we make, it is her decision. That was really hard for the nurses, myself included, because we are here to fix everything and that is something that happened that we could not fix, so what else can we do?

Involving the police is one important option for women. In fact, Ratner (1995) concluded that police involvement was one of the contacts that contributed to improving women’s health outcomes. However, in this study health care professionals in their zeal to fix the problem often viewed calling the police not as an option, but as course of action that a woman should take.
Fixing Problems

Nurses repeatedly told me that because they saw themselves as “fixing problems”, dealing with violence was untenable because they could not “fix” the problem. For example, in the following exchange, I was responding to Yvette asking me what I thought was acceptable practice in response to violence.

C: I think we need to figure out what is success, what does success look like because sometimes I think we are operating with the goal of

Y: “I’m going to fix this”, you feel you have to fix it and maybe you don’t, not right away.

C: and fixing it often to us means handing it over to the Police or having the woman immediately leave home.

Y: I think that is how I sort of somehow see it, “now that I know this, can I send her back to that”.

A little later in the same interview, Yvette continue to struggle with what she thought would be acceptable practice.

Y: Is it acceptable to say to these people, give them 10-15 minutes and if that is enough and it has got them started, that “this is important, people do listen, people do care”, is it acceptable to let them go home them and follow-up with their family doctor if that is what they want to do?

C: What do you think?

Y: Well I have this gut feeling “No. Get out of there. It’s not going to get better”. This is my feeling but I don’t know. They say that they will abuse again and again and it gets worse, so my gut is if I know about it, I have got to fix it, so I don’t know if that is okay. What if she gets killed overnight?

In accounts of influencing choices, nurses viewed “doing nothing” as unacceptable, and wanted to “do something” from their interest in fixing problems, their fear for the woman, and their perception of the woman’s interests. In these accounts, the woman was not constructed as an active player. Health care providers “look at the scenario”, “send somebody in to look at the
situation”, decide “yeah, she can go back” or are reluctant to “send that woman back”, and thus make choices for the woman “for her own good”. Influencing choices seems to depend on seeing the woman as unable to make choices in her own interests.

In the following passage, Lulu is talking about influencing women’s decisions, and uses the example of influencing women who have been sexually assaulted to decide to have a sexual assault exam. Lulu’s willingness to influence the woman rests with her perception that the woman may not know what she wants, that she is vulnerable and passive, that the aftermath of an assault is “not a good time to make decisions”, and that she is behaving in an “almost childlike” manner.

L: Sometimes people don’t know what they want. I, (I shouldn’t say we), may be directing unintentionally.

C: Trying to influence?

L: Trying to influence their decision. One of those ways is, I do think that women should think about the examination, having the examination at the time of the sexual assault. That doesn’t mean that you have to do anything with it afterwards, but at least you’ve got it there. I think there can’t be anything in this world more devastating emotionally than being sexually assaulted and that is not a time to be making good decisions. So trying to influence the woman enough to let her know that I believe that it is hard to make a good decision right now, so if you have this examination then you do have choices afterwards. At that vulnerable time a woman may go ahead with the examination passively, passively have it and then 2 weeks down the line have the anger that she needs to follow through with charging whoever it is, if she knows who it is, or follow through with a police investigation. Whereas, at the time that she is here, almost childlike, turning to me, I would say, “just tell me what I should do now.” So hopefully, in directing, giving people choices and directing what you think is the best choice you really are giving them the best choice. I hope that having the examination isn’t another assault, and that would be a fear.

As Lulu’s words and the critical analysis by other nurses implies, nurses did not see influencing women’s choices as unproblematic.
Influencing Choices as Problematic

Health care providers’ attempts to influence women’s choices and construction of the women as a victim are problematic in at least three ways. First, in constructing the woman as a “victim”, health care providers may see the woman as a victim only, possibly inviting stereotypical thinking, and possibly diminishing attention to the woman’s primary health concern. Second, influencing the woman’s choices, which is predicated on the woman being a victim who cannot make her own choices, constructs the health care provider as the expert, and takes control away from the woman. Thirdly, the health care provider’s ideas about choice may be dramatically different from the woman’s ideas, and may lead to the health care provider trying to influence the woman to make decisions that may be unrealistic to the woman, inappropriate to her circumstances, or, most importantly, may not be related to what the woman wants or may even be dangerous for the woman.

The Victim Only

In recounting instances of influencing choices, nurses tended to talk about women in ways that constructed them as passive victims. This was not merely a tendency of individual nurses, rather, it was characteristic of much of the talk and many of the texts that I encountered throughout this study. For example, an initial draft of an Emergency Unit “Domestic Violence Protocol” in one of the study sites read

The [Hospital] Emergency Department will implement a generic screening process to identify women and men subjected to domestic violence. All patients recognized with a positive domestic violence response will be offered counseling to make an informed decision regarding the choices available to them. The primary role of [the hospital] is identification, assessment and referral.

WE WILL:
* nurses, physicians & social workers on staff in the emergency department will work cooperatively and will consult on all cases of potential domestic violence.
* all patients both male and female seen in the emergency department will be asked if they have been subjected to domestic violence by the primary care nurse.
* a primary care nursing assessment will ask specific questions to identify if the patient is currently in a violent relationship or at risk.
* any patient with a positive response to DVP will be referred to the social work department for further follow-up.
* any patient with a positive response to DVP identified during the evenings will receive counseling from their primary care nurse to inform the patient about community resources for domestic violence situations.
* provide training for all staff in the emergency department to understand the dynamics of domestic violence, identify patients at risk, and use effective intervention techniques, i.e. counseling and referral to transition houses.
* work cooperatively with other health professionals from community resources, while respecting patients right to confidentiality.

In this text, not surprisingly (it is, after all, a document to outline what the health care providers should do), health care providers are active. They “WILL” “work cooperatively” (with each other and “professionals from community resources” and “consult” (with each other). They “will ask specific questions”, “identify patients”, and “use effective intervention techniques”. However, what is of interest to this discussion are the ways in which violence and people who have experienced violence are constructed in this text. The women (and men) are “patients” or “cases”, and their experience of violence is constructed in the passive “subjected to domestic violence”. There is no indication of who is committing the violence (except when unintentionally action is ascribed to the primary care nurse), although later the document states that staff will “try to provide appropriate referrals for males identified with perpetrating violence”. Patients are predominantly constructed as passive. They “will be asked”, “will be referred”, “will receive counseling”. Even the disclosure of abuse is constructed in passive terms “with a positive response to DVP”, which is a medicalized way of saying that the person says “yes” to the protocol questions. The only action ascribed to the “patients” is that they will be offered counseling “to make an informed decision”.

The relationship between “professionals” and “patients” is thus active to passive. While “professionals” will work cooperatively and consult with each other, there is no indication that
they will do so with “patients”. This document is a well intentioned attempt to insure that health care providers will “do something” in relation to violence, but reflects the construction of “patients” as passive which is characteristic in most contemporary health care settings.

Constructing the woman who has been abused as a “victim” is congruent with much contemporary literature. It is not use of the term “victim” (in fact many nurses did not use the term) but rather the construction of the woman as a victim that is problematic. As Carter (1997) illustrates with her analysis of the narratives of women who experienced battering, the construct of “victim” oversimplifies the experiences of women and imposes ideas that are incongruent with women’s identities and lived realities.

In constructing the woman as being without active agency, the woman may be seen as the victim only. Several times during field work, I was directed to patients as being “one for me”, and patients who were identified as having been abused often became the “abused woman”. For example, the young woman who came to Emergency unable to move or speak was identified by at least five staff members as a “domestic violence” or “an abuse”, and the possibility of violence overshadowed alternative explanations for her presentation.

In an example mentioned earlier, an 83 year old woman told me in the presence of another nurse that her supraventricular tachycardia always occurred when her husband became abusive. When I returned to the nursing station after a lengthy conversation with the woman, the nurses greeted me with meaningful looks. I explained that the woman knew about available resources and did not want any assistance at this time, partly due to fear for her life, partly because she felt she had no options, and partly because she had decided long ago how she would deal with her husband’s violence. The nurses were angry at her husband, did not understand why she remained in the situation, and were frustrated at being unable to "do anything". For the duration of her
stay, the woman’s status as a “battered woman” was preeminent, the significance of her
dysrhythmia diminished. Susan described a similar experience:

And the nurse came back to the nursing station, and let the charge nurse know that we
shouldn’t let the husband in for now. They pulled the curtains around the lady, turned off
the lights in the space that she was in, and that space (pause) they left the next bed empty.
And when they talked about HER, there was no question of addressing the pain of her
headache, or what might be causing her migraines or any kind of physiological basis for her
complaint, she immediately became the “abused patient”. Everybody spoke in very hushed
tones. The only conversation about her became the conversation about the abuse.

An ambulance worker told me of his experience of taking a woman to a hospital that had an
abuse screening protocol, saying “I’ve seen it [screening] work in the negative”. I asked him to
explain what he meant.

He tells me that at [an inner city hospital] he has seen nurses “over-identify” with women
who have been battered. He says that nurses should not be dealing with women “woman-to-
woman”, but “nurse-to-woman”, and that four nurses should not be looking after a woman
because she has been battered, at the expense of other patients (I do not ask him if he thinks
that it is OK that four nurses look after an MI patient at the expense of others). (Field Notes,
July, 1996)

A social worker described how being seen as the “victim only” can depersonalize the
woman and bring health care provider’s assumptions to bear on the woman.

It becomes you are the victim, then you are somewhat faceless. Before at least you were an
individual gallbladder who might have been causing some problems, now there are a lot of
assumptions that go on about you.

In each of these cases, the abuse was central to how the woman was seen, and the
“presenting complaint” shifted into the background. This is a fascinating paradox, in that the
presenting complaint is displaced by abuse as the central concern. However, this shift makes
sense when viewed in light of the pattern of Emergency practice which tends to reduce the
patient to a single most important problem.
Taking Control

In order to influence the woman’s choices, health care providers must think that they know what choices the woman should make. This positions the health care provider as the expert. This is another interesting paradox in that none of the Emergency Nurses I interviewed claimed expertise in relation to dealing with violence and abuse. Taking the position of expert, and attempting to influence decision-making means exerting power and taking some control. Taking control of decision-making implies that the control is taken away from women.

Several nurses analyzed the way in which health care providers take control. At an interview following a shift I worked during which many staff were frustrated by a situation in which a woman was thought to be being abused, Lenore said

I think as nurses we tend to want to cram it down their throat. Again, the woman last night is a perfect example, if you think about the number of people who sat around thinking “what are we going to do with this woman?”, because we all highly suspect it, “what are we going to do?”

When women are viewed as lacking in agency, as being child-like, they may be treated as such. A social worker described the way in which nurses “scolded” women.

There is some judgment that you often have to deal with, both on the nursing side and on the patient’s side, that they may be getting scolded or “you really have to do this, it’s for your own good dear.”

Taking control and shifting responsibility can create conflict between various health care providers. For example, Helen, a social worker, saw being asked by other health care providers to see a woman without that woman’s permission as problematic. She said

You walk in and the woman is like “this is just one more abuse, one more ‘take the power away’ .... That is particularly important when working with spousal abuse because they’ll [nurses] assume that every woman that’s been abused must see me and it’s my perception that’s not true, that they are adults, they’ve got choices, if they do not want to see me then I don’t see them.
Taking control was perceived by the women I interviewed as being less than helpful.

Louise, a woman who had been repeatedly battered by her husband said that anytime someone else takes “an authority position” the woman is put back into “the victim role.”

If you negate the emotional stuff, and take an authority position, like “its going to be OK”, “tomorrow’s a new day”, putting a bit of blame on to the woman, if you take that authority position, you are putting her back in the victim role, or a childlike role, where she doesn’t fell like she has some control.

Similarly Nadia said helping doesn’t mean being judgmental or making the decision for women.

**Ideas About Choice**

Health care providers accounts of influencing women’s choices were accompanied by particular ideas about choice. When talking about influencing women’s choices, health care providers seemed to see women’s choices as being similar to the choices they themselves had, or thought they would make, and often did not talk about the ways in which women’s choices might be limited. In accounts of influencing choices, health care providers also talked about abuse as the single deciding variable, and rarely talked about other variables (such as children, economics, valuing the marriage, safety) which might make decision-making complex. Health care providers talked about the envisioned choices (disclosing the abuse, calling the police, and leaving the relationship) in terms of immediately fixing the problem, and with little discussion of the long range consequences of those decisions. This again was not merely the predilection of individual health care providers, but rather was a reflection of the Emergency mandate to offer short term strategies to deal with immediate problems, and was mirrored in the talk of most health care providers and the texts I encountered.

Health care providers thought women should leave relationships, knew that women did not leave, and struggled to understand why. Women’s resistance to influence and decisions to make different choices than those health care providers thought appropriate were explained by nurses
in several ways. Explanations focused primarily on the women themselves, and included women’s lack of knowledge, lack of self regard, and metaphors that suggest an addiction to violence. Other explanations focused on factors external to the woman and invited examination of limitations to choice.

In the following passage, Anne is talking about women being responsible for their own choices. She is talking about “choice” but is referring only to making the choice that Anne thinks the woman should make. Anne explains not making the decision to leave a relationship as a lack of skill or knowledge, or, if the woman has skill and knowledge, then considers the woman to be similar to those with alcohol and smoking addictions.

I think that our society is getting to the point where people are responsible for their choices. If she could go through that whole process and feel more uncomfortable providing less for her children and herself then she would be feeling more materially but less emotionally comfortable. If she could make that choice and be comfortable with it, then that is her choice. I can’t, if a woman is that capable of analyzing the situation and making that choice then I don’t feel that there is any need to intervene. Where I feel that I have a point is where people really don’t have the knowledge base or the skills, I feel that is where I can affect change. There are people that know that alcohol is bad for them but they become alcoholic, they smoke when they know they are going to get lung cancer, to me I lump those people into those scenarios. They are smart enough, they have enough knowledge base, they’ve got all of those things to make choices and they make the choice anyway. They make the choice and I don’t feel badly for them. I don’t. I can’t. There are too many other people that can be helped. That may sound pretty depressed, but that’s how I feel.

Lack of self regard was repeatedly, and most commonly, used as the explanation for women not leaving relationships. Anne also thought lack of self-regard was part of the explanation.

“Even people who are feeling helpless, hopeless they have completely devalued their own life, so if I see people that are really very vulnerable, emotionally kind of down, they have gone through devalue.” Lenore thought that loss of self esteem was a gradual erosion that led eventually to the point at which women do not “know who they are or what they are doing.”

Low self-esteem... self-esteem is such a funny thing, you can have it and you can be in a relationship where it slowly gets whittled away over the years until someday the woman
wakes up and they don’t know who they are or what they are doing. I would say women suffer from low self-esteem more than anything.

Interestingly, in this study women who had been battered were sometimes compared to alcoholics. The implications here are that there is an addictive component to women’s experiences of violence, and that violence is something one could choose to “quit”. In the following passage, Bo constructs being in a relationship where there is violence as a choice, as though women know that abuse is part of the choice they make in choosing a partner. However, she also examines the limitations to leaving that are beyond the woman’s control.

... since meeting you I’ve done a little looking into it and looking at women that become involved in abusive situations and it seems to me that they don’t have that ability [to get out]. They get themselves into this environment and it is harder to get out than it is for me to tell them to get out. They may have children, where are they going to go, they may not have a facility to live, their family members may not be supportive, they may not have that ability to move on, so I think it is a massive subject. I think its like trying to get somebody off alcohol, or somebody off drugs [emphasis added].

Particular ideas about choice supported influencing choices. Women are seen as having choices, but particular “choices” are seen as appropriate by health care providers. Interestingly, some health care providers thought that times of crises, such as during a visit to Emergency, were not good times to make decisions, yet women were influenced toward significant choices, and the ways in which choices and decision-making were limited received little attention.

Limits to choice. Women’s choices are limited both by their personal situations and by the options available to them within the community. Nurses did not often talk about the ways in which women’s personal situations might limit their choices. In the following passage, a social worker told me about a woman with whom the nursing staff were angry for her unwillingness to make the choices they wanted. In this situation, the social worker thought that the nurses had unrealistic hopes for the woman, and unrealistic expectations of the social worker.

I think she was dealing with a drug addiction as well, this guy was her supplier but she had been abused so many, many times that she knew there was no one that could help her... In
that situation the nursing staff, I think, were hoping for a miracle if I went and talked to her for a while and that doesn’t happen. That’s one of the difficulties I think about what [nurses] think this job can do.

Both influencing and offering choices were limited by the context in that the choices available were limited and in that individual health care providers had few, if any, opportunities for follow up, and often had no way of knowing if their approaches of offering and supporting choices made any difference.

Hospital based health care providers were not always aware of what resources did exist in the community. Throughout my study health care providers described their lack of knowledge regarding what resources were available. This lack of knowledge limited the alternatives that were offered to women. For example, in one community, until the end of my study, hospital staff were unaware of the availability of translation services, and so continued to rely on untrained translators even in very difficult situations. In addition, health care provider’s ideas about choice limited the extent to which they pursued knowledge about alternatives. Lulu said:

It is hard to get your head around the fact that there are other ways to help her without calling the police in. How can we make her safe, i.e. getting a social worker involved, is there a safe house, can she relocate, can she get away from her [abuser], all of those things, without involving the police.

Further, health care providers were also often not aware of the limitations to what services were available. In both study communities there were serious limitations to the choices available to women. In both communities there was one transition house, no temporary shelters, no shelters or transition houses for women without children, and waiting lists for various services. In each community there were specific needs for which there were no resources. For example, one community did not have a “children who witness violence” program.

Both communities were also affected by the limits of the criminal justice system, although health care providers did not seem to have much awareness of these limitations. Health care
providers were often unaware that involving the police in an assault may result in charges, but that the person charged is usually not jailed, may or may not be issued a restraining order (which is a piece of paper that orders one person to stay away from another), which may or may not have an effect on the person so restrained. Throughout my field work, community workers, including Police, Victims’ Assistance, directors of transition houses and crisis services, treated the idea that an assaultive man may immediately re-contact and re-assault his partner as common knowledge.

Health care providers’ lack of awareness about the limitations to choice can lead to actions that are not helpful to women. For example, a social worker said that nurses did not seem to be aware that women are often not able to safely talk on the phone, and therefore nurses routinely do not facilitate safe follow up.

So I’m left with “I think this woman was assaulted, could you phone her at home tomorrow”. Of course 9 times out of 10 I can’t do that because there is never a safe time to phone them that there isn’t a watcher, a lot of them know that they have their telephone calls monitored or he is always around, there is no safe time they can talk because there is extended family and in some of the ethnic communities they never get to live alone anyway so there is a mother or sister-in-law, a brother or somebody is there so it is never really safe. Those are the ones that it is really hard and what I’ve asked nursing staff to do is let them know here, give them a phone number and tell them to call back and then they can pick the time that is safe and let them know there are services here...That is what I continue to stress, “let them know they can call us” but I continue to get the notes that say “call them in the morning” and I have to assess from what little nursing notes there are whether that would even be safe.

Women who have been abused may know the limitations of the criminal justice system from previous experience, and may decide not to call the police in the opinion that to do so would be more dangerous than not calling. In two specific instances, one in each study site, women who had been choked to the point of unconsciousness were pushed to call the police, but there was no discussion of how the women’s lives would be protected. In one case, the assaultive man was thought to be involved in selling drugs, and to have friends who witnessed
the choking without intervening, suggesting that perhaps the woman’s life would not be safe even if the assaultive man were jailed.

In another example of a lack of awareness of the limitations to community resources, the draft protocol referred to earlier specified referral to transition houses as one of two effective interventions. In that community, however, an average of 1200 women per year (Shelter Statistics, 1997) are unable to be accommodated at the one transition house that exists, resulting in hours of time spent by shelter workers and others trying to find alternate accommodations. Further in that community it is particularly difficult to accommodate women without children (because of the number and needs of women with children). Referral to a transition house may be hampered if a “bed” is not available, or women may not want to go to a transition house. Two women interviewed described very negative experiences when they called a transition house.

Ideas about choice underlie many health care provider’s accounts of their approach to women that have been abused. Women are constructed as having choices, but the choices (to disclose abuse, to call the police, to leave the relationship) are those that health care providers think they should make. Women are constructed as having choices, but are vilified if they do not make the “right” choices, despite the fact that those choices may not be helpful from the woman’s perspective.

**Whose Interests Are Served?**

Although influencing a woman’s choices is an attempt to do “something”, this pattern is counter to the health care provider’s interests in at least two ways. First, the health care provider may become frustrated with the woman if she is unwilling to comply with the health care providers choices for her. Second, health care providers are aware that they may be making choices which are counter to the woman’s interests, and that they may be making matters worse.
**Frustration.** To the extent that the woman is unwilling to be influenced, the health care provider may become frustrated with the woman. Many nurses in both study sites talked about their frustration with women who did not take the options available. Faye was frustrated with women who were unresponsive to her suggestions and returned for abuse-related issues.

I have found in my past experience though, that a lot of them are reluctant, either out of fear or just their pattern, their life pattern, they don’t always want to stop that, they don’t know how to stop that. That I find is very frustrating sometimes, because they - You feel you want to sometimes take them by the shoulders and just shake them and say “you don’t have to do this, you don’t have to stay in this kind of a situation” and some of them are responsive but most of them generally, say “yeah I know” and often you see them coming back in again.

Not surprisingly, frustration arises in relation to the woman not making the decisions the health provider thinks she should make: the decision to leave her partner, the decision to call police, and the decision to accept help and deal with the abuse definitively at once.

Both the desire to influence a woman’s choices and frustration may be borne of fear for the woman and a sense of powerlessness on the part of the health care provider. For example, Faye talked about her fear for a woman who decided to return to an abusive partner after a severe beating. She said “I don’t know, you just pick up really bad feelings and I was really was afraid to let her go, but you can’t do anything if the woman is determined to go back.” Elaine talked about her sense of powerlessness in relation to a woman who had been beaten to the point that she lost consciousness, and was returning home with her several small children.

She would not allow me to call the police and of course, you know, you feel kind of guilty because, your not really helping, like your just.. you know this is happening but...and you know that she could be dead the next week, but you can't, your hands are kind of tied.

Similarly, a head nurse talked about the difficulty of being unable to protect women.

But always in the back of your mind is, she is going to be discharged from the hospital, she is going to go back out there and there is her [abuser] and what if he does kill her next time? So that issue is very, very difficult.
Frustration can lead to health care providers seeing the woman as less deserving, and thus to the justification of “doing nothing” further for the woman. Lulu told me about the Emergency staff’s anger and frustration toward a woman who had been choked, and refused to call the police out of fear for her life.

It upset all of us, everybody was really upset. She ended up stroking and having deficits from the stroke and she was adamant about the police not being involved. Not just myself, but many other nurses in the department were furious with that.

Susan told me about a “non-white” woman who came in repeatedly with migraine headaches.

She didn’t fit the victim model that we like to construct. See, we like people who haven’t accessed services before, have never been offered help, have been violently abused, etcetera, but she didn’t fit it because it had been taking place over a long period of time, she had been offered help before and returned. She had resources to leave but wasn’t leaving and so because she wasn’t doing what we wanted her to do she didn’t get the, I wouldn’t use empathy I would actually use sympathy, that the people tend to get if they fit the mold that we want them to fit and she didn’t fit it. So not only was her physical problem not dealt with but she wasn’t given any empathy or respect because people said “hey, she’s had the choices, she’s had the opportunity, there she is behind the curtain, Social Work is dealing with it” and nothing further was done or said.

Thus, when women return to the Emergency repeatedly, and repeatedly do not make the choices that health care providers think they should make, the woman’s concerns may be dismissed before they are presented. Monica said “It is very easy to be judgmental and say “Mrs. So-And-So is back again and she’s got the usual”. Similarly, Anne saw such judgments as “buying in to the same process” as the women themselves.

C: ...you said some of the nurses more have an attitude of, she’s been here before, she is not going to be doing anything about it. By your hand motion I take it,
A: That’s right, sweeping it under the carpet. That’s a worrisome thing that women will get to that point you see, and why, we are doing exactly the same thing as the woman who refuses to recognize that she is in a violent relationship and do something about it, by being professionals and saying “she’s just going to do it again anyway, she’s not going to do anything about it.” We are in fact buying into her process, buying into the process.
Thus the “deserving victim” can be constructed as not only seriously physically battered, white, not poor, and non-drug and alcohol abusing. She is also a “first time customer”, and compliant with the health care provider’s choices.

Frustration may remain directed only toward the woman, or may lead the health care provider to question whether influencing choices may be “making matters worse”. This questioning, coupled with encounters to the limitations to women’s choices, may shift health care provider’s focus of frustration to the “system”.

**Making Matters Worse.** As well as being frustrated with the women themselves, health care providers also directed their frustration at the “system” for women’s lack of choices, and some nurses expressed their awareness of the limits to women’s choices. For example, one nurse said “...they may have children, where are they going to go, they may not have a facility to live, their family members may not be supportive...”

Many health care providers saw influencing choices as problematic, and questioned whether or not the choices they pressed women toward were helpful or not. Although Lulu tried to convince women who had been sexually assaulted to have a sexual assault exam, she was concerned that having the exam might be “another assault”. Lenore was concerned about the long term impact of influencing a woman to leave her partner, although she did not necessarily apply her reservations to the community in which she currently worked.

When you are dealing in a small community like that it is all relatives, everybody is related so you think you are doing the right thing when you come out here, you get these people out of the house, they go to a safe house in another community, but eventually they have to go back to that community, that is the only life they have ever known, that’s the only people they know.

Yvette worried that the lack of resources available for women might mean that opening the “can of worms” would make matters worse.
It's only going to be short term, isn't it. Okay, so now we get to the point that we feel that we can open up this can of worms and we are staffed, or whatever we are going to do, whether it is just our attitude, then what are we going to do? They can’t all be admitted to the hospital but you can’t put them back in the community. Because they are now more vulnerable than when they came in, and so we have made it worse.

The general lack of opportunity for follow up, which is a characteristic of Emergency practice, leaves health care providers wondering whether they helped, or made matters worse.

We had a case with a young girl who had a newborn and she was being beaten by the father and we had connected her with social work and the Crisis Center and she was going to go to [the transition house] but she had to stop on her way home to pick up things and they told her that she really shouldn’t do that she should just go straight to [the transition house]. I don’t know whatever happened to her though....I think in those cases where we do step in or where [people] do try to help that person it would be nice to hear somewhere down the road what happened. Did it help, did it honestly help what we did, or did it make the matter worse. Sometimes I think you wonder if you influenced a situation out of control instead of [helping]. (Natasha, Admitting Clerk)

It is difficult for all of us in Emerg. because for those of us who hunger for a bit of continuity, which is me and I know some of the nursing staff as well, to know what happened with those families and most of us don’t get that, I don’t get it with most of my [patients]. (Helen, Social Worker)

Influencing choices is justified and supported by ideas of the woman as primarily a victim who is deserving of care, due primarily to the severity of physical injuries. Influencing the woman’s choices serves the interests of the health care system in that women are directed toward existing resources and solutions, but is counter to those interests to the extent that existing resources are inadequate or inappropriate to the particular woman’s situation. However, noticeably absent from most accounts of influencing choices are discussions regarding the ways in which women’s choices are limited; as limits to choices are discussed, the mode of intervention shifts toward offering rather than influencing choice.

Influencing the woman’s choices serves the health care provider’s interests in that doing “something” generates less of a sense of inadequacy than doing “nothing”. However, to the
extent that a woman is unwilling to be influenced, the health care provider may become frustrated with the woman, and to the extent that health care providers encounter limitations to choice, they may become frustrated with the “system” and worry about the appropriateness of the choices they pursue. Frustration with the woman arises from the health care provider disagreeing with the woman’s decisions regarding what the health care provider sees as her choices, and may lead to seeing the woman as less deserving, and thus to the justification of “doing nothing” (further). Such frustration may also lead to questioning the efficacy of influencing choices and to examining limits to choice. Influencing choices may serve the woman’s interests in so far as her experiences are taken as a matter requiring action, and to the extent that the choices meet her needs, but are counter to her interests in that she may be constructed and treated as a victim without agency, be further victimized, and be influenced to make choices she does not want.

Offering Choices: The Woman with Agency

...I try, when we get to that point, I usually try and let her make that decision, I just say you’ve got alternatives, these are your alternatives, would you consider making any of these alternatives a choice for you today? (Anne, Emergency Nurse)

Strikingly different from the accounts which construct the woman as a deserving or undeserving victim are those accounts which construct women who have been abused as having personal agency. Such accounts were accompanied by reports of approaches to care characterized by the offering of choices by the health care provider to the woman. Notably, these accounts construct women in terms which are similar to those used by women themselves, and describe care which the women I interviewed requested of nurses. In contrast to influencing choices, offering choices was characterized by giving up control, and included strategies such as listening, respecting choices, and encouraging the woman to come back. Importantly, nurses accounts of experiencing “success” were characterized by offering choices.
A woman with agency challenges the notion of “victim”. In the following passage, Susan is contrasting a particular woman with her preconceived notion of “the victim”. In this case, poverty, alcohol are not involved, the woman’s skin colour and class are not marked, and she does not have “blatantly obvious” physical injuries. To Susan, the woman is different from her vision of “the victim” because the woman is “dynamic”, and actively discloses the abuse in a “matter-of-fact” manner.

She was a 45 year old lady, very dynamic, she came in with abdominal pain... I picked up on break relief, and I had walked in behind the curtain and the nurse was talking to the patient and the patient just in the course of giving her history said “I usually get sick when my husband is in a bad spot”. The nurse asked “what do you mean by your husband being in a bad spot” and she said “well when he gets in a bad spot he gets very abusive and gets very violent” and neither myself or the other person knew quite what to do with that and the woman was so matter of fact and it was just in passing as in naming your medical allergies or, it was amazing to me and I know the other nurse was amazed because she didn’t do anything with it either. We finished talking to the lady and I can’t actually remember what we said to her but I know that it was totally inadequate, I remember that feeling. We went away and got Social Work involved, but what I remember most about that woman was how she didn’t fit my preconceived idea for what a victim looked like.

Offering choices was a pattern of practice that overlapped with influencing choices within the accounts of many nurses. For example, Lulu, who talked at length about influencing a woman to have a sexual assault exam, and described some women as “passive” and “childlike”, also described instances in which she emphasized the importance of offering choices.

I took them both into the one room that we have with a door, because I felt privacy would be important to her. I asked her if she wanted to tell me what happened and she said that her husband had hit her and that he had made her have sex when she didn’t want to. So with the door closed, I said what do you want to do now? She says, well I just want to check to make sure -- no, it was her leg that she was concerned about, she had pain in her leg, he had been kicking her after he raped her. So I examined that and I talked to her a lot and I gave her choices.

Similarly, Anne, who talked about the team making choices for a woman “for her own good” talked about the importance of respecting a woman’s freedom of choice.

Morally I feel an obligation to help in any way that I can that is supportive to the person without taking away their freedom of choice. I feel that’s my influence, that’s my limit. So
I guess that whole scenario we just discussed, never take away that woman’s logic, decided choice.

**Giving Up Control**

Offering choices was characterized by discussions about “giving up control”. The nurses cited above and others saw shifts in their practice toward offering choices as improvements, and saw these shifts as being related to giving up control through critical evaluation of their own thinking, considering the woman as a whole person, giving up their own interests in “fixing problems”, and putting the interests of the woman ahead of their own interests. They described these shifts as being “hard”. Lenore said “The hardest thing to do is to support whatever decision they [women who are abused] make.” Referring to a woman who refused to have the police involved, Lulu said

That was really hard for the nurses, myself included, because we are here to fix everything and that is something that happened that we could not fix, so what else can we do? ...So it is us rearranging our thoughts and our attitudes to fit what is best for the client, rather than what we think is best and, hopefully, in that case we did that.

Not surprisingly, nurses thought that dealing with the patient as a whole person was the direction in which practice needed to be changed. Here Susan expresses this idea, and her sense that the change would be enormous and difficult.

I thought that we probably needed to change from addressing a single thing about a person to addressing who the person is and who they live with and what their context is and how they relate to other people. I didn’t actually know the best way to do that, actually I was quite, I wouldn’t say dejected, I was aware of what a large task it is to effectively deal [with].

The nurses who had experienced violence in the position of wife were very clear about the importance of control and choice. For example, Kathy said

It has to be their decision ultimately and I think if they know that there is help out there that maybe they will make that decision [to leave] but you can’t force somebody to do what they aren’t ready to do. I think they have to decide in their own mind that they have had enough. I think if we provide information and support that maybe we can give them, I guess give them enough support that they make that decision because I think a lot of times it is just
self-esteem that they feel they can't survive on their own. I think you are beating your head against a wall if you tell someone “you have to leave and you have to go here” because that’s not going to work.

Although Kathy is using the idea of “support” in terms of influencing a particular decision, she is emphasizing the importance of the limits of such an approach, and illustrates the overlap between influencing and offering choices.

Shelby talked about the allure of being able to be the “turning point” in someone’s life, and how she countered her urge to influence the person’s choices and tell the person what to do by drawing on her own personal experiences.

It’s like you want to tell them “this is the rock bottom”, “this is it”. You know, “today’s the day”. You’d love to be able to be that turning point, but I find that when I think about how long it took me to build up that confidence and that strength to realize that I deserve better, and I needed to get out, and I needed to work on me, etc., etc....

In fact, Shelby thought that the biggest step she had taken was being able to respect a person’s choices to the point where she could say “this may not be the day”.

I think maybe I’m doing more than I think I’m doing sometimes, maybe I am empowering more, and by just telling them that this doesn’t have to be the way it is, and that... I think the biggest thing for me to do and the biggest thing, that what seemed to me to feel like the biggest change, and what I said to somebody who had been abused, was “today may not be the day.”

Health care providers who had the most experience dealing with violence at work also tended to be very clear about the importance of not taking control. Social Workers and nurses in leadership positions (Assistant Head Nurses, Nurse Managers), or consultative roles (Clinical Nurse Specialist, Psychiatric Emergency Nurse) and dealt with a number of women who had been abused, talked about the importance of not taking power away. A social worker said:

My stance is very clearly give as much power back because this is the most essential thing that has been lost, separate from the fractured nose or the torn ear or the punch in the stomach, this is what you have to establish is a working contract....sometimes all you’ve got is five minutes, that much time to talk to them and let them know that there is help, it is their choice whether they access it or not and somehow give the message that they have some control over that...That is my agenda, giving control. Nurses can do that too, “this is
available, there are these people here in Emergency that can talk to you and tell you where you can get help, you don’t have to say anything right now, think about it” and give them a card.

Accounts of offering choices were accompanied by descriptions of women as active social agents. In these accounts, women were described as knowing what was best for themselves. For example, Mary said

Most often too, they are going to know what’s right for them. They really know the answers, but it's needing you to validate that and to validate what they are feeling and what they...what their course of action should be and quite frequently, all I find that I am doing is just listening and supporting them to work through what their options are, what their choices are, and which one they are going to chose to follow.

Thus, a critical components of offering choices were listening and validating, respecting the woman’s choices and encouraging her to come back.

Listening

Nurses and other health care providers, and women who had been abused all agreed on the critical importance of listening. Repeatedly nurses talked about the importance of listening in a non-judgmental manner and validating the woman’s experience. Kathy said “I think the big thing is empathy, active listening and being non-judgmental”. When asked what was important to do, Lulu said simply “listening to the patients”. When asked what she would do differently, Bo said “I would have to learn better interviewing skills when dealing, pulling information out of patients. I would have to learn to listen and not talk so much, and cue words to get them to talk.”

Women who had experienced abuse as wives agreed. Alicia, Lana, Louise and Nadia all talked about the importance of listening. When I asked Louise what she thought nurses ought to do in relation to women that have been abused, she said “I think the listening and not necessarily taking an authority position always over a woman. Nadia said “sometimes all it takes is to listen because by the time you have finished a conversation you know exactly what to do”.
Listening can be a powerful experience for women who are currently living with an abusive partner. The elderly woman who I saw in Emergency with supraventricular tachycardia felt she was trapped in her marriage by economics, but greatly appreciated being listened to.

At this moment (we are holding hands), [a resident] comes in and starts talking to the woman by introducing herself and saying that she has talked to [another physician]. I make to withdraw, and the woman looks at me a bit tearfully and grips my hand, holding me to the bedside with amazing strength. “Thank you for letting me talk, thank you for listening.” (Field Notes, July, 1996)

This woman later thanked me again, and offered to help with my study, and as mentioned earlier, offered me money and tried to write me a cheque for the local shelter. Similarly, after having an experience of being listened to by Bo, Nadia described the experience in very positive terms. Although Bo spent no more time with her than with most of her patients, Nadia said “I got more attention from you two than I got in nine years from my husband…”

Listening is in direct opposition to the patterns of practice in Emergency nursing that dictate that nurses maximize their efficiency by staying focused on dealing with physical problems. Listening requires a time commitment and an emotional commitment, and in order to take the time to listen, nurses must see listening as being in their own interests, and be prepared to make the emotional commitment to listen. In several stories of “success” in dealing with women who had been abused the success was attributed to the nurse having time. For example, Nicole said “You have to look at the whole picture, our whole job, it was quiet, I had the time.”

Taking the time to listen is sometimes done in defiance of the rules, and in defiance of peer pressure, and is sometimes woven into practice in a skillful manner. Anne described listening as part of an approach to care in which she initially focuses on the physical, and then returns to talking and listening to find out what the woman wants as a prelude to offering choices.

Presently I certainly will tend to nurture the physical things first and deal with that in sort of a very clinical process, make her safe, make her comfortable, make all of those adjustments. I don’t usually bring up the why this happened sort of scenario, maybe just initially so I’ve
got that that is part of it, then I kind of let it go and deal with the physical side, then
certainly before the lady leaves I will re-address it, you know, look we’ve got to talk about
it, let’s talk about why this happened. Then I let her talk, get a feeling for what her attitude
is towards having been violated in some way. What is it, is it an issue of concern, am I
likely to have any luck with follow-up and what kind of follow-up is most likely beneficial
to her, is it someone in her own group, is it a family member or is it someone like Social
Services or the Police.

Respecting Decisions

Offering choices without influencing those choices required respecting women’s decisions.

Even after attempting to influence a woman in a particular manner, some nurses described
accepting and respecting the woman’s choice. For example, Faye described without acrimony
the decision to return home made by the woman who she “had to the point that she was
convinced”.

During the time that she was sitting there she changed her mind and said she wanted to go
home. She ended up going back and I said “if you ever change your mind you can just
come here and we’ll set you back up again”.

Thus an important choice offered was the opportunity to come back. Nurses repeatedly
described encouraging women return, using terms such as “leaving the door open”.

So, you need to go in and be able to act on it, or at least be able to give her the option of
saying “look, do you want us to do anything, do you want us to give you some follow-up on
this” and if the woman says “no, I’m quite happy the way it is at the moment” at least
you’ve opened it and you’ve put the seed there and if she has problems she can either go
back to her doctor... whatever. At least open the door for her. (Monica, Emergency Nurse)

Well, I think what I did was I encouraged her to come back if she’s having problems. I
guess all you do is hope that one day when they do come in that, you’ve been giving them
support from previous, somewhere down the line it’s going to be them that says yes.
(Nicole, Emergency Nurse)

Accounts of Success

Interestingly, accounts of success were accounts of offering choices. During interviews I
asked nurses to give me an example of a situation in which they felt that they had made a
difference to a woman who had been abused. Lulu’s experience of success was as follows:
She did end up seeing the social worker here and had follow-up visits with the social worker for about three weeks; she kept coming in to see her. She ended up going home with the girlfriend, so she wasn’t comfortable going back to her own home at that particular time. But it was her choice.

Mary described what she thought she did that contributed to her feeling of success in relation to a particular woman.

...if anything it was just absolutely listening to her and kind of opening doors and getting her to look at her options and where her supports lay and where her possible areas of danger lay and having her tell this to me brought them all out on the table and kind of made a turning point for her, she could see them in front of her and...she said them out loud and they became real, and you did that by just sitting and listening.

I asked Palen if she ever felt that she had “made a difference”. Her reply illustrates that although she had ideas about what this woman’s choices ought to be, and encouraged the woman toward those choices, she also respected the woman’s choice and “left the door open”.

C: ...Have you had a specific instance in which you can remember feeling like you made a difference?

P: Yes, my very first abuse in [another hospital]. It was wonderful. She was a really tiny, pretty, little blond with a very abusive fellow and a small child. She came in maybe 2, 3, 4 times in a row and I documented and I talked to her and I gave her numbers and every time she came in I would say “you know you deserve better than this, you can get away from him, I have places for you to go, I have people for you to talk to, there are safe places you can go to be away from him”, we just went through the whole protocol every time she came and then one time she came in with her daughter who was sick and her daughter and herself and her father came in, and she had left him.

C: So after that you felt like you had contributed to that in some small way and

P: She verbalized that I did, so that was nice.

C: What did she say?

P: (pause) “Thank you”.

C: That doesn’t happen to you very often, does it?

P: (long pause, breaks down crying). No (quietly whispered). So we can make a difference, every now and then (struggling to regain control).
Experiences of success were rare partly because nurses have little opportunity for follow-up or may not be on shift when a person returns, and if the nurse’s actions did contribute to ending violence in the woman’s life, the woman may not have a reason to return to Emergency.

Offering choices led to experiences of success partly because the approach was better for women, and partly because the nurses defined success differently. Offering choices allowed success to be redefined. Rather than success being defined in terms of a woman making a proscribed choice, success could be defined in terms of the woman making her own choice. Monica and Lenore both said that they had begun to see their practice as extending beyond the immediate situation.

You have a feeling of accomplishment because you feel that you are doing something, not just sort of taking care of the immediate situation, which I think used to be Nursing, you take care of the problem and then they go somewhere else, but now there is the responsibility of what happens after that, that something goes on and that you have people that you can put in contact with them.

**Whose Interests Are Served?**

Clearly, offering choices is predominantly in the interests of the women who have been abused. Offering choices and respecting the choices a woman makes are more likely to lead to outcomes that are meaningful and helpful to the woman than “doing nothing” or pressing a woman toward health care provider’s choices. Offering choices would not be in the woman’s interest if the choices are not available.

Offering choices and respecting choices required time and carried an emotional cost for the nurses that I interviewed. Nurses found it hard to see women return to dangerous situations, and talked about the women for whom they had cared with various emotions, including fear and sorrow for the woman. Lindsay described her feelings about a woman who she has seen repeatedly in relation to abuse.

There is one particular gal, who is not Native but has been living on the reserve with a gentleman for a lot of years... I was on probably 3 times in a row over 3 or 4 months where she had come in with a broken nose, a fractured cheek bone, bruises everywhere and she
would say [David] “did it” and I’d say “do you need some help, here is the Social Worker, what can we do about this for you”. I felt so intensely emotional for her that she was stuck in that crack, in that cycle of abuse “well he said he was sorry and he promised he wouldn’t do it again” and off we go back up to that circle. I never, I still see her coming in once and a while and she has been better. She says she had got a job now and she is doing well. I didn’t ask about [David] as to whether they are together, I just let her talk to me.

Despite the emotional and temporal cost, offering choices was in the interests of nurses and health care providers in that it led to experiences of success. Offering of choices is counter to the interests of the hospital and health care system in the short term, in that offering choices requires time, and may result in increased pressure on existing resources. Further, if nurses see offering choices as counter to the interests of the hospital, they are less likely to pursue such strategies.

Toward Untying Our Hands

The nurses in this study knew what was required to improve care. Their ideas were expressed variously, but collectively they identified changes to their own thinking, and changes to the context that would be conducive to effective responses. Bo thought that what was required was an emotional commitment to dealing with abuse.

We need somebody who has a genuine keenness about it, like a cancer it spreads and then the other person gets it and they get keen, it’s like seeing when you first came and everyone says “no we don’t get involved in this”, but then one or two do and then think, this is not bad, this is really kind of keen and now you are overrun by people who were maybe slightly frightened, they are not frightened. Because they really are not too intimidated as to help, it is to help, it is to care.

Susan thought that there were three elements to improving practice: 1) self-knowledge, 2) organizational support to treat more than physical complaints with priority, and 3) considering a person from a holistic perspective.

The first step might be if we as nurses were better educated to know who we were and the ways that we brought that into an interchange. If we as nurses were given the freedom and support to know that violence or abuse or alcoholism or any of the other shady things were just as valid and needful of your time as the physical complaint was and that we should actually, the same where we see an ST elevation and we go “MI? You get my time, I’m yours for an hour”, maybe we should be looking at that. We would make just as big a difference... if we said “Right, violence? You need me, I’m here” or “You need someone
and they are there”, but it is not given the same weight at the moment and like it or not we
don’t practice in isolation and we pick up what other people think, believe, feel. That would
be another step that we could take. The third one would be what I already said, addressing
the person as a whole as opposed to addressing pieces of them, which is not only ineffective
but wastes a lot of time and sticks a nice big label on the patient.

Shelby saw the improvement of practice as beginning with health care providers challenging
the idea that they are different from women who have been abused. She argued that there is a
continuum of abusive behaviour in which we all participate.

S: I think just people need to pull away and say to themselves, “how different are we really
than any of these people - the ones being abused, the ones doing the abusing.” I mean it’s
all just a matter of extreme, it’s all on a continuum..

C: And we’re not above it...

S: No! I mean we’re right in the middle of it. We’re all in it, because really all it is, is
human nature and how we treat each other, and it’s just that what we’re seeing and what
we’re trying to help is pull the extremes more towards the middle..

She argued that not only are health care providers people who may be abusive of others, but that
they also accept abusive behaviour from others.

..when we’re angry, you can’t say that we’re not mean occasionally to people and it could
be categorized as a little bit of emotional abuse, on the other end you can’t say that we
haven’t accepted it and not said things. I mean... there have been times when I’ve accepted
condescending attitude and condescending stuff from the docs at times, where it has
hampered me from being able to fully develop as a professional nurse in the Emergency
Department because I haven’t had the confidence...

She thought that in order to change, nurses and other health care providers need to see
themselves as part of the problem in order to be part of the solution.

I mean really, it’s a continuum, we’re all on it, and I think when you kind of... I hate to use
the word, ‘force’.. but when you do force people to take a look at themselves as being part
of this whole picture and not just a separate entity, then maybe they’ll start to realize that
well, then of course, it’s got to be my responsibility, and how could it be that hard?
Summary

In dealing with violence in the Emergency setting, the three patterns of response that I have described: doing nothing, influencing choices, and offering choices, are neither discrete nor mutually exclusive. Furthermore, individual health care providers did not describe only one pattern of response. Rather, these patterns are overlapping and intersecting. For example, a referral to a social worker can be a shifting of responsibility to enable the health care provider to do nothing. Such a referral can also be part of taking control and influencing the woman's choices, or it can be a choice offered to the woman.

"Doing nothing" seems to serve the interests of the health care system best, and is congruent with dominant interests in society at large. Doing nothing seems to serve women who have been abused least, in that the woman's experience may be minimized and negated, and in that no action is taken to deal with the abuse. Doing nothing serves the interest of health care providers in that they can maintain their efficiency and limit their emotional involvement, but only serves these interests to the point at which they see doing nothing as inadequate. At this point, doing nothing intersects with the modes of intervention.

"Influencing choices" also serves the interests of the health care system in that women are directed toward existing resources and available solutions, but only serves those interests to the point that those resources and solutions are actually available, and end violence, preventing further abuse related health care costs. Influencing choices serves the interests of women who have been abused to the extent that the available resources and solutions are appropriate from the woman's perspective, but may leave a woman feeling disempowered and further victimized. Influencing choices offers the health care provider a sense of adequacy that is greater than that incurred by doing nothing, but is counter to the health care provider's interests when influence
fails, leading to frustration with the woman and/or the limitations to choice imposed by the context.

"Offering choices" seems to best serve the interests of women who have been abused, in that they may have a wider range of options, and may be able to make safer choices for themselves. Offering choices serves the interests of health care professionals in that this pattern may lead to a sense of success rather than frustration. However, offering choices requires an emotional and time commitment on the part of health care providers, and may lead to frustration at the limitations to choice. Offering choices least serves the health care system in the short term, in that women may make choices that put added strain on existing resources, and increase the demand for further resources. However, in the long term, if offering choices holds the best promise for ending violence, this pattern of response will also best serve the health care system's interests.
CHAPTER NINE

UNTYING OUR HANDS: CONCLUSIONS AND IMPLICATIONS

Early in my field work several nurses referred to having their hands tied in relation to dealing with violence. “What can you do?” asked one nurse, “Your hands are tied”. Later, nurses used the same phrase to talk about their practice in general, especially with regard to their sense of a lack of control over resources. Indeed, a feeling of helplessness and hopelessness at the overwhelming nature and scope of the problem of violence against women was commonly expressed by those I talked to and interviewed, and was often a shadow at my shoulder as I worked through the process of creating this study. However, more often, nurses and others in this study shared a sense of hope and commitment to making a difference. It is with this sense of hope and commitment that I now turn to drawing some conclusions and making some suggestions about how we could untie our hands to deal with violence through nursing practice.

Conclusions

The primary objective of this study was to describe how the structures and relationships within the social context affect nurses' practice with women who have been abused, and to describe how nurses' practice in turn affects the context. In relation to this objective, the conclusions that can be drawn from the interpretations of the data as presented are as follows:

1. The social structures and relationships within the context of Emergency nursing practice create patterns of practice which obscure violence and which can produce the neglect of violence.
2. The patterns of practice which obscure violence and foster neglect arise from the influence of dominant interests on the allocation of health care resources and are sustained by an ideology of scarcity in health care.
3. The predominant practice pattern, in which patients are efficiently processed creates moral conflict for nurses in regard to their practice in general. The possibility that violence is neglected in this efficient processing creates further conflict and adds to nurses' feelings of inadequacy.

4. Dominant ideologies embedded in discourses about gender, class, and "race" influence the degree to which health care providers see certain individuals as deserving of care in general and, intersecting with discourses of violence, influence the ways in which health care providers recognize and deal with violence and abuse.

5. When individuals practice in congruence with dominant ideologies, collective practices that sustain unequal power relations are facilitated. With regard to violence and abuse, violence is overlooked and dealt within ways that reproduce power inequities. Conversely, when individuals practice in resistance to dominant ideologies, collective practices that challenge unequal power relations are promoted. With regard to violence and abuse, such resistance can create collective practices that can contribute to ending violence and abuse.

The overriding conclusion that can be drawn from this study is that ideology that sustains violence is the greatest barrier to health care providers contributing to ending violence against women. That is, it is ideology that ties our hands. It follows then, that the route to untying our hands in relation to ending violence, is to begin with unmasking these ideologies and the practices they sustain, that is, developing a critical consciousness. In this study, I have attempted to examine those ideologies which seem most salient to the neglect of violence against women. It remains for individuals to examine what beliefs and assumptions they hold, how their ideas influence their practice, and how their own interests are served by these ideologies. As Bannerji (1994), following Marx, notes, without the agency of individuals, "no transformative politics would be possible" (p. 18). I believe that critical reflection upon personal experience is
particular powerful for this task of developing a critical consciousness, of unmasking ideology and the ways in which ideologies serve specific interests. Acting with greater awareness of dominant ideology, individuals can practice in greater resistance to such ideology. And from individual practices, collective practices of resistance can be created. From these conclusions, there are three central areas that I will discuss and examine for implications and possible directions for action: ideology, personal experiences, and collective practices.

Ideology

The ideologies that contribute to obscuring violence and producing the neglect of violence in health care are not all specific nor particular to violence, nor specific nor particular to health care. Rather, some of these ideologies are those that sustain unequal power relations throughout society and sustain particular forms of violence against certain members of society. The health care practices examined in this study were enacted primarily in congruence with intersecting dominant interests of wealth, class, “race”, gender, ability, age, sexual orientation, and so on. These practices serve dominant interests through ideologies embedded in discourses which function to sustain unequal power relations. Although all these various interests intersected to influence practice, class and “race” were particularly salient. Three specific areas of discourse will be examined: discourses of scarcity in health care, the discourse of deservedness and discourses of violence, including those that pauperize and racialize violence.

Within these areas of discourse are dominant ideologies, that is, ideas and images that function to sustain unequal power relations. Most insidious are the ideas and images that *appear to counter* unequal power relations, yet serve to mask those very power relations. The discourse of scarcity predominates, insuring that certain interests are served, yet this discourse is masked by rhetoric about “health for all”, “universal access” and so on. Similarly, discourses of
multiculturalism and equality serve to mask the interests of white supremacy. The implications then, is that in unmasking dominant ideologies these more subtle ideas and images must be revealed.

**Scarcity in Health Care**

In this study the ideology of scarcity, replete with images of sparse, insufficient, and shrinking and resources, influenced practice in the Emergency setting to the extent that the predominant practice pattern was oriented to the efficient physiological processing of patients using minimum resources. The ideology was pervasive, and although nurses were oppressed by the set of practices such ideology sustains (for example, by nurse/patient ratios inadequate to provide care with which they were comfortable, staffing patterns that limited steady employment, workload created by lack of services elsewhere, and so on) they unwittingly reproduced this ideology, by rationing resources and buffering patient dissatisfaction with care. Other ideologies, such as those about individual responsibility, “race”, gender and class also pervaded the context, particularly influencing nurses’ judgments about how to ration resources, and thus sustaining existing power relations by allocating resources to those already more privileged.

As patients are processed as physiological problems, and as immediate consequences of physical problems (as opposed to the causes of problems) are the focus of intervention, the overall health of patients is not served by this pattern of practice. In particular regard to violence, as noted earlier by Kurz and Stark (1988) health care providers categorize abuse along with other diseases that require treatment. Only the immediate physical consequences of violence and abuse are addressed, the causes of abuse are not addressed, thus the health of those abused is not served, and power relations are sustained as abuse continues unchallenged. In fact, Ratner’s (1995) suggestion that the negative effect of contact with health care providers is due to the
consequences of their focus on physical injuries to the exclusion of attention to the nature of the woman's experience, is a contention supported by interpretations in this study. Thus, the predominant patterns of practice may make matters worse for women who have been abused.

The predominant practice pattern caused significant conflict for nurses, both in regard to their practice in general and in particular to violence. Although the pattern allowed them to do the best they could within the resources available, most nurses in this study felt inadequate. Ray (1987) described the conflict between the demand for nurses to "define themselves in economic and accounting terms in the health care system", and the "need to preserve the humanity of the patient through caring activities", as one of the dominant moral conflicts of contemporary nursing. Similarly, Mohr and Mahon (1996) asserted that in the United States, marketplace health care may be incompatible with ethical behaviour. Importantly, however, nurses in this study often saw the shortcomings of practice as individual professional failures rather than as ethical dilemmas. In an ethnographic study of the care of "frequent flyers" in Emergency, Malone (1996) observed that nurses often experience their failure to "fix problems" as personal failures, "when it is actually the social and medical systems that have failed to support both patients and caregivers" (p. 182).

Concurring with Malone, I believe that individuals and groups at all levels of the social and health care systems are answerable for the inadequate response to violence against women, and thus all must contribute if meaningful changes are to occur. As the response to violence arises from ideologies and practices which are not particular to violence, the required changes are not all particular to violence, and are required at the level of social policy, hospital policy, and in all modes of nursing practice. Ideological workings must be unmasked in order for worthwhile
changes to be possible. Alternative ways of thinking about resources must replace scarcity as the primary driving force in health care.

Such alternatives might include “power sharing” as suggested by Gloria Smith (1997), “holism”, or health promotion frameworks. By “power-sharing”, Smith is proposing an alternative to the scarcity model. Smith argues that in the scarcity model, resources are seen as finite, and that if you give up power, you have less of the total available. Power-sharing posits that total resources can be increased, but in order to do so, power must be relinquished. By “holism” I am referring to the concern with the whole person that has been espoused by most nursing theorists. Power-sharing, “holism”, and health promotion suggest that cost-benefit analyses of care replace cost-efficiency analyses, suggestions that have been made elsewhere (e.g. Ray, 1987).

To better serve the health of patients, and in particular, the health of those who experience violence, I suggest using a four-part strategy for countering ideology: 1) recognize ideology and its influence, 2) consider the interests served by dominant ideologies, 3) assess individual interests in light of other interests served, and 4) determine actions based on one’s own analysis.

The ideology of scarcity must be recognized and refused, and replaced with a critical awareness of ideology at the level of social policy and hospital policy and within nursing.

Critical Awareness at the Level of Policy

Policies based only on fiscal concerns must be challenged, and instead policies must be also based on concern with health and social justice. First, the very notion of a fiscal crisis in health

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1 I am using the term “health promotion” in its most generic, “lay” sense, rather than with any theoretical rigour. I am not advocating a particular “framework”, but rather adding my voice to the call for a concern with health and holism, argued widely in many disciplines. In addition, however, I think that the strategic use of health promotion rhetoric may be useful for nurses and others to advance agendas of social justice.

2 I am not, however, simply advocating that a “nursing model” be imposed on nursing practice. To do so within an ideology of scarcity would only create more conflict for nurses by sharpening the contrast between how they can work and how they want to work, and by adding to the mixed messages they receive about how they should practice.
care must be examined. Northcott’s 1994 analysis of health care spending suggests that the fiscal
crisis in Canada is actually a crisis of debt and debt servicing, and that “the perception of a crisis
can be manipulated and used to induce a passive acceptance for the previously unacceptable” (p.
8). Further, he claims that

The politics of fiscal austerity have a tendency to become the politics of blame, as
governments, service providers and tax payers defend their self-interest by assigning blame
to others and by justifying their preferred strategies. The crisis rhetoric appeals to the
emotions and calls for exceptional sacrifice - sacrifices that the aging population and the
health care system have made and will be called upon to make. [These sacrifices] reflect
politics of austerity variously justified by the rhetorics of the alleged health care, aging and
economic crises. (p. 21).

The exposure of ideology offered by this and other critiques (e.g. Minkler & Robertson, 1991)
suggest that nurses should become critically aware of the relationship between political economy
and health care, and should seek involvement and influence wherever possible. In particular, in
this study the ideology of scarcity which pervaded the Emergency setting can be heard as an echo
of the crisis rhetoric, and as such, must be thought through with critical awareness.

The fact that the resources that nurses are working with have been allocated by some one or
group (rather than simply being a “fact of life”), and the fact that nurses are allocating and
rationing resources must be recognized by policy makers and nurses, including practitioners and
educators. If thinking is to be changed at the level of policy, nurses with a commitment to social
justice must become engaged with policy formulation. This further suggests developing
interdisciplinary skills, as policy is formulated within multidisciplinary contexts. Nurses
currently in leadership positions must take interest and action in policy advising and formulating
bodies at all levels. Nurses who are in clinical practice must be encouraged and supported to be
involved in decision-making bodies. Specifically nurse leaders must advocate for economic
support for nurses who earn hourly wages and therefore are not paid for professional
involvement outside clinical practice, and offer mentorship and encouragement to nurses who may lack confidence entering multidisciplinary arenas.

Educators can particularly contribute to unmasking ideology, specifically by offering critical analysis of health care economics, and promoting an understanding of the relationship between economics, health care policy, and how we actually do what we do in nursing practice. Further, educational experiences must include opportunities to develop skills and confidence in interdisciplinary relations, and communication skills useful in meetings, lobbying, and so on.

Research must be undertaken to examine the ways social and health care policy functions ideologically and influences nursing practice toward social injustice. More nurses must develop skills in policy analysis so that they may explicate the impact of not only government policy, but also local hospital and unit policies. Such analysis must occur through both formal research and routine policy analysis in practice. Ideological workings in policies and their enactment must be constantly interrogated. For example, data in this study suggests that drug and alcohol screening policies and practices be examined from ideological and ethical perspectives.

In addition, I believe that all nursing research must be examined for both its ideological workings and its policy implications. For example, nursing research in the area of violence against women should be considered for the ways it may support or resists power inequities. Recently there has been a trend toward examining violence among certain “racial groups” (see for example the NNVAWI conference proceedings, 1997). In what ways can these studies sustain and perpetuate, or challenge and resist, racist stereotypes? Before policy and practice implications can be proposed, careful analysis of ideological workings must be undertaken.
Critical Awareness at the Level of Practice

Throughout nursing, rather than participating in an unquestioning manner, nurses must practice with an awareness of their own role in resource rationing. The trick of presenting resource decisions as “reality”, masking the fact that all resource allocation decisions are, in fact, decisions, must be recognized as such, so that the points of decision-making can be identified. The idea that “there is no money (or time or resources)” must be challenged with the idea that there is money, but it has been allocated elsewhere. Alternative ways of thinking about resources must replace scarcity as the primary driving force in health care and as the unexamined ideology underlying nurses’ understanding of their practice world.

In particular, I would like to draw attention to the ways nurses talked about their time in this study: time was seen as short, lacking, inadequate, non-existent. Based on her analysis of nurses’ talk about time in several of her earlier studies, Stelling (1994) concluded that this talk about time is not really about time at all...When nurses say they do not have time for interactional work with patients, the real problem is that they are unable to maintain its high priority when confronted with the demands and expectations of others. Thus time can be seen as a metaphor for autonomy and control; the emphasis on the shortage of time reflects the importance and pervasiveness of the lack of autonomy and control. (p. 210)

Rethinking lack of time as a lack of autonomy and control, suggests different implications than simply augmenting time, and I suggest that this is a component of rethinking scarcity.

I am suggesting that when nurses in practice are told that there “is no money” for a triage nurse, they should counter with the understanding that this rhetoric presents what is actually a decision as an inviolable fact, and request a fuller accounting as to how the decision was made, and among what other priorities the need for a triage nurse was considered. Further, nurses should continue to strive to be actively involved at every possible level, in every possible
decision. If even half of the nurses in any one Emergency inserted themselves into the decision-making process, the impact would be profound.

Specific to Emergency, practice driven by alternatives such as power sharing, “holism”, or health promotion must replace practices driven by scarcity. Nurses in this study knew what would make their practice better, but were limited by both the material conditions of practice and the ideology of scarcity. Change will depend not only on unmasking the ideologies, but also on changing the material conditions of practice, thus both politics and action are required.

In her ethnographic study of two inner city trauma center emergency departments, Malone (1996) concluded that

frustration with a system that focuses on control often leaves ED [Emergency Department] clinicians feeling like failures as they try to pick up the pieces for failing or absent families, communities and social programs, can contribute to the stigmatization of HU [Heavy User] patients, missed clinical diagnoses, and reduced nurse morale” (p. 176).

Staff nurses alone cannot rectify the failings of the social and health care systems. In fact, Malone recommends, and I concur, that nurses need to acknowledge the limits of their control and responsibility, and not accept blame for the restrictions to practice imposed by the structures of the health care context. Excavating the ideology of scarcity will contribute to a clearer understanding of the maze of influences responsible for creating the features of practice.

Examinations of what such practices would look like in contrast to practices driven by scarcity need to be undertaken. If a power sharing model were used in Emergency Nursing practice, nurses would focus on mobilizing different resources (e.g. family members, communities, groups) differently. What if, for example, Alcoholics Anonymous were invited as partners to offer services to people who wanted help with alcohol addiction? What if nurses

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3 I am not naively suggesting that nurses should simply get “more of the pie”, but rather that they participate actively in decision-making regarding resource allocation, that such allocation be informed by nursing’s invaluable perspective, and that decisions be based on more holistic views of health and health promotion than currently operate in many settings.
refused to “throw out the drunks” to empty stretchers, and insisted on treating alcoholics like “people”? Malone (1996) recommends that nurses engage in simple recognition and inclusion practices with “frequent flyers”, who “revealed strong attachment to hospital Emergency departments as institutions of not only helping, but recognition and inclusion” (p.180).

If a health promotion approach were used, Emergency Nurses could also focus on causes rather than solely on the consequences of health problems. What if, for example, constipation, a major cause of abdominal pain in people presenting to Emergency, was addressed? What percentage of repeat visits could be prevented? What if nurses refused to simply give alcoholic street people bus fare to the next community, and instead insisted on offering interventions aimed at the long range health of such individuals? Again, what would be the long range savings in terms of human suffering as well as economics?

Such suggestions imply a need for focused effort. I would suggest that partnerships between educational institutions and health care settings could be strengthened to foster such innovations. For example, faculty could work with clinical staff to obtain funds for pilot projects and research, and collaborate on research. Educational experiences should increasingly permit students to collaborate with staff to innovate programs. The number of practice change opportunities offered within research utilization or policy analysis courses should be increased. Nurses could increasingly forge interdisciplinary alliances, especially with physicians.

Specific to violence then, alternative ways of thinking, such as power sharing and health promotion, should be used to drive practice. For example, using such thinking, practices such as universal screening would shift from a tool of efficiency to a tool of resource mobilization and would be focused on health outcomes for women, rather than on compliance rates with screening tools, or identification rates. Such shifts in violence-specific practices must be accompanied by
shifts in the general approaches to practice. Imposing a health promoting, power sharing approach to violence upon an efficiency-driven practice context would be unlikely to succeed.

When asked, the staff nurses in this study already knew what strategies would be more effective in dealing with violence and abuse, but, participating in patterns of practice dominated by scarcity, they were largely oblivious to the problem. The strategies that would most improve practice in dealing with violence: listening, offering choices, respecting, supporting and so on, are those which have been suggested in the literature (e.g. Fishwick, 1995; A. D. Henderson & Erickson, 1994; Hoff, 1993; Yam, 1995), and are strategies which would also improve nursing generally, but are counter to the predominant pattern of practice. Thus, improving practice in general, or in particular to violence will require replacing the ideology of scarcity.

In order for nurses in practice to recognize, refuse and replace the ideology of scarcity, support is required from nursing education and research. As noted, education of nurses must include critical analysis of health care policy and economics. Further, research is required to bring efficiency and the promotion of health together in nursing in a meaningful manner. Cost cutting and cost shifting, which have been the primary responses within the Canadian health care system to economic depression (Rachlis & Kushner, 1994) must be replaced by the redistribution of resources in a way that will actually improve health rather than merely save money. To determine how to best deploy nursing resources, research focused on health outcomes in relation to nursing intervention is required. To follow the example of constipation, study of the impact on health outcomes and return visits to an Emergency might be able to demonstrate the value of nurses investing their time differently in Emergency.

In summary, the ideology of scarcity drives nursing practice in Emergency in ways that create conflict for nurses and ultimately do not serve the health needs of patients. In order to
transform practice in ways that would be meaningful to both nurses and patients, nurses must first recognize their participation in these “relations of ruling” (Smith, 1990), and then seek alternative ways of thinking and practicing.

Deservedness

One of the ways that nurses participate in and reproduce the ideology of scarcity is by making judgments about who is more or less deserving of care. Drunks, drug abusers, “frequent flyers” are the most obviously “undeserving” in Emergency. Underlying these and other judgments regarding deservedness are the ideas, images and assumptions, particularly about class, held by nurses and other health care providers. For example, it is not merely alcohol abuse that makes a person less deserving; it is being poor and abusing alcohol, for poverty, as this study shows, makes a person more open to health care provider’s scrutiny, and poverty makes alcoholism more visible. “Frequent flyers”, the people who use Emergency repeatedly, generally have multiple health and social issues: most commonly chronic illness, poverty and drug or alcohol abuse. As Canada’s “social safety net” frays, and the ideology of scarcity drives the entire social welfare system, the Emergency unit in increasingly pressed to deal with and sort those who fall through the net. As Rachlis and Kushner (1994) note, “the poorer you are, the worse your health is, and the greater your need for health services” (p. 158). And, given the economic impact of health, the worse your health is, the poorer you are likely to be. Yet, in the Emergency, the poorer you are, the less deserving you are seen to be.

As “race” intersects with class, the deservedness of people of colour are judged using both classist and racist ideas. “Culture” is conflated with “race” and used to explain all sorts of health problems and behaviours. In respect to violence, using such ideas, health care providers both assume violence occurs and dismiss abuse as a “cultural problem” among certain people.
Gender bias in judging the deservedness of care was not specifically examined in the everyday practice of nurses in this study. However, the way in which Emergency units are structured to privilege certain health problems demonstrates how deeply gendered and embedded is the notion of deservedness. For example, Emergency units are physically structured to most effectively deal with chest pain and myocardial infarctions (the monitor beds are always central), long thought to be predominantly male problems, and many nurses know that their ideas about the presentation of chest pain are biased toward recognition of male symptoms. Maximum resources are mobilized dramatically when a patient is infarcting. Contrasting this allocation of resources with the lack of attention to violence against women suggests who is seen as most deserving in our health care system.

The idea that nurses make social judgments regarding patients is not new. Nurses constructing patients as “good” or “bad”, “popular” or “unpopular” and the role of social judgment in power relations, clinical decision-making and pressure to get patients to acquiesce to nursing and medical goals have been previously studied (Carveth, 1995; Johnson & Webb, 1995a, 1995b; Kelly & May, 1982). However, unique to this study is the way in which the idea of deservedness functions with the ideology of scarcity to allocate health resources in ways that sustain unequal power relations. As Rachlis and Kushner (1994) note, “the rich get richer ... the poor get sick” (p. 85). And, as any estimate of the health of First Nations peoples in Canada illustrates, the “not-white” get sick too. This study illustrates how at a local level nurses are unwittingly participating in these dynamics through judging deservedness.

This interpretation sheds new light on previous research (Kurz and Stark, 1988) which found that health care providers responded positively to women they saw as “deserving”, “true victims” of abuse and did not respond at all to women they saw as undeserving because the
women were evasive or used alcohol or drugs (p. 256). The present study suggests that this process is a specific case of social judgment that is integral to the routine provision of care, and fundamental to rationing limited resources within dominant ideologies.

Countering this complex ideological system again begins with the unmasking of ideas and images and examining how they function. Nurses must examine the bases of their judgments in determining deservedness and rationing resources. In order to transform practice toward social justice, nurses must begin the enormous task of unlearning racism, classism and sexism and adopt anti-racist, anti-classist, anti-sexist strategies, beginning at the triage desk. Nurses must also learn to see health problems and individuals with health problems within their social contexts. Such transformation is especially difficult in the Emergency where practice is focused on reducing a person to, and dealing with a single manageable physiological problem.

Nursing education can contribute to this transformation by including analyses of social and health care policy and an emphasis on study of the social determinants of health. Explicitly anti-racist and feminist pedagogy must be employed to assist nurses to examine and unmask ideology underpinning practice. Educators must purposefully use clinical experiences to challenge dominant ideologies, rather than to merely learn congruence with predominant practice patterns.

In nursing practice, education and research, particular attention must be paid to the violence done to people in the form of racism and classism, especially within health care through the notion of deservedness. And discourses of violence must be extended to encompass more than just the obvious and physical violence done to women.

**Discourses of Violence**

The discourses about violence that predominated in the health care settings in this study were discourses that pauperized and racialized violence. In these discourses are embedded
classist and racist ideologies. However, at a more fundamental level, these ideologies function to sustain unequal power relations with images of the less privileged as more violent, and thus protecting the more privileged from accusations of violence, allowing violence with impunity.

I have concluded that all dominant discourses about violence sustain unequal power relations by separating the violent from the non-violent. Dominant interests are served by discourses of violence that separate the violent from the non-violent, and violence from everyday behaviour, because if violence was seen to be an extension of taken-for-granted patterns of abuse of power, then countering violence would call into question all unequal power relations that characterize our society. If, for example, what “counts” as abuse was expanded to include dominance enacted through demeaning remarks, angry silences, and so on, then each person’s oppressive behaviour could be seen as contributing to a violent society.

Dominant interests are thus served by discourses that make violence a problem of “other”. For example, those who see themselves as “different” from poor people are served by discourses replete with images of the poor as violent and themselves as “above” violence, because such discourses preserve notions of class superiority, limit scrutiny, and permit more violence with more impunity among certain people. White people are served by discourses of black people as violent, for the same reasons: white violence is overshadowed, made less visible. More powerful men, (and men are not all equally powerful) are served by discourses that make violence a problem of certain men: black men, poor men, “sick” men. And women are served by discourses that make violence a problem of men. Individually and collectively we engage in a circular dance of making violence someone else’s problem.

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4 I am using the term “black” in its political sense signifying people who experience racism on the basis of skin colour.
5 I had a particularly difficult time reconciling myself to the existence of female violence, until I understood violence as an exacerbation of unequal power relations. Using this perspective, I could see women’s relatively low
Thus ways of thinking and talking about violence that separate violent from non-violent, and permit those with privilege to posture as non-violent, mask the violence of some, and expose the violence of others. Thus both class and “race” can be seen as social categories particularly convenient for distancing violent from non-violent.

Individual interests are served by ideas that separate the self from the violent other. To the extent that individuals are members of dominant groups, these ideas function in their interests. However, as sites of dominance and oppression intersect, these discourses are also counter to individual interests. For example, while racialized discourses of violence serve the interests of white women by making violence a problem of non-white people and thus sustaining images of white superiority, such ideas and images mask the violence that white women experience as women in sexist societies.

I see violence as an extension of the abuse of unequal power relations, and propose to replace discourses of violence as “other” with discourses of violence as an extension of unequal power relations. Wherever unequal power relations exist, there is a potential for abuse. And, violence is not merely an outcome of unequal power relations, violence is a way of sustaining those power relations. Replacing existing discourses of violence will require rereading and reinterpreting some theories of violence, and extending others, continuing to excavate existing discourses on violence, and using personal experience to revise personal interests.

Rereading Theories of Violence

Most theories of violence seek to separate violent from non-violent, as though people actually “belong” in one category or another. Theories that focus on individuals (victims or perpetrators) separate violent from non-violent on the basis of psycho-pathology, those that focus incidence of violence as a consequence of relatively rare positions of dominance, and women’s violence against children as congruent with this view.

on families separate violent from non-violent families on the basis of family dysfunction, and
those that focus solely on gender separate violent from non-violent on the basis of gender. Thus
these theories function to serve dominant interests.

Drawing on the work of theorists who have already attended to oppression in their study of
violence (e.g. Bograd, 1988; Dobash & Dobash, 1988; 1992; Stark & Flitcraft, 1991; Yllo, 1988,
1993) theories of violence could be reexamined for the ways in which they serve dominant
interests. For example, the way in which theories of violence that focus on the psychology of
individuals and ideologies of individual responsibility work in concert with one another and with
the need to ration resources, could be analyzed. The history of theories of violence could be seen
as a series of strategic developments to sustain unequal power relations as preceding theories are
unmasked. Discourses that have served all men (such as those theories that posit women as
“asking for it”, or suffering from learned helplessness) have previously been unmasked, and have
been replaced with theories of violence that shift responsibility to certain men, to dysfunctional
families, and so on, each seeking to make violence and abuse a problem of “others”. As one
victim-blaming or other-blaming theory weakens under scrutiny, a more subtle theory replaces it.

The first task of nursing, and nursing education in particular, is to have theories of violence
read at all. In accordance with the deeply sexist nature of our society, violence against women is
rarely a priority for social and health agencies, and receives limited attention both within health
care and nursing education. Secondly, I believe that feminist (meaning also anti-racist, anti-
classist, anti-homophobic, and so on) readings of violence theories are essential to dealing with
violence and abuse in congruence with social justice rather than in congruence with oppression.
Information about violence against women must be interpreted using a critical awareness of
ideology. For example, although recent Canadian research suggests that there is some
correlation between wife beating and the inter-correlated variables of low socioeconomic status, common-law relationships and men’s age (Johnson, 1996), the tendency of some nurses’ to assume that violence occurs predominantly among those who are poor and in common-law relationships demands a more critical understanding of research findings, and more importantly of ideology. Thirdly, critical theories and discourses of violence must be used to provide alternatives to dominant ideology and a basis for alternatives to neglect.

**Further Excavating Discourses of Violence**

The ways in which discourses of violence function ideologically within the health care system have been examined in this study. These interpretations may serve as an example of the dynamics that sustain violence within society in general and within other specific contexts. Such examination should be undertaken in other specific social contexts such as the legal and criminal justice systems, social services, counseling services, the popular media, and so on. For example, what discourses of violence in the criminal justice and social welfare systems sustain the practice of allowing abusive men contact with the women they have abused through their children?

There are two discourses of particular note that have been excavated in this study: racializing and pauperizing discourses of violence. These discourses function ideologically to make a violence a problem of “other” along the lines of “race” and class. Examining these discourses for their ideological power can potentially disarm them, and lead to counter strategies. As “race” and “class” intersect, and as discourses of violence operate within the ideology of scarcity in health care, the association of poverty and violence is a particular case of classist ideology that operates routinely in health care and works in a similar fashion to the racialization of violence. Thus only the racialization of violence will be explicitly discussed, leaving the
reader to understand that racialization is the most salient ideology among many that intersect to inform nurses and other health care provider’s understandings of violence.

Racialization of Violence. Throughout this study, violence was racialized by many of the health care providers with whom I spoke. Violence was seen as a problem of “other”, defined by “race” and class, and “others” were seen as violent. This racialization of violence seemed to “work” in the interests of individuals, as it enabled distancing from violence, preserved a sense of safety, and limited the extent to which individuals have to examine themselves and others with whom they identify. The lack of recognition of violence was explained by many health care providers as an unwillingness to see violence in a bid to preserve ideas about one’s community and create a sense of safety.

I was confounded. How could health care professionals tell me that they knew from research that violence crosses all classes, cultures, “races”, and so on, and simultaneously associate violence with non-white people? How could health care professionals hold racist beliefs and value social justice? In these apparent contradictions I had encountered an example of what Henry, Tator, Mattis and Rees (1995) call “democratic racism”, which, they argue, is the racism that operates in Canada today. This form of racism is an ideology that permits and sustains people's ability to maintain two apparently conflicting sets of values. One set consists of a commitment to a liberal, democratic society motivated by the egalitarian values of fairness, justice, and equality. Conflicting with these values are attitudes and behaviours that include negative feelings about people of colour and that result in differential treatment of them or discrimination against them (p. 13).

Viewed from this perspective, the apparent contradictions in the ways health care providers think about violence and “race” can be seen as congruent within Canadian democratic racism.

Canadian democratic racism embraces the contradictions of liberalism and racism. In health care, these contradictions are heightened by the humanitarian commitments of health care
workers. Despite an increasingly diverse population in Canada, health care organizations and practitioners have failed to adopt anti-racist responses. Rather, stances of multiculturalism have been adopted, masking racism, and leaving the status quo unchanged. And in Canada, within the status quo, white is “normal”, white privilege rarely recognized and challenged.

When confronted with violence and abuse, health care workers can preserve their sense of safety and community by constructing victims and perpetrators as “other”. White health care providers can distance themselves from violence and maintain a sense of superiority. This racialization of violence is congruent with racial stereotypes that involve violence, aggression, and passivity, and is congruent with the fact that non-white people are “visible” to white health care providers, and that as class and “race” intersect, some people are more readily scrutinized than others by health care providers. Thus, the racialization of violence seems to lead to differential anticipation and recognition of violence, which in turn reinforces the process of racialization, the sense of safety that is created, and racial stereotypes that are held.

Throughout this study, the idea of culture, conflated with “race” obscured violence, and obscured violence as deeply gendered. Ideas about “race” and violence work with the idea that “people of colour have cultural problems”, an idea that Henry et al (1995) argue is one of the myths that permit a pattern of denial essential to maintaining Democratic racism (p. 25). Thus, white men who beat their wives are wife beaters, non-white men who beat their wives (and the non-white women they beat) have “cultural problems”, ideas which help to naturalize violence among non-white people, and make it unamenable (and unnecessary) to change.

Not only do health care providers anticipate violence among certain people based on skin colour and other physical attributes. In addition, the behaviour of individuals may be interpreted through a haze of racist assumptions. Discussing health service delivery, Henry et al (1995)
workers. Despite an increasingly diverse population in Canada, health care organizations and practitioners have failed to adopt anti-racist responses. Rather, stances of multiculturalism have been adopted, masking racism, and leaving the status quo unchanged. And in Canada, within the status quo, white is “normal”, white privilege rarely recognized and challenged.

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Not only do health care providers anticipate violence among certain people based on skin colour and other physical attributes. In addition, the behaviour of individuals may be interpreted through a haze of racist assumptions. Discussing health service delivery, Henry et al (1995)
point out that "racial stereotyping often skews the initial assessment of therapists who may view traits such as aggressive behaviour as indicative of a personality disorder when in fact they may be a normal response to living in a racist society" (p.160). Similarly, aggressive behaviour may be interpreted as an indicator of violence. In the disturbing instance in which Emergency staff suspected that the husband of the woman with paralysis and aphasia was abusing her, the apparent reason for suspecting abuse was the husband’s anger and hostility toward the staff. The woman’s brother was also angry with the staff for not having any explanations for his sister’s condition and for assuming violence was an issue, anger which, using racist assumptions could be interpreted as further evidence of a “culture of violence”.

The racialization of violence also works with the need to ration health care. In addition to judging as less deserving those people who are perceived as drunk, demanding, using Emergency services frequently and inappropriately and making little effort to improve their lives, in relation to women who have been abused, “race” seemed to play a role. In this study, predominantly white health care providers routinely associated violence with racialized groups. Many expressed more comfort in questioning poor and ‘non-white’ people in comparison to wealthy and white people. When recalling women who had been abused, health care providers tended to recall ‘non-white’ women. Thus violence and abuse can be seen as “naturalized” among certain people, justifying “doing nothing” in response.

From this analysis, I consider racism to mean “thinking (uncritically) in terms of race”, and propose using such a definition as a starting point for unlearning racism. Multicultural discourses that mask racism must be refused and replaced with anti-racist discourses. With specific regard to violence, the task of disengaging violence against women from “race” seems enormous. Rattansi (1995) claims that anti-racist strategies must be locally determined and
contextually decided. Within nursing then, rather than trying to unlearn racism specifically in regard to violence, I believe that because racism is so blatant in health care in relation to violence, examination of the issue of violence could be used as a focal point for unlearning racism. That is to say, examining the issue of violence against women should be used as a vehicle in nursing education to challenge racism (and classism and sexism) in general.

Gill, Singh and Vance (1987) argue that anti-racist education includes not only recognizing anti-racist ideology and practice, but also examining the ways in which the education system participates in racism, and working out ways the education system can be used to challenge racism. Thus nursing education itself ought to be examined for the ways in which it participates in racism. In what ways might education program admission policies, teaching methods and content be racist? In what ways might these policies and practices be transformed? In what ways can education be used to create an anti-racist critical consciousness among individuals?

Personal Experiences

I have argued that an essential step in developing critical consciousness in nursing is for individuals to examine their own personal interests in regard to dominant interests with the goal of unmasking and operating with a critical awareness of ideology. As “interest” has been seen in this study as an exigency for action which originates outside social agents, but is produced and defined by social agents (Peillon, 1994), interests can be redefined by social agents. The dynamics between personal experiences, personal interests and personal practice as presented in this study suggest that personal experience is a valuable starting point for unmasking ideology, developing critical consciousness, and redefining one’s own interests.

In particular, personal experiences of violence and abuse could be analyzed to examine the relationship between personal and dominant interests. Reconsidering what “counts” as abuse and
examining one’s own power relations and abuse of power could bridge the distance between self and violent “other”. Reinterpreting personal experiences of violence from a critical perspective could help individual nurses examine their own interests, and realize similarities with other women based on gender that transcend perceived differences based on class and “race”.

Conversely, a critical reinterpretation of such experiences could help individuals analyze their own experiences of privilege, based on “race”, class, ability, and so on, as well as their own experiences of oppression. In seeing one’s own privilege, individuals might better see the oppressor in us all. Examining one’s privilege and participation in oppression would provide a basis for resistance to ideology and practices of oppression. Collins (1993) argues that “there is no compelling reason to examine the source and meaning of one’s own privilege”, and that thus, such analysis relies on individuals to freely choose a non-oppressive stance (p 43).

This argument suggests that nursing education ought to encourage critical analysis of personal values, beliefs and assumptions, purposefully drawing upon personal experience and creating personal knowledge. Such strategies cannot be undertaking lightly or thoughtlessly. I am not recommending that nurse educators require students to expose their personal experiences of violence, nor make confessions about acts of oppression. Rather, nurse educators should encourage a personal analysis of experience, acknowledging both the value of such experience, and the danger in uncritical use of such experience as a basis for practice.

In particular, however, personal experience needs to be used in education to examine notions of “culture” in nursing (see Lynam, 1992). Nurses must be assisted to examine their own “cultural” norms, to see their own biases and the assumptions that they use in making judgments about patients, and to help disentangle culture and “race”, and culture and violence.
Further, the examination of the relationship between personal experience and ideology in this study calls into question the trend in nursing education and research to privilege “lived experience” as incontestable knowledge. Whenever “lived experience” is drawn upon, how such experience is interpreted within ideology must be examined. For example, the lived experience of women who have been abused must be examined for how interpretation of that experience (by both women themselves, and other readers) is influenced by ideology.

Examining and reframing one’s own personal interests are essential but insufficient for transforming practice patterns congruent with dominant interests and ideologies. Personal interests can lead to individual practices of resistance, but collective changes are required to transform practice.

Collective Practices

The practices in Emergency and in relation to violence that were examined in this study arose predominantly from ideologies of scarcity and ideologies of violence in relation to “race” and class. These collective practices served dominant interests, and served to sustain and reproduce unequal power relations. However, other practices stood in opposition to the predominant patterns, and thus serve as a model for change. Moving collective practices of resistance to prominence would require that individuals engage in the recognition, refusal and replacement of these ideologies, but importantly, individuals must collaborate on the strategies of resistance. A single nurse spending time “listening” to a patient will be penalized by her peers, unless her peers understand that act to be in the interests of the patient, the nurse and themselves. A single nurse treating a drunk with respect will be ridiculed as “soft” by her peers, unless that respect is seen as being in the interests of nurses and nursing.
As noted earlier, nurses in this study knew what to do to transform practice (although they
did not think they did in specific regard to violence and abuse), and could be seen in their
practice moving back and forth between congruence and resistance with dominant ideologies and
practice patterns. Nurses preserved and attended to the whole person, spent time listening and
offering choices, and so on, but did so primarily as individuals, and tended to find collective
support sporadically. What is required is a collective effort to change practice.

Collective efforts are made especially difficult by the fact that staff nurses do not have the
space within their paid work time to research best practices or to examine and plan their
collective practice. Partly for these reasons, nursing practice is often dictated by others. Staff
nurses are thus challenged to work with administrators in ways that enable the staff nurses to
control nursing practice. As shown in this study, dictating practice changes “top down” does not
necessarily result in improved practice, as the contradictions between predominant practice
patterns and “ideal” practice are not necessarily resolved. Staff nurses and researchers must
work together to obtain evidence regarding best practices in terms of both patient health
outcomes and economics.

The argument will of course be made that nurses do not have “time” to “do” ideal
practice, and that time and resources are finite. This again invokes the ideology of scarcity,
which is only one way of looking at nursing practice. Nurses at present ration their time in
accordance with certain priorities and within certain ideologies. With a critical consciousness,
nurses may collectively decide to allocate their time and resources differently, in ways that are
less oppressive and more oriented to health outcomes. And using the ideas of power sharing,
nurses may mobilize different resources. As the British Columbia (BC) Task Force on Family
Violence noted in the face of the staggering costs of violence, "It is not a question of can we afford to pay or not, it is a question of do we pay now, or do we pay later?" (1992, p. x).

At all levels of the health care system, nursing leaders can (and ought to) engage in policy analysis and development and champion social justice in the allocation of health care resources. Theorists can refine violence theory and discourses, researchers can link health outcomes and “best” practices, and educators can promote analysis of social, economic and health policy and the development of critical consciousness and lobbying skills among nurses. However, the success of collective strategies in transforming practice is likely to depend most on the words and actions of informal opinion leaders in nursing practice; that is, upon nurses like those who contributed to this study as my “buddies” and consultants. These nurses, having proven themselves clinically, are best able to resist the ridicule and sanctions that keep the predominant practice patterns in place. It is to these nurses that I pose the challenge of change, and offer this study.
REFERENCES


Rudge, T. (1996). (Re)writing ethnography: The unsettling questions for nursing research raised by post-structural approaches to “the field”. *Nursing Inquiry, 3*(3), 146-152.


APPENDIX 1: Information Letter for Nurses and Other Health Care Personnel
Letter for Nurses and Other Health Care Personnel

Dear Colleagues

Re: Research Study The Social Context of Nursing in Relation to Violence Against Women

I am a student in the PhD program in the school of nursing at the University of British Columbia. For my dissertation, I am studying how the social context within which nurses work affects the care of women who have been battered. I hope that this study will provide the basis for improving care for women who have been battered and for proposing goals of care and interventions that will be effective.

Because 22-35% of women who come to emergency units do so because of an abuse-related injury (Warshaw, 1993), nurses in emergency have a great potential to make a difference to the lives of women who have been battered. I would therefore like to focus on the social context of nurses working in hospital emergency units. I am planning to observe how practice occurs in an emergency setting and to interview people regarding the social context as it affects practice in relation to violence against women. I am seeking your participation in this study in any of several possible ways:

1. I would like to observe the practice of nurses and other personnel working in emergency.
2. I would like to "buddy" with nurses who are willing to act as guides for me during observation.
3. I would like to interview nurses and other personnel working in emergency regarding their understanding of the social context in relation to practice with women who have been battered.
4. I would like to invite your active participation in any way that you would like.

Observation
If you are willing to be observed during your practice, it will not require any additional time. I will be in the emergency unit "buddied" with a nurse and observing how the unit works. I will be making field notes about my observations. If you do not wish to be observed, I will not make any notes concerning activities that surround your practice.

"Buddy" Nurses
If you are willing to be one of my guides to the unit, it also will not require any additional time. I will work whatever shift you are working and will be observing how the unit works during that time. Being a buddy would involve helping me understand how the unit works, what practices and policies are, and how the unit interfaces with the rest of the hospital and community.
APPENDIX 2: Information Letter for Patients
APPENDIX 3: Consent to be Observed
Consent to be Observed

Re: The Social Context of Nursing in Relation to Violence Against Women Study

I, ________________________, agree to be observed in my practice. I understand that the purpose of this study is to describe how the social context influences the care provided to women who have been battered. This study is being conducted by Colleen Varcoe, a graduate nursing student at the University of British Columbia who is working under the supervision of her committee, of which Dr. Katharyn May, R.N, DNSc. is the chair.

I understand that the observation will involve observation of my routine practice. I further understand that notes will be made to enable the researcher to collect accurate information for analysis.

I understand that my decision to participate is entirely my own. I also understand that my name will not be recorded with in the notes or identified in any report that may be published.

I understand that I am free to withdraw from the study at any time and I may refuse to be observed at any time. If I withdraw from this study, there will be no negative consequences, nor will anyone other than the researcher know about my decision.

My participation in this study may help me to critically consider my practice in relation to women who have been battered. The findings from this study may benefit other health care professionals and ultimately, women who have been battered.

I understand that the notes from observations will be kept for a further analysis, and will be destroyed by the researcher when such analysis is completed.

I agree to participate in the study described above.

Signed ________________________ Date ____________

Please print your name __________________________

I acknowledge receiving a copy of this letter and consent form.

Signed ________________________ Date ____________

Witness ________________________

**Please return this form and letter unsigned if you do NOT wish to be observed at this time**
APPENDIX 4: Consent to be Interviewed
Re: The Social Context of Nursing in Relation to Violence Against Women Study

I, ______________________, agree to be interviewed regarding my experiences of caring for women who have been battered and how the context in which I work is related to my practice. This study is being conducted by Colleen Varcoe, a graduate nursing student at the University of British Columbia who is working under the supervision of her committee, of which Dr. Katharyn May, R.N, DNSc. is the chair.

I understand that the interview will be a discussion which will last 1-2 hours. The interview will be held at a location which is convenient for me. I will discuss my experiences of caring for women who have been battered and the relationship of the context to those experiences.

I further understand that the interviews will be audiotape recorded to enable the researcher to collect accurate information for analysis. If I feel uncomfortable with what is on the tape, I am free to ask the interviewer to erase that part of the tape in my presence.

I understand that my decision to participate is entirely my own. I also understand that my name will not be recorded with my interview or identified in any report that may be published.

I understand that I am free to withdraw from the study at any time and I may refuse to answer any specific question. If I withdraw from this study, there will be no negative consequences, nor will anyone other than the researcher know about my decision.

My participation in this study may help me to critically consider my practice in relation to women who have been battered. The findings from this study may benefit other health care professionals and ultimately, women who have been battered.

I understand that the tapes of the interview and transcriptions of those tapes will be kept for a further analysis, and will be destroyed by the researcher when such analysis is completed.

I agree to participate in the study described above.

Signed ___________________________ Date ____________

Please print your name ___________________________

I acknowledge receiving a copy of this letter and consent form.

Signed ___________________________ Date ____________

Witness ___________________________
APPENDIX 5: Letter for Health Care Personnel Not At Study Sites
Possible Interview Questions

You know that I am interested in understanding how the social context, including the unit you work in, the hospital, the health care system, and society in general, influences how women who have been battered are cared for by nurses. Can you tell me in your own words what you think about this?

Can you tell me in your own words what your experience has been with women who have been battered?

Can you tell me how you think the organization influences how you care for women who have been battered?

Can you tell me how you think you have influenced the organization with regard to the care of women who have been battered?
APPENDIX 7: Additional Interview Questions
Interview Questions

Code Name_________________________ Date of Interview__________

Interview #_____________________

INTERVIEW QUESTIONS

Background (education, ER experience):

Questions:
You know that I am interested in understanding how the social context, including the unit you work in, the hospital, the health care system, and society in general, influences how women who have been battered are cared for by nurses. Can you tell me in your own words what you think about this?

Can you tell me in your own words what your experience has been with women who have been abused?

Can you tell me how you think the organization influences how you care for women who have been abused?

Can you tell me how you think you have influenced the organization with regard to the care of women who have been abused?

Would you like:

• a copy of this interview transcribed?

• a summary of my dissertation?

• a copy of the completed dissertation?
APPENDIX 8: Description of Observations

Observations will include:

1) Detailed description of the physical layout of the emergency setting.

2) Observations of the culture of the unit, norms of practice and relationships among personnel and between health care personnel and clients.

3) Observation of specific practice examples relevant to the focus of study
## APPENDIX 9

### Data Collection Time Sequence

<table>
<thead>
<tr>
<th>Phases</th>
<th>Data Collection: Site 1</th>
<th>Data Collection: Site 2</th>
<th>Data Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct. - Nov./94</td>
<td>preliminary fieldwork</td>
<td>preliminary interviews</td>
<td></td>
</tr>
<tr>
<td>May - June/96</td>
<td>initial fieldwork phase 1 interviews</td>
<td>initial field work</td>
<td>initial formal analysis (initial coding of interviews and development of conceptual categories)</td>
</tr>
<tr>
<td>June - July/96</td>
<td>continued field work and interviews</td>
<td>initial field work</td>
<td></td>
</tr>
<tr>
<td>August/96</td>
<td></td>
<td></td>
<td>formal analysis of phase 1 interviews: development of initial conceptual framework</td>
</tr>
<tr>
<td>Sept. - Nov./96</td>
<td>phase 2 interviews continued field work</td>
<td>phase 2 interviews continued field work</td>
<td>ongoing formal analysis</td>
</tr>
<tr>
<td>Dec./96-May/97</td>
<td>phase 3 and follow up interviews</td>
<td>phase 3 and follow up interviews</td>
<td>formal analysis (phase 1 &amp; 2 interviews): development of theoretical arguments</td>
</tr>
<tr>
<td>April - June/97</td>
<td></td>
<td></td>
<td>• non-study site interviews</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• development of central thesis and further development of theoretical arguments</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• formal analysis of phase 3 interviews and field notes</td>
</tr>
</tbody>
</table>
### Number of Participants and Interviews

<table>
<thead>
<tr>
<th>Study Site</th>
<th>Non-Study Site</th>
<th>Nurses</th>
<th>Other Health Care Providers</th>
<th>Women who experienced abuse</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Sample</td>
<td>Secondary Sample</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Participants</td>
<td>12</td>
<td>4</td>
<td>5</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Number of Interviews</td>
<td>18</td>
<td>4</td>
<td>5</td>
<td>9</td>
<td>5</td>
</tr>
</tbody>
</table>
APPENDIX 11: Example Letter Requesting Feedback on Draft Analysis
## Study Site Emergency Nurses’ Experiences of Violence at Home and at Work

<table>
<thead>
<tr>
<th>NURSE</th>
<th>AT HOME</th>
<th>Violence Against Women AT WORK*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Nicole abused by alcoholic father</td>
<td>yes</td>
</tr>
<tr>
<td>2</td>
<td>Kathy abused by boyfriend</td>
<td>yes</td>
</tr>
<tr>
<td>3</td>
<td>Shelby abused by boyfriend</td>
<td>yes</td>
</tr>
<tr>
<td>4</td>
<td>Anne witnessed abuse of mother by father</td>
<td>few</td>
</tr>
<tr>
<td>5</td>
<td>Faye witnessed consequences physical abuse of 11 year old daughter by step-father</td>
<td>few</td>
</tr>
<tr>
<td>6</td>
<td>Lulu witnessed consequences (death) of abuse of adult daughter by daughter’s husband</td>
<td>many</td>
</tr>
<tr>
<td>7</td>
<td>Lindsay witnessed consequences of physical/sexual/emotional abuse of husband by husband’s father</td>
<td>yes</td>
</tr>
<tr>
<td>8</td>
<td>Palen witnessed consequences of abuse of sister by sister’s husband</td>
<td>many</td>
</tr>
<tr>
<td>9</td>
<td>Vail witnessed consequences of abuse of sister by sister’s husband</td>
<td>many</td>
</tr>
<tr>
<td>10</td>
<td>Susan witnessed consequences of abuse of sister by sister’s husband</td>
<td>yes</td>
</tr>
<tr>
<td>11</td>
<td>Lenore none</td>
<td>many</td>
</tr>
<tr>
<td>12</td>
<td>Susanna none</td>
<td>many</td>
</tr>
<tr>
<td>13</td>
<td>Elaine none</td>
<td>many</td>
</tr>
<tr>
<td>14</td>
<td>Monica none</td>
<td>few</td>
</tr>
<tr>
<td>15</td>
<td>Dorothy none</td>
<td>none</td>
</tr>
<tr>
<td>16</td>
<td>Yvette none</td>
<td>none</td>
</tr>
<tr>
<td>17</td>
<td>Bo none</td>
<td>none</td>
</tr>
</tbody>
</table>

*Some nurses had particularly profound experiences of caring for children who had been abused, but one of these nurses did not recall any experiences of women who had been abused. The term “none” is used when nurses specified that they could not recall any experiences, “few” when they either specified “few” or were able to recall only a few instances, and “many” when they specified “many” or “lots” and were able to recall multiple situations of abuse. “Yes” is used when nurses told about various instances of abuse, but did not estimate the extent of their experience.