"WHO IS THAT NURSE?"
WHAT IT MEANS TO BE AND ACT AS A REGISTERED NURSE: THE CLIENT'S
PERSPECTIVE

by

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ABSTRACT

What does it mean to be and act as a registered nurse? This qualitative study examined the professional identity of the nurse from a client's perspective.

Using interpretive description methodology and purposeful theoretical sampling, 10 informants participated in unstructured, open-ended interviews that were audiotaped, transcribed verbatim, and analysed. Findings revealed that, from the informants' perspective *being* and *acting* are not equal facets of the nurse's professional identity. Rather, the nurse's being is central, providing structure to and influencing the way that the nurse acts.

To *be* a nurse is to be intrinsically motivated to care for another person. Uniquely expressed, the result of the nurse's personal history and natural talents, this motivation is the unique descriptor identifying suitable candidates for the profession. Evident in these individuals before their nursing education begins, it sustains them in a complex and difficult role requiring intellectual, emotional, and physical capabilities. Being a nurse is relational, imbued with great responsibility because of the nurse's consistent presence with the client.

To *act* as a nurse is to be identifiably involved in a client-focussed endeavour. The nurse's acting is a consequence of the nurse's being, with attitudinal traits operationalised as professional attributes. Although clients value nurses' unique knowledge and believe that all nurses will be proficient in specific nursing competencies, without excellence in verbal and non-verbal communication something vital is missing. The nurse, easily recognisable through her bearing and approach towards the client, communicates professional pride and ability.

The study findings suggest many implications for nursing education and practice-- particularly recruitment and retention issues. Further research should explore variations in client perception related to age, culture, or perceptions that may change over time.

ACKNOWLEDGEMENT

DEDICATION

This project is dedicated to the multitude of clients who have patiently taught me throughout my years of practice as a registered nurse and to the ONE who has given me a love of people and a passion for the nurse's work.

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CHAPTER 1: PROBLEM IDENTIFICATION

Background

Who is the nurse? Where is the nurse? What does the nurse do? Although research into and discussions around "professional identity" have become increasingly visible within nursing literature, clients remain perplexed. What do they expect to see or hear when encountering a nurse? Clients are often unsure of who is involved in their care, unable to identify the registered nurses they assume are providing care, and uncertain about what to expect from the nurses when they have been identified.

Nurses, with their relatively recent and hard won professional status, speak of their professional identity. They are assured of its presence, but less confident when asked to describe all that it actually entails. The prevailing attitude within the profession seems to be that "you know it when you see it" (Lehna, et al., 1999, p. 192). With the continuing evolution of the healthcare system, professional roles within healthcare are increasingly blurred. Expanded practice roles are being explored and developed for qualified nurses; but the roles of other professional and ancillary staff are evolving as well. For those working within practice models advocating client-centred care, it is important and necessary to discover, understand, and respect the client's viewpoint (Taylor, Hudson, & Keeling, 1991; Young, Minnick, & Marcantonio, 1996), and to critically appraise and reflect on practice issues raised from that perspective. Yet, the importance and influence of the clients' perspective on the shaping of nursing practice and the development of professional boundaries is rarely considered (Chapple, Rogers, Macdonald, & Sergison, 2000). As nurses, how can we value and respond to the client's perspective of nurses and nursing, if we don't know what it is?

While there are articles on this topic with historical merit (Holliday, 1961; Tagliacozzo, 1965), Radwin's 1998 study exploring the patient's perspective of quality nursing care was described as, quite possibly, the first of its kind (Radwin, 2000; Schreiber, 1999). In fact, relatively few research articles in contemporary nursing literature explore the professional identity of the nurse from the client's perspective (Cherry & Jacob, 1999; Holliday; Mangum, Garrison, Lind, & Hilton, 1997; Santo-Novak, 1997; Schreiber; Tagliacozzo). Instead, articles seem to feature discussions about clients' perceptions of nursing practice, quality of care, and client satisfaction. Is it possible to ask clients what they consider makes excellent nursing without first asking them their perspective of what constitutes the nurse performing in that manner? What are our clients looking for, and what do they see?

Having been a registered nurse (RN) for over 33 years, I can give personal testimony to the evolution of both the profession and professional practice. Recently, while discussing the progress of a particular client with his surgeon, the surgeon asked me about the individual seated at his patient's bedside. He wondered whether this individual was a "friend" or a "nurse." He saw her behaving like an "old-fashioned nurse," sitting at the patient's bedside and writing in a notebook. "These days," he observed, "when nurses aren't busy they sit at the nursing station." This individual was a nurse on that unit, but was not behaving in the manner that the surgeon was expecting. Similarly, after a History of Nursing presentation to first year nursing students in which I dressed in my graduation "costume," many students sought me out for conversation. They were particularly interested in my nursing cap, a symbol I had happily discarded shortly after graduation. They described their need for an instant nurse identifier and related their difficulties in identifying the RN of whom they were

to ask their practice questions. If both surgeons and nursing students--individuals familiar with the healthcare setting--have differing expectations and difficulties identifying the registered nurse, how do our clients begin to describe what it means to be and to act as a registered nurse?

This chapter introduces my research study. The background of the research problem and its purpose is described, and the question being addressed in this project is identified. It is anticipated that the increased understanding about the client's perspective gained through this qualitative interpretive description study may have significance for application to nursing education, practice, and research, as well as to client education.

The Impact of One Client's Perspective

Early in 2002 a Vancouver patient expressed real and personal concerns in a Vancouver Sun feature article (Bramham, 2002). Hospitalised after major surgery, this patient's first nurse was equated to a "Keg waitress,"[1] noting the crisp uniform, Vancouver General Hospital nametag, and introduction, which included both name and status. As her hospitalisation continued, she longed for more nurses like the Keg waitress. With no firm dress code, nurses were "indistinguishable from other hospital staff, their name tags either missing or covered with sweatshirts" (p. A4). She graphically recounted several disturbing incidents where staff (who could not be identified as professional due to casual attire, missing nametag, and lack of verbal introduction) initiated personal medical treatment, and responded inappropriately (in her opinion) in an emergency situation. The article expressed this client's view of what she experienced at the hands of those she presumed were registered

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[1] Vancouver-based Keg restaurants, the leading franchiser of steakhouses in Canada, hire staff who are enthusiastic, outgoing, and welcoming. All waiters wear long-sleeved white shirts and distinctive ties.

nurses. The lack of professional identity, which she perceived, translated into diminished patient confidence as it related to nursing competence and patient care.

This newspaper article was distressing. I experienced a sense of personal embarrassment, as a long-practising RN, at this exposé of professional practice that obviously failed to meet this client's expectations. The fact that this had occurred in the facility where I was employed as a clinical educator was additionally discomfiting. Although some might dismiss the article as the personal expression of an individual having a "bad day," or having difficulties during a critical illness, for me it stimulated reflection on my own professional practice and that of my colleagues.

Other Client Perspectives

Exploration of the concept of the nurse's professional identity from the client's perspective during a Conceptual Knowledge in Clinical Nursing course at the University of British Columbia helped to clarify the attendant issues and confirmed the need for further attention to this problem. Having proposed an operational definition of the concept, some of its claims were tested with a select group of my acquaintances. Most of those I approached had difficulty with the concept of professional identity, sometimes confusing it with the concept of image. As well, some respondents questioned whether nursing was a profession or a job where the nurse simply follows the instructions of others. However, each informant had vivid stories to tell of nurses whom they felt exemplified or personified what they were looking for from the nurse in the nurse-client encounter. Some also shared negative exemplars, recounting less supportive experiences with nurses in care situations. Because I found the exercise so enlightening, I circulated my course papers among various nursing

colleagues, who also found the information interesting and confirmed that this should be an area of concern among nursing professionals.

In exploring the literature for that course project, I was particularly drawn to the work of Fagermoen (1997) whose research centres on identifying values embedded in meaningful nursing practice. Her work embraces symbolic interactionism, a social psychological theory affirming that "values, both moral and work values….are inherent in developing and sustaining professional identity and are expressed in nurses' actions in relation to others" (p. 436). In addition, Fagermoen utilises moral philosophy and work-sociology, having recognised the importance of both self-reflection and social interaction in the development of professional identity. But what I found most compelling in her work is her reference to the nurse's professional identity as the nurse's personal philosophy of nursing--"what it means to be and act as a nurse" (p. 435). Ohlen and Segesten (1998), who report that the professional identity of the nurse involves more than simply working as a nurse works, support her view.

Further consideration of Fagermoen's definition from the client's perspective seemed warranted since it offered a direct link between the conceptual idea and how it might be explored with the client. There was also the question as to what values nurses brought to the nurse-client interaction and whether the client recognised those values as unique to nursing. Roberts (2000) claims that because nursing has internalised the values of medicine and the medical model, nursing values are all but invisible and rarely recognised in patient care.

Research Purpose

The purpose of this qualitative interpretive descriptive study is to explore and describe the professional identity of the registered nurse from the client's perspective.

Research Question

In this study I will explore the following question: From the client's perspective, what does it mean to be and act as a registered nurse?

Assumptions

Assumptions that are inherent in this study include the following definitions and philosophical beliefs:

1. In my contact with clients, as well as physicians, nursing staff and nursing students, it is clear that the status and role of various individuals providing care is uncertain. Throughout this study, whenever reference is made to "nurse" or "nurses," it is implied that these are "registered nurses," practitioners who have met the criteria established by their regulatory or licensing body and have maintained their credentials as mandated by this body.

2. The term "client" is used exclusively to describe the recipient of the nurse's attention, even though some individuals may be more comfortable with the term "patient." "Client" is increasingly the term of choice used to describe "consumers" of healthcare who are encouraged and empowered to participate in their own healthcare decision making and care planning (Ponte et al., 2003).

3. Each of us, whether professionals or clients, are unique individuals. The values we hold as individuals inform our attitudes and responses.

4. Although clients and nurses are both male and female, for ease of writing where gender is not essential to the story, the nurse is assigned female gender and the client male.

Summary

This chapter began with the identification of my research problem. The background of this problem and the prime motivation for pursuing this question were outlined. In addition, reasons why the pursuit of this knowledge is relevant to nursing were described. Both the research question and the assumptions underlying this study are stated.

CHAPTER 2: LITERATURE REVIEW

The purpose of this literature review is to place this research project within the literature regarding the client's perspective of what it means to be and act as a registered nurse. This topic is embedded in the concept of "professional identity." Historian, E. J. Hobsbawm, cited in Addis (1996) observed that concepts "are not part of free-floating philosophical discourse, but [they are] socially, historically, and locally rooted, and must be explained in terms of these realities" (p. 1383). Therefore, in this chapter the concept of professional identity will be reviewed from a variety of perspectives. The usage of this concept within other professional spheres is identified and compared with its current application in nursing practice, which has as its pivotal point client care. The importance of the client's perspective is increasingly evident. At a fundamental level there can be no individual filling the role of the nurse without someone filling that of the client. It is a relationship where each is dependent on the other. In addition, the acceptance and promotion of healthcare models such as patient and family-centred care underscore the need to gain understanding of the nurse-client relationship. Although it may be argued that valuing and responding to the perspective of another is simply the hallmark of any respectful human interaction, grasping this concept is of vital importance to nurses and nursing, especially if a post-modern view, where multiple ideas, values, and beliefs are held, is embraced.

Professional Identity: What Is It?

The search to delineate the meaning of professional identity began with The *Oxford English Dictionary* (OED) (Simpson & Weiner, 1989). "Profess," the root word of professional is from the Latin "profitere" meaning "to declare publicly." Prior to the 1500's it was used only in reference to those taking religious vows. Monasteries and nunneries were the medieval universities, protected centres of culture and education, art and learning. They

provided society with the specialists of the day in many fields. Not only the religious were schooled in this environment, but also artists, teachers, lawyers, and political advisors (Campbell, 1982). How the military came to be seen as a distant member of this original professional group is unclear, although Campbell suggested that it was because induction into military service involved the swearing of loyalty to one's superior. Those deemed professionals shared some sort of public declaration. The religious had ordination vows, the physician had the Hippocratic oath, the barrister was "called to the Bar," and the military took an oath of loyalty to the ruler.

The term "profession" was applied strictly to the professions of divinity, law, medicine, and the military through the 18th century. It particularly denoted vocations "in which a professed knowledge of some department of learning or science is used in its application to the affairs of others or in the practice of an art founded upon it" (Simpson & Weiner, 1989, ¶ 6). Then, in the 1800s a broader application of "professional" included those engaged in pursuits "considered socially superior to a trade or handicraft," as well as those occupations or trades where there was some theoretic or scientific expertise "that raises his trade to the dignity of a learned profession" (Simpson & Weiner, ¶ 5). In this way, a distinction was made between a technician and an engineer. By the mid-1900s the term was also used to describe "that standard or quality expected of a professional person or his work" (Simpson & Weiner, ¶ 4d). In this case, the professional might not be the one involved in the activity, although whoever was performing the task did it "like a professional." Common usage now accepts that the term may be applied to any calling or occupation by which a person habitually earns his or her living, elevating that occupation from being simply a pastime to a life-work and a means of livelihood (Simpson & Weiner). And so, it is common

to hear of professional hairdressers, professional home or business organisers, and in the retail industry, there are professional buyers. In fact, Merton (1982) suggests that the altruistic behaviour, which is a distinguishing mark of those engaged in more traditional professions, can be seen in any setting where the individual's concern for others is inseparable from their own self-interest.

The word "identity" has as its Latin root "identitas" meaning "the same" (Simpson & Weiner, 1989). Identity, therefore, refers to "the sameness of a person or thing at all times or in all circumstances" (Simpson & Weiner, ¶ 2a). Interestingly, mention is made (Simpson & Weiner, ¶ 10b) of a philosophy-based "Identity Theory" that suggests that physical, psychological, and social perceptions are identical, but viewed and expressed in different ways. In mathematics a symbol known as an "identity sign" is used to express the equality of all values on either side of it. In psychology "personal identity" is described as "the condition or fact of remaining the same person through the various phases of existence" (Simpson & Weiner, ¶ 2a) with "identity crisis" then being viewed as the individual's difficulty in maintaining this coherence. Within Social Identity Theory, developed in the early 1970's, it was proposed that part of an individual's self-concept is based in his or her social group membership and the value associated with that group (Hind et al., 2003). An individual shifts between personal identity and group identity depending on the situation and how he or she interprets and evaluates the group. Similarly, identity can also be used to refer to that which "identifies the holder or wearer" (Simpson & Weiner, ¶ 10a), such as a card, paper, military badge, or the patches sewn to prisoners' garments in World War II.

Based primarily on the *Oxford English Dictionary*, one might conclude that professional identity refers to that which marks an individual as a member of a particular

profession. As the subsequent literature points out, the ways in which this professional

identification occurs vary.

Professional Identity: Perspectives From Other Professions

Given the definitional variations proffered by the *Oxford English Dictionary*, it is

hardly surprising that there is not universal agreement as to the meaning and attributes of this

concept, or related concepts, in the literature chosen for review from a variety of professional

domains. Still, certain themes emerge.

Socialisation as a Process Leading to Professional Identity

Clear-cut definitions of professional identity are hard to find in either the legal or

medical literature. Perhaps the historical tradition surrounding these early professions

presupposes an understanding of their professional identities so intrinsic and fundamental

that further description is deemed unnecessary. Instead, the reviewed literature, targeting the

medical and legal professions, focuses on one aspect of professional identity--the

socialisation process whereby new members are assimilated into the professional body.

The sociologist Merton (Merton, Reader, & Kendall, 1957), writing on the

socialisation which occurs during medical education, states that this socialisation is

instrumental in providing the student-physician with a "professional identity so that he comes

to think, act, and feel like a physician" (p. 7). This process begins with the student's personal

self-image or identity, incorporating both personal values and those that are normative within

the student's associated medical community. However, the influence of professional identity

goes beyond the practitioner's personal identity and also impacts on the professional's

relationship with their client, other colleagues, and the larger community.

Legal education, like medicine, tends to occur in a unique environment with students separated from those of other disciplines in ways that create both a distinctive yet isolated experience (Kandel, 1993). While interdisciplinary contact is thought to be worthwhile and relevant, there is an exclusive note to the lawyer's professional development. Kandel, a law professor, affirms that "legal education…employs all the best methods of socialisation – education, initiation, language, and assumption of professional identity….Being a lawyer becomes not merely an identity but a status and a professional role – a system of ethics and a set of interests" (p. 14).

But socialisation into a professional identity involves more than the educational initiatives. Addis (1996) describes a study of entrants to medical and law schools that compared how these students began to learn and to practice their professional roles. It was reported that the students often choose "a figure in the profession, a practitioner known personally or one known only by repute, as a model to imitate and an ideal with which to compare their own performance" (p. 1391). This adoption of a role model is another part of the socialisation process.

Membership to a Reference Group

Professional identity is further described as a sociological phenomenon. In an extensive study into the professional socialisation of medical students that builds on the work of various sociologists and psychologists, Broadhead (1983) notes that professional identity involves being assigned membership to the particular reference group by both oneself and others. The individual acquires "a perspective consisting of assumptions, definitions, attitudes and values that individuals use as a frame of reference to organise and inform their thoughts and actions toward self and others" (p. 38). Thus, in these settings, one's

professional identity also involves acquisition of certain role specific attributes - some assigned to the individual by those outside the profession. Merton (1982) calls this the "halo effect" whereby, with acquisition of membership to the reference group, the professional is expected to exhibit behaviour and attitudes considered normative to that group.

Different From Image

Professional identity and image are not synonymous. Ibarra (1999), writing from a business perspective, defines image as "the impressions people believe they convey to others" (p. 765). And so, according to Ibarra, as the individual is being socialised into the profession, that individual's image and identity are being considered, constructed, and evaluated based on internal and external feedback. It seems that the development of both one's professional identity and professional image are experimental processes.

Components of Professional Identity

Merton (1982) states that all professions are rooted in a triad of values--knowing, doing, and helping. Therefore, the individual's professional identity incorporates attitudinal and technical components, linking systematic knowledge and a high level of skill, and demonstrating a commitment to an ideal of service to others.

But, in the literature associated with counselling psychology, Weinrach, Thomas, and Chan (2001) define professional identity as the core values and differentiating attributes that are associated with the particular profession. The profession's distinctiveness is credited to that profession's philosophy, history, and worldview, as well as its curriculum and practice.

History is also important in the development of the educator's professional identity. Within education literature professional identity is viewed as a composite of all those with whom the teacher shares history--the children, parents, community, administration, board of

education, as well as the curriculum, beliefs, and values which guide the encounters (Connelly & Clandinin, 1999). There, identity is understood as a narrative construct that takes shape as life unfolds: "Different facets, different identities, can show up, be reshaped and take on new life in different landscape settings" (p. 95). As such, it would not be unusual for the teacher to experience multiple identities depending on his or her life and work situations. Here, professional identity is presented as an evolutionary process that is influenced by the perception of those others with whom contact is made.

Business literature also recognises the change associated with developing a professional identity. Ibarra (1999), studying business consultants and investment bankers, defines professional identity as "the relatively stable and enduring constellation of attributes, beliefs, values, motives and experiences in terms of which people define themselves in a professional role" (p. 764). Grounded in theories of learning and adaptation, it is assumed that one's professional identity, while more adaptable early on, is formed over time as experiential insight is gained. To those who might wonder whether business is a profession, the Harvard School of Business presents as its motto "To make business a profession" (Lawrence, 1999) and business literature is contributing to the discussion of what role specific attributes constitute a professional identity.

But a clear understanding of professional identity was not universally present in the reviewed literature. In the fields of social work and occupational therapy, confusion, anxiety, and concern regarding credibility are expressed (Bruhn, 1991; Netting & Williams, 1996). Based on this limited review, one wonders whether a distinctive professional identity is not conveyed because the requisite values described by Merton (1982)--a special attitude and body of knowledge--are not articulated by these groups.

Needs of Clients

In the many professions mentioned previously in this section, emphasis is placed on the needs of clients. But within business domains there is often more concern for shareholders' stakes and profit margins. Still, business and nursing are connected in the current health care climate where practitioners are admonished to "know what business we're in, and who our customers are." And certainly, there is common ground if there is agreement that "in any form of customer service work, the ability to convey public images of competence and credibility is critical" (Ibarra, 1999, p. 767).

Given that the professional values helping others, perhaps the special attitude associated with professional identity is altruism. Merton (1982) defines altruism as "behavior which benefits others at the expense of the benefactor" (p. 110). He claims that this altruistic attitude and behaviour where the client's needs are paramount, is a required part of the professional's identity such that the professional will act altruistic even if there is no altruistic feeling.

Related Concepts

Actual definitions of professional identity seem easier to locate when exploring the literature associated with professions of more recent history. Perhaps there is a need for newer groups to explain and carve out their place in the existent professional landscape and culture. In fact, it is suggested in the Thesaurus attached to the PSYCHINFO database that the term, professional identity, was not introduced until 1991. In this database professional identity is explained as concepts of self and role within a professional domain. As such, it is thematically linked to such concepts as role expectations, role models, and role satisfaction.

Summary

And so, the complexity and depth of this concept begins to emerge. Professional identity may include core beliefs and values as well as unique distinguishing characteristics, absorbed through socialisation into and within the professional body. While described by some as an evolutionary process, others see professional identity as a steady, more dependable collection of characteristics. The idea that role specific attributes may be assigned by individuals outside the profession is of particular interest in addressing this study's research question.

Professional Identity: Nursing's Perspective

The increasing interest, within nursing literature, in exploring the concept of professional identity is hardly surprising. A mental review of my own nursing education and career notes the evolutionary quality of both my personal and professional identities. I recall the 1970s and 1980s as a time for development of nursing frameworks as part of the quest to establish nursing's legitimacy as a profession with its own unique body of knowledge. Having identified role confusion in nursing, various theoretical perspectives of the nurse's professional identity are explored in nursing literature where efforts are made to articulate the components of the nurse's professional identity and the ways in which the nurse's professional identity is developed.

Role Confusion

Review of nursing literature reveals that by the 1990s nursing authors are intent on beginning to articulate the unique characteristics of the nurse, once again grounded in research and theoretical models. Around this time, a study of Swedish nurses about their professional role found that these nurses are not simply following the orders of the physician.

Still, these nurses understand and describe their role in an unclear and diffuse manner, even though they see their work as "guided by the needs of the patient" (Odling, Ohlsson, & Danielson, 1990, p. 140). Consequently, when involved with students or novice staff, the nurses transmit an equally confused model. They fail to model the idea that understanding what a role consists of or implies is essential before one can truly fulfil that role. And so, though difficult, there is a will to describe the nurse's unique attributes and the ways that registered nurses make a difference.

Role confusion is also shown to influence both recruitment into the profession and staff retention (Cowin, 2001). Cowin notes that without a firmly grounded professional identity, efforts aimed at solving the nursing shortage will be ineffectual because of the critical impact self-concept has on employment issues involving both recruitment and retention. Because large nursing shortages are forecast, it is critical that the essence of nursing practice is understood. And that essence includes what it means to be a nurse as well as what nurses do. Beliefs about what nurses do, inform not only career choices but also the way in which that career choice is engaged (Spouse, 2000). After all, there are other professionals who also claim to provide leadership in patient care (as a 2004 poster advertising the services of respiratory therapists attested at the acute care facility where I am employed).

Theoretical Perspectives

Professional Identity as a Social Process

The professional identity of the nurse has been investigated from a variety of theoretical perspectives. It is described as "a narrative about the self – a story produced in a social and cultural context" (Managing identities, 2002, p. 31). Fagermoen (1997) suggests

that each nurse's value set, which is both institutionalised and socialised, is "inherent in developing and sustaining professional identity and...[is] expressed in nurses' actions in relation to others" (p. 436). Thus, personally held beliefs and values guide the thinking, interactions, and actions of the nurse. And so, that which is personally meaningful in a nurse's work shapes that nurse's professional identity (Fagerberg & Kihlgren, 2001). A particularly important component of that nurse's perspective of professional identity is related to the way the nurse focuses on the patient. Recognising the importance of both self-reflection and social interaction in development of professional identity, Fagermoen grounds her work by applying both moral philosophy and work-sociology. As well, she utilises symbolic interactionism, a theoretical framework from the tradition of sociology, which, as Tashiro (2002) describes, emphasises the "situational nature of identity, its social construction through interaction, and the constant negotiation and renegotiation of identity that occurs through a sense of group position" (p. 6). Thus, the nurse's sense of professional identity is a product forged through a social process.

Professional Identity as an Evolutionary Process

The research of Ohlen and Segesten (1998) not only embraces symbolic interactionism, but also recognises Erikson's theory of psychosocial development as theoretical frameworks linking the individual's personal and professional identities. Development of the nurse's personal identity is seen as a prerequisite for the evolution of the nurse's professional identity (Ohlen & Segesten) because personal identity and a personal worldview exist before the nurse enters the profession (Roberts, 2000). Erikson's theory places professional identity within the growth and development continuum, attained when the nurse has "experienced the inception, infancy and growth of the development of trust,

autonomy, initiative and industry" (Ohlen & Segesten, p. 724). Because this describes movement from adolescence through midlife, it seems that professional identity from the perspective of the nurse might be presented as an evolutionary process that unfolds over a lifetime. Rogers (2001) further finds that it involves personal and professional growth in "caring", requiring self-disclosure and emotional maturity. A general sense of altruism evolves into a set of specific, differentiated values critical to the nurse's professional identity development (Fagermoen, 1997) and commitment to the public good.

Professional Identity as a Developmental Process

MacIntosh (2003) describes professional identity of the nurse as a three-stage developmental process. It begins with the individual nurse assuming professionalism and adequacy in practice (Stage 1). But as the nurse begins to observe and critically reflect on her own nursing practice and that of her colleagues, she begins to question her professional title and explores the personal meanings of professional identity (Stage 2). As reflection on practice continues, the nurse reworks her professional identity construct (Stage 3). Successful navigation of the process finds the nurse with a professional identity that "reflect[s] reputations for expertise, interests in learning, active contributions to the profession, and assistance to new nurses...an increasing depth of understanding and integration of professional and personal identity" (p. 737). Interestingly, specific mention of the client seems to be missing from the remarkable list of professional attributes in MacIntosh's construct, which is all about the nurse. However, just as "trickle-down-economics" are thought to benefit those at the lower end of the economic spectrum, perhaps MacIntosh's process is meant to result in "trickle-down-benefits" in client care. But how do our clients recognise or respond to these different iterations of the registered nurse?

Powerless or Powerful

On a somewhat different note, Roberts (2000), viewing nurses as traditionally powerless, uses feminist and African-American models of oppressed groups to ground her model of identity development. Benner (2001), however, presents a much more empowered perspective of nurses even though that power is exerted from a position of relatively low status in the healthcare hierarchy. She notes that nurses are:

> The ones who are there, and they know how to work the system. A patient can have a very skilled, knowledgeable physician, but if the nurse is lacking in diagnostic, monitoring, or therapeutic skills – and most serious of all, if the nurse does not care – the patient's chances for recovery, or for dignity and comfort in dying are slim (p. 216).

This describes a position of enormous power, and it is one that Clark (2002) suggests requires that nurses reflect on their role in healthcare and assume responsibility for empowering their profession. If, as she asserts, hands-on, intimate caregiving and responsible client care remain core values of professional nurses, "a means to continue these in our practice and professional endeavors must be articulated and enacted" (p. 26). Clark sees the current trend of nurses toward individualisation or membership in subgroups as less than helpful in the development of a collective professional identity within nursing. And this may have an impact on clients. For example, while I may identify more as a perioperative nurse after many years in that practise area, friends and neighbours see me as a generic nurse and come to me with general nursing and health questions.

Components of Professional Identity

Early research reported in nursing literature centres on identifying the values that are embedded in meaningful nursing practice. But nurses interviewed for subsequent studies on this topic describe the most distinguishing characteristic of a nurse with a developed

professional identity as one who expresses a feeling of *being* a nurse as opposed to one who reported simply *working* as a nurse (Ohlen & Segesten, 1998). Ohlen and Segesten contend that the nurse's professional identity has two dimensions. The first is a subjective element (the individual's perception of ability to practice skilfully as a nurse) which supports the second, an objective component (other people's perspective of the individual as nurse). So the first element addresses how the nurse sees herself, and the second addresses how others see the nurse. Considering this construct, Fagermoen's (1997) definition of professional identity as the nurse's personal philosophy of nursing-- "what it means to be and act as a nurse" (p. 435)--has particular merit since it also describes both subjective and objective components.

Developing Professional Identity

Socialisation

Certainly, nursing students acknowledge the importance of their education in shaping their professional identities (Beeman, 1991). Those with baccalaureate preparation view advanced education as critical in developing the self-confidence to practice independent decision making around client care. One student in Beeman's study succinctly observes, "professionalism is an attitude exhibited through behaviors" (p. 66). But while the nurse's professional identity is necessary to feel more confidant and garner respect, it also develops over time with experience. It is not conferred by a document at the end of a program of study (Muscari & Archer, 1994; MacIntosh, 2003). And so, as Roberts (2000) summarises:

> Socialization as a nursing student, prior experiences, and work as a nurse all combine to develop the assumptions and beliefs about how to behave as a professional. These three merge into a professional identity that continues to develop and change throughout the career (p. 78).

In this way, the professional identity of the nurse evolves as it is influenced by "interaction with other nurses and through internalization of the knowledge, skills, norm, values, and culture of the nursing profession which are acquired by the process of socialization" (Ohlen & Segesten, 1998, p. 722).

Needs of Clients

The 1996 American Nurses Association campaign championing the idea that "Every Patient Deserves a Nurse" raised the profile of the nurse as a knowledgeable professional focussed on meeting the needs of the client (Lange & Polifroni, 2000, p. 514). In commenting on this marketing strategy Lange and Polifroni suggest:

> If nursing has a social responsibility to the public, then we have a responsibility to dress for the role, to wear a readable and informative name tag, to identify ourselves, and to educate the public about our role and the roles of others in the system. To do any less is shirking our responsibilities and leaving our patients vulnerable (p. 514).

And so, meeting the needs of clients involves being trustworthy in a provision of service in the public interest. It is an essential part of the nurse's professional standard of practice (Registered Nurses Association of British Columbia (RNABC), 2003).

Similarly, in their literature review, Fagerberg & Kihlgren (2001) note that being a nurse means being there for patients, meeting their needs, and being committed to them. These researchers report that nurses see themselves as protectors of their patient's human dignity. Therefore, knowing their patient is important and requires that the nurses be attentive to both the verbal and non-verbal cues given by the patient. Ewens (2003), echoing this perspective, suggests that in order for nurses to be successful in role transitions and professional identity transformation, they need to "recognize the growing culture of partnership and focus upon user priorities" (p. 227). While there needs to be demonstrated

consistency between the nurse's professional role and the nurse's self-concept, an understanding of how role identity shapes the nature of the work accomplished and the patient care provided is crucial. For example, if the nurse's understanding of her professional role is clear, the impact on client-focused care of changes or options in service delivery such as altered "staff mix" (i.e. RN, Licensed Practical Nurse (LPN), and care aide ratios) is understood.

Context of Work

In addition, the context in which the nurse works contributes not only to development of her skill and expertise as a nurse, but also to development of her identity as a nurse (Fagerberg & Kihlgren, 2001). Staffing variables may affect development of professional identity if the environment is such that collegial exchange and support is difficult. Further still, workplace philosophy and systems may influence the nurse's professional identity. A work system promoting task assignment such as assigning a nurse to dispense all medications on a unit may impact on the nurse's professional identity differently than a system emphasising patient assignment where total care of that patient is the nurse's focus. But it is unclear whether the nurse exhibiting the personal characteristics of a developed professional identity, which Ohlen and Segesten (1998) identify as "compassion, competence, confidence, conscience, commitment, courage and assertiveness," (p. 726) interacts with each system differently.

Related Concepts

There seems to be conceptual overlap in the nursing literature. Fagermoen (1997) notes that "professional identity was often addressed in terms of related concepts, especially as professionalism, perceptions of the nurse role, the professional self or self-concept of

nurses" (p. 434). Other closely related concepts identified by Ohlen and Segesten (1998) are occupational identity, self-esteem, self-image (professional and personal), and the role of the nurse. The relationship between these concepts and the prevailing themes of professional identity as an evolutionary process involving socialisation and role definition seems appropriate.

Summary

There can be no doubt that nursing is incredibly complex. Dame June Clark, speaking to 1997 ICN delegates in Vancouver, BC, expresses this notion aptly: "Saying that nursing is what nurses do is like saying that loving is what lovers do" (cited in Picard, 2000, p. 244). Clark describes nursing as an activity requiring commitment and personal investment on the part of the nurse, the development of a relationship that focuses on the well-being of another, and the intellectual knowledge and skill with which the scientific application of nursing practice is achieved.

This elegant description of the intricate fusion of science and art is at the heart of the nurse's professional identity and is supported in contemporary nursing literature (Cherry & Jacob, 1999; Fagerberg & Kihlgren, 2001; Fagermoen 1997; Mangum et al., 1997; Odling et al., 1990; Ohlen & Segesten, 1998; Rogers, 2001). Even so, nurses that I have recently encountered describe themselves as "care-givers" and "patient advocates," but then state, "Just tell me what to do and I'll do it." Perhaps they should be asking their clients, "How can I help you? What is most appropriate right now?"

Professional Identity: The Client's Perspective

Fagermoen (1997) further augments her interpretation of professional identity to include the "values and beliefs held by the nurse that guide her/his thinking, actions and

interactions with the patient" (p. 434). If professional identity refers to the nurse's conception of what it means to *be* a nurse, then adoption of Fagermoen's definition of professional identity provides a direct link between this conceptual idea and how it is operationalised in daily nursing practice. But the values brought to that nurse-client interaction are not identified. Nor is it clear how clients, who have their own values and beliefs, interpret those of the nurse and formulate an opinion about the nurse's professional identity. Roberts (2000) claims that nursing's values are indistinct from the values of medicine. And so, it is important that those values, which clients perceive as unique to nursing, are identified. And this knowledge can only be obtained from clients. Perhaps the client views the nurse as a medical assistant or as a nursing care expert. It may matter.

Historical Perspectives

One of the first publications presenting the client's perspective of the nurse comes from Sister (Sr.) Gabriel (1935), a Sisters of Charity hospital consultant and educational director with 35 years of hospital experience. It does not appear that patients are invited to review her manuscript, *Through the Patient's Eyes*, or to offer their opinion of her observations even though it might be expected that the patient is best qualified to comment on his own views and perspectives. Sr. Gabriel writes that the patient desires a healthy looking professional with a great smile and a pleasing personality, who is clean and attractively dressed. It is also important for the patient to feel that he has his nurse's prompt and undivided attention, since this inspires trust, just as his confidence in the nurse grows when his complaints are acknowledged and not thoughtlessly dismissed. She notes that the patient's first impression is often the lasting impression, and that attention to the small details is noticed and remembered by patients. While Sr. Gabriel feels that co-operation in the

provision of care will produce the best outcomes; it is unclear whether the patient is the one with whom that co-operation is sought. There is an impression that study of the patient and his interaction with his nurse is more an observation of the patient rather than an exploration with that patient. I wonder whether the views of our clients today would be radically different from those of Sr. Gabriel's patients.

Nearly 25 years after Sr. Gabriel's publication, a study sponsored by Teachers College, Columbia University, New York set out of show that patients have an opinion on the ideal characteristics of a professional nurse (Holliday, 1961). A small, eight participant focus group interview of hospitalized patients identifies functional and expressive traits, which are part of the ideal professional nurse's practice, producing a composite description with the traits appearing in the rank order that they emerge in the study. These informants think it most important that their ideal nurse is skilled and knowledgeable. These characteristics are followed closely by various people skills such as congeniality. It is interesting that the nurse's ability to communicate explanations related to tasks she is performing was near the end of their list, just before their desire that the nurse displays a professional appearance. When this synopsis was presented to the nurses of that day the general response was that they didn't have time to meet these patient expectations even though nurses were aware of their patient's desires.

Following-up on Holliday's (1961) study, Tagliacozzo (1965) confirms that patients have expectations of the professional nurse and particularly valued the nurse's attentiveness and kindness to them. These informants also express concerns about the "shortage of skilled nursing personnel…impersonal nature of care, the constant change of personnel and the infrequent presence of the head nurse" (p.221). These patients wonder who will protect them

since it is their view that errors are less likely to occur if the nurse knows them and takes a personal interest in them. Most importantly, they interpret the nurse's prompt response to their calls for assistance as a real demonstration of the nurse's interest and reliability. When placed in the current healthcare context, it seems that little has changed in the intervening 40 years.

Then in 1988, while identifying the care components most important to an institution's patients and their families, Rempusheski, Chamberlain, Picard, Ruzanski, and Collier observe that to former patients the characteristics of a nurse and the nurse's professional image are very important. The nurse's characteristics included affective, cognitive, and psychomotor traits common to primary nurses. It is important that these informants are unable to separate service from care, noting that "when service needs are not met, perceptions of even the most competent, caring nurse behaviors may be dampened accordingly" (Rempusheski et al., p. 47). If this is so, the client may not view the care of the professional nurse any differently from that offered by any other caring, licensed (i.e. LPN) or unlicensed individual. Perhaps clients simply see such practitioners as offering different levels of technical expertise.

Still, Taylor et al. (1991) note that explorations of quality nursing care rarely involve the consumers of that care. Interviewing 140 healthcare consumers, the attributes of the nurse such as personal qualities and proficiency are overwhelmingly most important to the informants irrespective of the nurse's practice setting. It was the nurse's personal qualities which informants thought most influenced the nurse-client interaction and relationship. These informants comment on nurses using such descriptors as nice, flexible, efficient, helpful, gentle, courteous, conscientious, confident, caring, knowledgeable, and technically

competent. Although the informants also mention the importance of the nurse's professional

characteristics, those traits are difficult to identify since these informants speak more

generically of professional attitudes, auras, and manners that reflect the nurse's responsible

attitude. In addition, professional dress is important, as is the nurse's obvious enjoyment of

her role with the patient.

And so, the idea that patient expectations are unknown and unmet is a thread that runs

through much of the literature reviewed. This theme persists even though interest in customer

service, patient satisfaction, and quality improvement are longstanding and healthcare is

increasingly being redefined and viewed as a consumer product. Furthermore, Cleary and

Edgman-Levitan (1997) suggest caution in exploration of client satisfaction, since they note

that it is possible for patients to be satisfied with poor care, and dissatisfied with good care

Image Linked to Identity

Review of the literature dealing with client perceptions seems to indicate that their

comprehension of the nurse's professional identity is a composite intrinsically linked to the

facets of nursing image that are displayed. But as previously mentioned, image and identity

are not the same. Kalish and Kalish (1983) present definitive work on nursing image,

defining image as "mental representations that influence how people see all aspects of life,

including nurses and nursing" (p. 4). As such, a professional image might be viewed as a

symbolic mental conception of the nurse which is representative of the attitude or the

individual or group holding the image (Rempusheski et al., 1988). For example, when

prompted to conjure up an image of a rabbit, Bugs Bunny might immediately come to mind.

But while Bugs Bunny is familiar in our cultural context, he can hardly be viewed as

representative of rabbit identity. And so, the nurse's image should not be confused with the

nurse's identity, which holds at its core the nurse's definition of what it means to be and act in the professional role.

Confusion of Identity

There is evidence in the literature that both nurses and their clients are confused about the professional identity of nurses. Odling et al. (1990), studying the professional role transmission between practising nurses and nursing students, observe that the nurse who consciously understands her professional identity has a clear perception and awareness of her professional role and is able to transmit it to both her colleagues and clients. Such a nurse is described by her client "as a supplier of facts and a helper" (p. 138). Because nearly half of the nurse informants in this study had such an unclear understanding of their own professional role that they could not easily share it with either student nurses or clients, the researchers suggest that the nurse's professional role be more clearly defined. Cowin (2001) further posits that a reason for confusion around the nurse's professional identity may be due to poor understanding of the nurse's self-concept particularly in leadership areas in nursing.

Although nurses express confusion around their professional role as nurses, there are studies suggesting that nurses' lack of identifiable dress and professional introduction contribute to clients' confusion about the professional identity of the nurse. Therefore, it is not surprising that commentary in the literature focuses on the nurse's appearance and introduction to the client as possible indicators to the client of the nurse's professional identity.

In the 1989 Alberta Association of Registered Nurses study exploring Public Opinion of Nursing in Alberta (1990), participants overwhelmingly express a positive image of nursing even though they have difficulty in actually identifying the RN. Although the

uniform, identity badge, and pin assist some clients with recognition, a small portion of the sample claim they do not know how to identify the RN. A similar survey in Saskatchewan conducted by the Saskatchewan Registered Nurses' Association (1989) notes that there is no clear or consistent indicator that a person is a RN. Because most people come into contact with nurses in hospitals, caregivers in that setting are presumed to be RNs. This finding is confirmed in more current literature (Lange & Polifroni, 2000; Oermann, 1999). Researching consumer descriptions of quality health care, Oermann observes that about 25 per cent of her respondents are unsure of who the RN is when they are receiving care. Lange and Polifroni learn that 28 per cent of their informants are unable to distinguish between nurses and unlicensed assistive personnel.

But it is reported in the literature that clients learn much more than the simple identity of the nurse from the nurse's attire. In their study evaluating the effects of the first impression of the nurse and nursing care, Mangum et al. (1997) point out that people use physical appearance to form impressions of one another. Therefore, the nurse's attire may influence the nurse-client relationship because that attire is seen to reflect that nurse's confidence in ability and judgement, as well as the nurse's professional identity. Mangum et al. state that "the way nurses dress symbolises role identity, function, authority, and their professional image of commitment and accountability....dress makes a statement to patients about the nurse" (p. 40). They also report that the nurse dressed in casual attire does not portray a clear professional identity. Concurring with this view, Cherry and Jacob (1999) relate that the nurse's casual attire conveys the message that "the nurse should not be taken seriously and has little regard for the seriousness of the situations encountered" (p. 41). Of course, the appropriateness of work attire depends on the nurse's particular workplace

setting. Although casual attire may be appropriate in some settings, nurse executives have long recognised that there is power, recognition, and authority in one's visual presentation. The nurse who is attentive to her outward appearance, both as an individual and as a member of an admired profession, demonstrates an understanding that she personifies professional excellence and quality care (Newton & Chaney, 1996). For the client there is assurance that if the nurse demonstrates care in personal grooming, similar attention will be extended, as necessary, to the client's health related needs. And so, Mangum et al. advise nurses to consider the significance of professional polish, something not to be taken lightly in a healthcare environment where support staff may appear indistinguishable from the RN.

Using a proper introduction may also influence the client's perception of the nurse's professional identity. In recent nursing literature individual nurses are urged to reclaim both their name and their title (Buresh & Gordon, 2000; Cherry & Jacob, 1999). "The use of first names, no names, and referral to everyone as the nurse has led to professional concerns that patients have no idea who is the nurse" (Cherry & Jacob, p. 44). Introducing oneself using both name and status identifies the nurse as a serious professional with important clinical knowledge for which accountability is assumed, and is in keeping with the behavioural standard in other professional groups. It demonstrates more than good manners. For the client it places the nurse within a select group for which beliefs and expectations as to the nurse's knowledge and expertise may have already been formulated. As such it is seen to promote trust. While some nurses have raised safety concerns about disclosing their full name, this allegation is difficult to support in nursing literature (Cherry & Jacob).

But even if clients have been introduced to the nurse and can identify the nurse, client confusion may persist. While investigating an elder population's expectations of their nurses,

Santo-Novak (1997) reports that most of these clients can not distinguish the role of the RN from that of other healthcare team members, nor describe the unique role of the nurse in their care. These informants saw the nurse's position as a dependent one, with the nurse working under the direction of the physician.

What Clients Want

Nurses Who Are Knowledgeable

Beginning with Holliday (1961) client's express their desire for a knowledgeable, proficient nurse. This sentiment is reaffirmed with Cherry and Jacob's (1999) report that clients in need of healthcare want to believe that their nurses are knowledgeable. Similarly, Santo-Novak's (1997) informants, focusing on the skills and tasks performed by the nurse, want nurses who are knowledgeable. Interestingly, Radwin (2000) reports that the quality of nursing care is not related to the nurse's level of experience. Perhaps, instead, it is a product of the amorphous *being*, that integral element of the nurse's personal philosophy of nursing which forms part of Fagermoen's (1997) conception of the nurse's professional identity.

Nurses Who Are Supportive and Anticipate Client Needs

The nurse's personality and need of people skills are foremost in Sr. Gabriel's (1935) patient's assessment of the nurse. They continue to be important. Tagliacozzo's (1965) informants want the nurse to be interested in them and kind to them. Holliday's (1961) participants see the ideal nurse as supportive of the patient, gentle and amiable while engaged in her work, and pleasant with all those she encounters in the course of her work. Clients want nurses who are caring, committed, and dedicated (Cherry & Jacob, 1999) and who can recognise client needs and respond in a competent, professional manner (Santo-Novak,

1997). These attributes are remarkably similar to those nursing traits identified by Radwin in her work with oncology patients (Schreiber, 1999).

It is suggested in nursing literature that clients value the practical ways that nurses interact personally with them while providing care (Gardner, Goodsell, Duggan & Murtha, 2001; Watson et al., 2003), while nurses value being recognised for what they know (Mangum et al., 1997). Given this discrepancy in viewpoint, these authors stress that it is important for the nurse to explore the client's perspective so that the client receives care that is important to him.

Nurses Who Are Trustworthy

The Pollara Public Trust Index routinely ranks nurses as the most trusted professionals and in another survey nurses topped the 1999 Gallup poll in regard to 'honesty and ethics' (Buresch & Gordon, 2000). Although nurses trailed fire-fighters after 2001's "9/11" crisis[2], nurses regained their premier position in subsequent polls (Domrose, 2002). It is a paradox that while the public holds nurses in such esteem, nurses seem to lack a recognisable identity.

But, the virtues such as honesty and trustworthiness, which are identified in these polls, are difficult for a client to discern on initial or limited contact with the nurse. And so, for clients the nurse's appearance, bearing, and how she introduces herself does influence their judgement on those characteristics of the nurse which are most prized--that the nurse is knowledgeable, caring, committed, and dedicated. This is neither new, nor locale specific. It is evident throughout the literature reviewed in this chapter, and expressed by the patient in the Vancouver Sun article story (Bramham, 2002) whose story prompts this research project.

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[2] The September 11, 2001 terrorist attacks on the World Trade Center in New York City and the Pentagon in Washington, DC.

Summary

Based on the literature, clients seem to see nurses as knowledgeable and skilled providers of care. It is also important to clients that nurses have personal qualities that support their interpersonal contact and relationships with their clients. However, clients are often unable to identify the nurse and express confusion about the nurse's role in their care. Clarifying these uncertainties is necessary if nurses are to maintain the confidence and trust commonly expressed by their clients and the public.

Rationale for Importance of Client's Perspective

As is evident from the literature reviewed in the previous sections, the perspectives of nurses and their clients may differ. Given that nurses have difficulty articulating their own perspective of the nurse's professional identity; the difficulties that clients have with this concept is not surprising. And so, it is apparent, from the discrepancies in viewpoint already identified, that there is a need for emphasis to shift from what nurses *speculate* that their clients think about the nurse, to what clients *actually* think about the nurse. If, as asserted, there can be no nurse without the client, then obtaining direct client input is essential. In fact, it is the client, the "other" component of this logical pairing with the nurse, who gives meaning and definition to the nurse's identity (Managing identities, 2002).

Learning and understanding the client's perspective of the nurse's professional identity is also important because it demonstrates the nurse's commitment to the client as a unique and valued individual. Benner (2001) emphasises that this commitment is essential and valued in all nurse-client care interactions. And, the client's perspective is key if the nurse is actually practising client-centred care (Taylor et al., 1991; Young et al., 1996). It is suggested in some literature that adoption of a client-centered focus is simply enacting the

"Golden Rule"--treating others the way we would like to be treated (Client-centered care,

1998). In fact, I recall many surgeons using the same mantra and speaking with family using

the words--"If this were my child/my parent/my spouse." But this is misleading. The client is

not our relative, and the option we might advocate, as a care provider, may not be what is

appropriate from that client's or family's perspective. Once again, the focus on the client's

perspective is missing, even though it is the fundamental tenet on which client-centered care

relies. Young et al. (1996) observes that "gaps between nurses' perceptions and patients'

actual views occur despite various efforts to build patient-centered care into hospitals' quality

improvement programs" (p. 19).

In as much as this gap exists, how can it be bridged? Spanning that gap requires that

the nurse understands and thoughtfully develops her personal and professional philosophy,

working in such a way that the values philosophically held are evident in her practice. After

all, as Radwin (2000) states, "the individual nurse's beliefs and abilities are more likely to

affect her...demonstrations of...attributes than formal organisational manifestos" (p. 188).

And so, the nurse who believes in understanding the client's perspective and is committed to

client-focussed practice will find her professional practice influenced by these personally

held beliefs to a greater degree than could be achieved by any organisational mission

statement mandating practice according to such a philosophy.

It is suggested in nursing literature that if the nurse has a better understanding of how

the client understands the nurse's professional role, nurse-client interactions may be

enhanced (Lehna et al., 1999; Watson et al., 2003). This has particular importance in our

current economic climate where skill mix and cross training is presented as a cost-saving

option for consideration within our health care systems (Herdman, 2001). At the same time

expanded roles for the nurse are being explored. Since, the client's perspective of how the nurse's evolving and expanded roles meet that client's needs is thought to determine whether such service will be accepted and utilised (Chapple et al., 2000), understanding their perspective is vital. Perhaps ideally, perceptions of both the client and the nurse may be brought together, such that humanistic values, scientific knowledge, and highly skilled technological behaviour are merged in the provision of care (Patistea & Siamanta, 1999).

Our clients are increasingly sophisticated, having access to information and opinions unavailable until the advent of the Internet. How they engage with their current nurse is influenced by their knowledge and their prior experiences with nurses, as well as that client's personal values and expectations (Oermann, 1999). Chapple et al.'s (2000) study reports that the identity construct of the nurse assembled by clients is a result of many factors including interaction with other people, using the services of the nurse, and from notions of medicine and nursing that the client has gleaned elsewhere. But, what that construct actually includes remains an elusive but important piece of information as nursing practice expands and evolves. Appropriately then, this construct--what it means to be and act as a registered nurse from the client's perspective--will be the focus of this research study.

Summary

In this literature review the origins and development of the concept of "professional identity" were explored across various professions, including nursing. Similarities and differences were identified. Refining the focus, literature pertaining to the client's perspective of the professional identity of the nurse was investigated. Several thoughts of particular significance can be extracted from these perspectives when considering the client's perspective of the professional identity of the nurse as presented in the literature.

CHAPTER 3: METHODS

This study is designed to explore client's perceptions of the professional identity of registered nurses. This chapter includes details about research design, data collection, and data analysis. The rigor demonstrated in this study is also discussed, ethical considerations identified, and limitations outlined.

Research Design

With study findings located in the experiences and actions of informants, qualitative studies are particularly appropriate for use in applied disciplines like nursing. Such studies are used to disseminate conceptual knowledge to nurses and explore questions around health and illness experiences critical to the advancement of nursing knowledge and clinical practice (Kearney, 2001; Thorne, Kirkham, & MacDonald-Emes, 1997). Rather than commencing with a fixed form of inquiry arising from prior knowledge, qualitative research is inductive with emergent methods responsive to the themes arising within the data (Sandelowski, Davis, & Harris, 1989).

Qualitative description is a research methodology that follows the philosophic tenets of naturalistic inquiry where there is neither pre-selection nor manipulation of variables (Sandelowski, 2000; Thorne, 1991). Because one is not constrained by a particular theoretical perspective, Sandelowski notes that the researcher can comprehensively summarise the phenomenon of interest using the everyday language of the informants to provide the rich description which is the hallmark of this methodology. Focusing on individual cases, both the documentation and interpretation of that information is presented from an emic perspective, which is the perspective of the informant (Denzin & Lincoln,

2000). This perspective is essential to exploration of this research project's question and is achieved through the gathering of informant narratives.

Thorne et al. (1997) propose that interpretive description addresses questions of "what." But Sandelowski (2000) expands the scope of qualitative description by suggesting that studies employing this methodology may be used to discover the "*who, what,* and *where* of events or experiences, or their basic nature and shape*" (p. 338). This inquiry produces a valuable finished product--the description itself. Sandelowski also asserts that this description is interpretive in that it depends "on the perceptions, inclinations, sensitivities, and sensibilities of the describer" (p. 335). It is a distinct category of qualitative inquiry, amenable to the influence of other qualitative approaches. In this way the truth described in the research is "subject oriented rather than researcher-defined" (Sandelowski, 1986, p. 30).

This project involved conducting an interpretive descriptive qualitative study. The study sought to address the research question by learning the perspective of those serving as informants (Caelli, Ray, & Mill, 2003). Therefore, it involved exploring and describing the client's perspective of what it means to be and act as a registered nurse.

Sampling

This study employed purposeful, theoretical sampling whereby informants were selected based on their ability to provide information about the research topic. The participants in this study had encountered and interacted with registered nurses in various settings such as hospitals, extended care, community clinics, schools, and home care. While attempting to account for some variation by recruiting from both genders across a significant segment of the life span and experience, it must be acknowledged that for a master's thesis,

recruitment to represent all the potential socio-demographic variables would be an impossible burden.

Recruitment of a cross-section of up to 12 male and female informants that could represent each decade from 20-80 years was planned. Recruitment was by personal invitation, or via friends or community groups to which I had access through association. Recruitment flyers were posted and circulated in the parish and health club where I am a member, and also circulated through friends and nursing colleagues who knew of individuals interested in participating. Thorne et al. (1997) note that "some subjects are articulate, thoughtful, and eager to share their abstractions and analyses of a situation" (p. 174). It was informants such as this whom I sought to recruit. As well, several individuals particularly articulate during other student projects were contacted and used as key informants. To facilitate recruitment, all prospective informants were provided with written information about this study and investigator contact information (see Appendix A).

Even though Canada is known for its ethnic and cultural diversity, these informants were English speaking and residents of an urban or suburban community. These individuals had not known me in a professional capacity, nor were they currently in a hospital or long-term care facility. In addition, informants who are or were registered nurses were excluded. It was hoped that these restrictions would limit responses directly influenced by the nursing culture of a particular individual, facility, or practitioner group.

Data Collection

Data collection was via unstructured, open-ended interviews with informants. The interviews were audiotaped and transcribed verbatim. The time and place of the interviews was mutually agreeable to both the informant and the investigator. They were scheduled so

as to ensure that the interviews took place in a private, quiet surrounding so that neither the confidentiality of the informant nor the quality of the audiotaping was compromised. In addition, field notes were kept to provide contextual and interpretive detail not otherwise apparent in the audiotaped data. These notes were written as soon as possible after the completion of each interview and were an additional source of data for analysis.

Based on previous experience interviewing clients, I knew that clients were interested in talking about this subject and had many stories to tell of their encounters with nurses. During that experience, although I had anticipated brief interactions lasting 20-30 minutes, the interviews usually lasted at least an hour. Therefore, informants were advised that each interview might last 60-90 minutes.

Each interview began by obtaining the participant's informed consent (see Appendix B). Participants were described through the collection of basic demographic data, which included gender, age, educational background, and employment status. Although, various research studies on "caring" and "patient satisfaction" were reviewed as I looked for particular surveys or instruments that might have application to this inquiry, I found none that seemed adaptable. Instead, a series of unstructured questions (see Appendix C) were used to guide the initial interviews. These questions were refined--added to or altered--during the study based on needs to explore or confirm information arising within the interviews as data collection and analysis progressed. The possibility of follow-up interviews, for the purpose of clarifying data, was discussed with each participant, and permission obtained to contact them should this be required.

Analytic Technique

Since the process of qualitative research is inductive, inductive reasoning was used to evaluate and interpret the data (Morse & Field, 1995). Given the phenomenological influence in interpretive description research, data analysis was guided by Giorgi's strategies as adapted by Omery (1983). The end result was a description of constituents identified within a unique data set (Morgan 1993; Sandelowski, 2000). The data were represented in their own syntax. In this case, the voice remained that of each client. In addition, constant comparison analysis was used to compare each subsequent interview with the others. By looking for similarities or differences in new data, possible relationships among the findings may be understood (Thorne, 2000).

In this project, data collection and analysis proceeded concurrently as the verbatim transcripts became available. This process was both reflexive and interactive. Through repeated immersion in the data, an intimate knowledge and understanding of my informants' perspectives informed my approach to subsequent participants and the information they provided (Sandelowski, 2000; Thorne et al., 1997). After obtaining a sense of the whole interview through review of the entire transcript, distinct units were identified within the transcript and memos written that described my understanding or reaction to that particular data or unit. As basic components within the data were identified, so too were common categories or themes, all of which aided in gaining the "big picture" perspective described by Thorne et al. Throughout this process I consulted with my thesis committee to ensure that my analytic process was valid.

This big picture perspective is essentially a descriptive synopsis of the data produced through the interpretive description research process. Sandelowski (2000) declares that

because of its depth and accuracy, this summary is enough on its own to recommend its use. As an added bonus, qualitative descriptive findings may be used "as entry points" (p. 339), facilitating further study of the phenomenon of interest. So, whether the data appears simple or sophisticated, it has value and the study that produced it has merit.

Trustworthiness

The value of any research study depends on demonstrated trustworthiness. Trustworthiness involves a process, not simply an ad hoc evaluation, which must be adhered to throughout the project (Morse & Field, 1995; Morse, Barrett, Mayan, Olson & Spiers, 2002). Although Caelli et al. (2003) describe it as a theoretical rather than a technical issue, perhaps it is both.

Thorne, in her February 6, 2004 Vancouver, BC Ethel Johns Nursing Research Forum presentation, stressed that it is most important that the researcher's logic be transparent and in keeping with the purpose of the study. In this way the researcher is responsible, accountable, and trustworthy, presenting work with "moral defensibility, disciplinary relevance, pragmatic obligation, contextual awareness and probable truth" (Emden, Hancock, Schubert, & Darbyshire, 2001, p. 208). As Morse et al. (2002) assert, "research is only as good as the investigator" (p. 5). As the "instrument" in qualitative research, it is imperative that any investigator bias be acknowledged, since it can have both an overt or covert influence on data collection and analysis at any time during the research process.

Just as this methodology has evolved, so too has the articulation of the concepts used to demonstrate research trustworthiness (Emden & Sandelowski, 1998). Morse and Field (1995) write that trustworthiness of research is shown if the issues around credibility, fittingness, auditability, and confirmability are addressed. But Morse et al. (2002) opine that

the process of rigor, essential from a project's inception, requires strategies of "investigator responsiveness, methodological coherence, theoretical sampling and sampling adequacy, an active analytic stance and saturation" (p. 5). Using this terminology, I attempted to demonstrate that a process of rigor was planned, assuring both descriptive and interpretive validity in this project through an accurate accounting of both the events and their meanings to the informants (Sandelowski, 2000). It was impossible to predict whether saturation would be achieved, although given the sampling limitations in this study, data saturation was unlikely.

Investigator Reflexivity and Credibility

Finlay (2002) describes investigator reflexivity as "thoughtful, conscious self-awareness" (p. 532), building on Hertz's (1997) portrayal of this function--"To be reflexive is to have an ongoing conversation about the experience while simultaneously living in the moment" (cited in Finlay, p. 533). Through reflexivity, the researcher acknowledges his or her personal history, reasons for the research, and beliefs, all of which have potential, both consciously and unconsciously, to influence his or her thinking, data analysis, and, ultimately, the research findings (Caelli et al., 2003; Finlay; Sandelowski & Barroso, 2002). Because the researcher is the instrument in qualitative research, the researcher's transparency in acknowledging any particular point of view relative to the gathering and interpretation of the data (either positive or negative) is essential (Strauss & Corbin, 1998). Investigator reflexivity is demonstrated throughout this research project, beginning with the personal disclosure that follows and continuing through the memos and field notes produced as data collection proceeded. Serving as additional data sources, these memos note my impressions, making any personal beliefs and biases explicit.

One's disciplinary orientation influences one's approach to research (Thorne, Joachim, Paterson, & Canam, 2002). The fundamentals of the research frame with which I approached this study are embedded in my personal philosophy of nursing, the construction of which began as a freshman in 1968 at the Holy Cross Hospital School of Nursing in Calgary, Alberta. Welcomed by Sr. Marguerite Letourneau, a diminutive member of the Grey Nun order who had the presence of a giant, I was told that what I needed to become a "good" nurse was the education that they would give me and personal experience as a patient (personal communication, September 1968). While decades before the term client became familiar or the philosophy of client-centred care was described, it seemed that Sr. Letourneau wanted my group of student nurses to comprehend that understanding another's perspective was essential if individualised, compassionate care was to be provided.

Now, with years of experience as a nurse, a parent, and a patient, I think that this understanding encompasses more than simply "walking in another's shoes" or adhering to the "Golden Rule." It is not a matter of responding with an "if I were you" caveat, since I am not you and the choices I might make or the support I might desire may not be yours. Central to this understanding is my belief that each human being is unique and imbued with intrinsic worth. Therefore, each individual has a unique perspective--one that is important to me in my unflagging commitment to promoting and providing a healthcare environment in which the nurse and client collaborate meaningfully.

In this study, it was important for me, as a RN with many years of experience, to be aware of my response to informant descriptions about professional colleagues or, possibly, my place of work. By using empathetic listening skills and remaining open and non-

judgmental, I could hear all that my informants were saying--both positive and negative--without interrupting or attempting to justify or explain their experience.

An important part of the entire research process, the investigator's reflexivity contributes to the study's credibility from the time the research is conceived through the articulation and dissemination of the research findings. Credibility is assured if the reader has confidence that the data has been presented in an objective manner by a researcher whose integrity and skill as the instrument within the study is accepted (Morse & Field, 1995). In addition, the study can be found credible, when the research process is transparent and is seen to actually investigate what it sets out to investigate (Emden & Sandelowski, 1998).

Methodologic Coherence and Confirmability

Assuring that the research question and choice of methodology are congruent is a necessary first step in assuring data validity (Morse et al., 2002). My sampling strategy, which is appropriate to the topic being explored, also ensures validity by targeting representative and knowledgeable informants. In seeking to understand the client's perspective, each participant used in this study had been a client of a RN. The male and female informants spanned the adult age spectrum, providing some generational variety in their outlooks.

As data collection and analysis progressed, new insights or understandings, in light of what was already known, were recorded in memos. This systematic and detailed record keeping is further evidence of study consistency. The use of direct quotations was offered as "proof" that any developing constructs or categories emerged from within the data, ensuring the validation of the findings, making confirmability visible, and reducing the possibility of data manipulation.

Active Analytic Stance and Auditability

Detailed documentation began with the verbatim transcripts, which were reviewed against the audiotapes to ensure accuracy. Analytic records of interactions taking place between the data and the investigator, were also kept. The extensive documentation, which included the interview transcripts, fieldnotes, and memos outlining the investigator's thoughtful analysis of the data, provide a dependable and credible description of the process and are available for review, forming a visible audit or decision trail. This trail traces and documents the "decisions, choices, and insights" made by the investigator throughout the project (Morse & Field, 1995, p. 144). Although such a trail does not guarantee replicability of the study, following the outlined research process can ensure a dependable approach even though the outcomes may be different. This is in keeping with Sandelowski's (1993) view that confirmation of validity is more a theoretical problem than a technical one. She explains that there is an aspect of art to qualitative research that allows the results of researchers faced with the same data to ultimately arrive at different conclusions. The ongoing review and critique of the research process and data evaluation by my thesis committee verifies the dependability of my audit trail.

Ethical Considerations

Approval to conduct this research was sought from the Behavioural Research Ethics Board at the University of British Columbia. Although qualitative research is thought to involve minimal risk to participants, ethics review confirms protection of human subjects (Morse & Field, 1995).

After presenting information about this research project--both its purpose and process--in language that my prospective informants could understand, their voluntary

participation was sought. By signing an informed consent (see Appendix B) before audiotaping commenced, the participants confirmed their understanding of this research project and their willingness to participate.

Confidentiality of all informants was guaranteed, their identity known only to me. Their privacy was protected, as I maintained their anonymity on both the audiotapes and verbatim transcriptions. Furthermore, I assigned informants a numerical code, which was used as a participant identifier on all verbatim transcripts so that informant anonymity was safeguarded. Identifying place names and proper nouns were deleted from the transcripts so that contextual identification could not occur. Only the most generic references to a particular town, facility, or employer were retained in the transcript.

While this research study was in progress, the audiotapes and transcripts were stored in a locked location separate from the numerical identifiers and participant list. The audiotapes will be considered confidential, and only shared, as necessary, with committee members. Should any of this research study be submitted for publication, all informants will remain anonymous. The audiotapes and transcripts will be retained for five years, as required by the University of British Columbia Behavioural Research Ethics Board.

There were no potential risks to the informants participating in this research project. Participation was voluntary. Informants could interrupt the taping if there was something sensitive they wished to say "off the record", and if they were uncomfortable with any part of the process they could withdraw from the project. Although it did not happen, it was planned that if the audiotaping process upset an informant, that informants could review their tape and delete any information they did not wish included. Potentially vulnerable clients, those who were currently hospitalised or receiving care were excluded from this study since it is

possible that they may feel that their responses might impact on the quality of their continuing nursing care.

The possible benefit to the informants was that which comes to anyone who has an attentive listener to their particular "story," bringing a sense of affirmation and self-worth which, in and of itself, is a positive outcome. It was also conceivable that the informants felt that they were contributing to the "betterment" of nursing.

Limitations

This is an exploratory study. As with other qualitative studies the findings are not considered generalizable. While sample selection recognises some demographic influences such as age and gender, it is impossible to account for other important factors that could impact on the findings. For example, the experiences, and meanings attached to those experiences, may be quite different for each individual. In addition, cultural orientation or an individual's English language skills may affect their interpretation of an event or experience. Therefore, it must be understood that the interpretations expressed by the informants in this study may not be representative of a wider population. This is in keeping with Emden and Sandelowski's (1999) claim that a "criteria of uncertainty" is a valuable limitation, since it openly acknowledges the tentativeness of research outcomes that cannot be otherwise in a qualitative study. Still, as Morse (1999) notes, with purposeful sample selection the knowledge gained may be transferable in similar situations.

Summary

This chapter includes the design of my research project and a description of the interpretive description method that was used. The details around sample selection, data collection, and the analytic process are outlined, and issues of rigor and ethical

considerations are addressed. In addition, limitations of this research project are

acknowledged.

CHAPTER 4: FINDINGS AND DISCUSSION

This chapter contains the results of this study. In an effort to avoid redundancy, the findings are discussed in light of relevant literature as the chapter progresses. All un-cited quotations are attributed to the informants who volunteered to be interviewed for this project.

The recruitment process described in Chapter 3 yielded more volunteers than this researcher could utilise. This spoke of the interest that the general public had both in this topic and in expressing their perspective. Members of my communities who were aware of this project regularly approached me to tell me their stories "off the record." Even a topical unsolicited letter was received. Although that sender eloquently told her story and expressed her perspective, she declined to participate in an audiotaped interview.

Ten in-depth interviews were conducted with male and female respondents representing all of the decades from 20 to 80 years of age. During these interviews, informants described what they thought it meant to be and act as a nurse, from their perspective and based on their personal experiences. Several participants were reminded and reassured that there was no "right" or "wrong" response and that what was most interesting, for the purposes of this study, was their uncensored viewpoint, not what they imagined this nurse researcher would like to hear.

This chapter will describe the client's perspective of what it means to be and act as a registered nurse. These findings will be discussed with references to related literature.

To "Be" a Nurse, From the Client's Perspective

Fagermoen's (1997) definition of the nurse's professional identity is comprised of two parts--what it means to *be* a nurse, and what it means to *act* as a nurse. There is a

difference between *being* and *doing*. Some informants seemed to understand the importance of both facets; others found it difficult to separate these concepts. To help them, I shared my reflections from a long ago meditation that had emphasised the difference with the conclusion that this was why we were called "human beings" not "human doings." Still, actions are important. How one acts and what one does are often the result of individual beliefs and values that are a fundamental part of our being (Fagerberg & Kihlgren, 2001; Fagermoen, 1997; Tashiro, 2002). And how one interprets the actions of another is likewise grounded in that observer's own beliefs and values. As an informant explained, "There's certain perceptions that everybody has of everybody and if that perception has changed or doesn't fit the preconceived perception that you had, then something should trigger in you and say, 'Okay, who are you?'"

It was evident from the data that, from the client's perspective, there were several aspects involved in being a nurse. These aspects included the informants' understanding that to be a nurse involved much more than the nurse's job description outlining specific duties. Participants saw being a nurse as a difficult career choice. As well, they recognised that the nurse played a special role within the healthcare hierarchy.

More Than a Job Description

Without exception, informants shared their belief that to be a nurse was much more than the fulfilment of the demands of a job description. This was illustrated in the narration provided by two informants:

> I see now how sincerely difficult a nurses' job really is aside from the job duties…they have no outline to…this is what you do in this situation or this 'cause its gonna differ from person to person, and patient to patient, family to family depending on, I think what their views or their hopes or their dreams or whatever the situation may be.

No job description in my mind could fully describe what a nurse has to do in her relationship with the patient because it's such a complex relationship in my mind....There's so many different interactions, requirements, the illnesses, unique situations, unique people you're dealing with.

While each nurse was seen as an individual and part of a collegial group, there was also an understanding that the nurse shared a common humanity with the client. As discussed later, relationship building was thought to be part of the common human experience and something many clients specifically sought from the nurse. Informants recognised that just as each nurse was unique, so too were that nurse's collegial body, the clients they serve, and their community. In addition, the values and beliefs that motivated the nurse, both intrinsically and extrinsically, were perceived as important factors contributing to the nurse's development as a professional, which then could influence the client's well being. Participants with more life experience spoke of how the role of the nurse had evolved over their life span. From their perspective, while nurses may retire, those same nurses never stop being nurses.

Nurses Are Influenced by Their Attitudes and Personality

Informants indicated that there is wide variety within the ranks of nurses just as there is variety within the general public. However, nurses were also seen to have some traits in common with other nurses. These common qualities were particularly valued and were also referred to as natural attributes by informants who spoke of particular nurses being "born nurses." An informant speculated that when nurses seemed very different from one another, it was because these nurses were expressing those common qualities in different ways. Informants suggested that these "natural nurses" be targeted and their natural attributes be developed and strengthened. This informant explained:

A nurse is the result of all her background experiences in what she feels is the

right thing and way at the time…its also your upbringing I'm sure, because we talk about the 'natural nurse,' the 'natural person,' the 'natural teacher' who just fits the role…They are a result of all of their previous experiences and how they interact with people…I'm not sure the textbook can teach you those things but I do believe that nursing schools can be selective in who gets into nursing on the basis of those qualities….They come to the school with a lot of those attributes and then they're hopefully built on.

Fagerberg and Kihlgren (2001) are in agreement with these sentiments. While studying the professional identity of nursing students, they evaluated related literature. They stress that what the student brings to the educational experience--his or her prior knowledge, skills, and interest--is simply added to or enriched by the educational experience. Described as one "paradigm of life" (p. 140), these precursors are not easily changed either during the student's educational experience or once he or she is subsequently employed.

And so, it may not be surprising that all informants clearly viewed the various attitudes displayed by nurses as unique to the individual nurse rather than broad generic attitudes espoused by their professional body. Some of these attitudes were remarkable in their contrast. Some nurses were seen as empathetic, kind, and nice while others were bitchy, brusque, and impatient. Some were rigid, approaching care "by-the-book," while other nurses were flexible, prepared to engage in original problem solving for the benefit of the client. One informant reporting on the brusqueness of a particular nurse, felt that the nurse's brusqueness was simply because she did not "know" him. If nurses really know their clients, and take a personal interest in them, there is less chance that they will be rude to them. This is especially true if, as another informant said, "Nurses love people." Sadly, as another participant remarked, "There are a lot of nurses that seem to not really like people." She expanded further on these nurses, saying they were "superficial people," ones who did not "have that deep down caring." She thought that if one investigated the overall differences

between nurses, nurses who liked people would have displayed very different attitudes and personalities prior to becoming nurses. They would have been engaged in empathetic, helping roles before entering the profession, such as babysitting, volunteering, helping their mom, raising a family, and would have had leadership roles and naturally assumed responsibility.

In remarking on the courteous and responsive behaviours of nurses who dealt with her father, an informant noted that these behaviours "depended on the individual, and their ability to empathise...depended on whether they could appreciate that...person." This was in stark contrast to her reflection on the episode where a friend received a medication to which he was allergic not once, but twice, from the same nurse. She recalled:

> [The] nurse that gave...Penicillin more than once...that was very frightening...
> I think it was just an attitudinal problem with that particular worker. When
> confronted with it his kind of laissez faire, like "Oh well" attitude was...
> particularly offensive. But that's an individual issue as opposed to a nursing
> professional issue, I think.

Adam (1991) says that "understanding and respecting the client imply...that the nurse understand and respect herself, as a person and as a nurse" (p. 53). And so, the differences that the client notices in the nurse may be due to that nurse's sense of self-worth and how it is displayed. Informants saw that this self-knowledge and self-respect did influence how the nurse approached them. An informant commented on the notion that the nurse's personal sense of self-worth influenced how that nurse's individual style and personality would be demonstrated. She remarked, "I think that personality goes with you regardless of where you are, where you work, what setting it is. I think setting is a small percentage.... self-worth, your own personality, you take that with you wherever you go." As a youth clinic client, this informant's experience was overwhelmingly positive, but she reported that other friends were

less satisfied with their interactions, encountering "judging eyes." Later, as the parent of a child having surgery she again met different nurses. While one was described as "awesome" and "approachable," another displayed body language that said, "Go away. Don't bother me." This impression was confirmed when that nurse said, "Well I told you, go sit down. You'll know as soon as I know." This participant believed that the nurse's personality and attitude influenced this repartee.

And so, informants reported that each nurse has individual attitudes and personality, which are ultimately made manifest and affirmed as that nurse's "professional attributes," discussed later in this chapter. But there were also differences related to the context in which care is given. Informants noticed that nurses working in different domains of healthcare seemed to display different attitudes and traits. Nurses working on different units (i.e. Emergency, Labour and Delivery, Intensive Care) or in the community (i.e. public health, home care) were seen to be different and to have different approaches to their roles. For example, an informant described Emergency Room (ER) nurses as very commanding. She recalled an ER nurse saying:

> "This is the way it is...you're not moving. I need to do this right now and you're going to get this." And she just gets everything done as fast as possible ...doesn't really deal...too much with you or your family. It's just like command issuing.

While Intensive Care Unit (ICU) nurses also wanted to get things done, this informant viewed them as inviting more client involvement in their care, being "encouraging and [telling] you what you needed to do to get through that moment."

Generally speaking, within the hospital setting, informants saw themselves as on the nurse's turf. But it was quite different when care was being provided in the client's own home. Then the nurse was on the client's turf. As an informant explained, "You have

different expectations of the homecare nurse...they were on my territory." In her view the

nurses providing homecare had different attributes and needed them to be successful in that

role. Similarly, another informant commented on the difference she observed between nurses

working in a hospital setting and those working in public health:

> [Public health nurses] They're one-on-one with you. And they do tell you what
> they're giving the kids and they do explain what to look for, and they do talk
> about what the shots, how they work...you know they take the time to tell you
> all that. And they take the time to play with the kids and get their confidence...
> they were very nice.

These are interesting observations. Informants saw that some nurses easily managed

multiple clients while others preferred work situations where staffing ratios appeared to be

one-to-one. To informants, the patient-load of the hospital-based nurse was self-evident,

whereas the extensive caseload of homecare or public health nurses was less obvious and

clients seemed to more readily feel that they were the focus of their nurse. But does the

context in which care is provided influence the nurse's response to the client, or does the

nurse with a certain attitude or aptitude seek employment in a setting that has innate appeal

for her? Certainly, the importance of context cannot be ignored since increasingly care is

moving from acute care facilities to community settings. Therefore, it is important the nurse

working in such settings have the requisite attributes. How this might be achieved is

discussed in the final chapter.

Further compounding this issue, is the idea that the client may perceive things

differently depending on whether he is the primary recipient of the nurse's attentions, a

family member, or a friend. Sometimes family members have quite a different perspective on

care issues than the patient does. Still, informants understood that to be a nurse was more

than a job description because each nurse's unique and individual attitudes and personality

influenced that nurse, even though some attitudes were thought to be common to the profession.

Nurses Share a Common Humanity

Nurses were thought to share an essential humanness with their clients. This basic feature was illustrated in informants' comments on their personal experiences as recipients of care from nurses and their personal interactions with nurses who they encountered in their communities. The nurse was envisioned as part of a collegial group, yet part of a local community. As part of that local community, nurses were described as "people like us" with similar day-to-day worries and aspirations. This community connection was important to informants because it indicated to them that the nurse was not completely separated or isolated from the experience of the client. Informants mentioned community contact with nurses through recreation centres, hiking clubs, and local shopping. These nurses were friends and sometimes relatives (i.e. wives, sisters) with whom participants shared a relationship outside that of the normal hospital or care-provision setting. And while participants seemed to make a distinction between nurses that they encountered in a professional nurse-client relationship and those that they viewed as simply friends, they pointed out some similarities. For example, these "friendship-nurses" expressed interest in the informant and his story, and were valued and relied on to provide information, advice, and even intervention. As discussed later, it is nurses like this who are thought to never stop being nurses, even after they retire from the active workforce.

An informant spoke eloquently of the nurse being part of his personal history. As a young man, in addition to being cared for by nurses during times of illness, this informant had social contact with nurses since student nurses were regularly entertained in his

childhood home. He recalled his community marking and celebrating the traditions that were such a part of the nurse's formation during that time--from entry as "probationers," through capping, and on to graduation. With roots in smaller communities, he noted that there nurses are known and quickly recognised as local community members. He went on to stress that "if you wish to become a member of a community quick – be a nurse." This is in keeping with Picard (2000) who writes that in Canada, nurses are present, touching the lives of those around them from the cradle to the grave. This presence of the nurse in Canadian society is not limited to a professional context, but is present in the wider social milieu.

Perhaps it is because nurses are such a large contingent within the healthcare sector that their presence in the community is noticed. However, from this investigator's extensive work experience in larger communities across Canada, the idea that nurses are quickly absorbed into the fabric of their community rings true. Working as a nurse provides a quick introduction into the new community setting, allowing the nurse to both know and be known. It is not the size of the community that is the factor, since larger centres like Vancouver can be divided up into many smaller communities. Rather, it is the nurse's participation in and relationship with her own community which informants see as informing the nurse's understanding of the client within his community setting.

Informants saw the collegial group to which nurses belong as unique. They spoke of nursing's proud history and "legendary" tales. Reflecting on the collegiality of students from hospital-based nursing programs, an informant perceived that experiences previously commonplace might be outside that of current nurses:

> I guess actually the nurses today might miss something in the fact they're not members of a group that are...bound together with a need, necessity and everything else...given they've seen the high spots and the low spots...they've

lived and suffered together...so...they're tied together for life...my daughters... because they went through the university part...there's not that tie....those nurses [from hospital-based programs] had...something extra.

When asked what that something extra was, this informant replied that "it was being a part of something, a group, the 'l'esprit de corps'"--the result of their training history and workplace networking. Certainly within the military, l'esprit de corps is fostered through uniforms, insignia, and shared experience. And it was such a bond that enabled this informant's wife and her nursing sisterhood to stay in touch over decades and across continents. The collegiality of nurses was further demonstrated by the network that these nurses developed. The very fact that these nurses worked together resulted in a remarkable professional bond. When moving to a new location, news travelled on the collegial grapevine and his wife had an instant community of colleagues and potential friends. This was seen as quite different from the loose ties which his daughters, more recent school of nursing graduates, maintained with their classmates. But there may be many reasons for the variation in collegial attachment that he observed, not the least that his daughters are members of a different generation.

The need for demonstrated leadership, role models, and mentors is not unique to nursing. In fact, it might be considered common to the human experience as played out in the family, the school, the community, or virtually any segment of society. An informant spoke of role models and mentors as vital in the professional development of nurses because of the ongoing support and leadership that they offer other nurses. Dynamic leadership was essential. A participant explained:

I'm not sure where nurses pick up these behavioural attributes other than by example of those they train under...I'm sure they talk about it in the course work, about bedside manner and how to show you are a caring nurse, or I hope they did. But a lot of our learning comes from...following the patterns of those

who teach us....We go back to that person who served us well and try to model after them.

The way that leadership is expressed within a group of nurses and the positive role models that are available for those nurses is known to impact directly on client care. Hence the intense interest in exploring quality of worklife issues in nursing literature. Telford (2004) points out that "the power of a leader is not derived from balancing the budget...[but] from using creative processes to influence the lives of others in order to accomplish goals (p. 10). After all, both enthusiasm and disinterest may be contagious.

And so, the idea that being a nurse was more than a job description was supported by the informants' view that nurses shared their human experience as members of a local community. Nurses were also described as members of a collegial group with a unique history.

Nurses Are Motivated by Caring

Informants described that which an individual values as that person's motivator. Since it spills over into everything that one does, participants thought that what motivated the nurse was evident to the nurse's clients. An informant expounded:

> For a nurse, I think, is a nurse motivated by a pay scale...by the hours?...If she tells me, "Well now I get five days off" then that tells me that she's really ready to get away from this place...Or is she motivated by compassion. It's good to know that...they're motivated by caring. That's what I would hope...you can sense it sometimes because certainly it shows...just by conversations...they've come back from a few days off and they're saying, "Well I'm back again. It's good to see **you**. How are **you** doing now?" That means something...if you see them kind of grousing around by the end of their...time...it...fills me with... concern.

And so, rather than complaining or focussing on herself, the nurse motivated by compassion was focussed on the client. It was this motivation which this informant discerned as the "essence" of the nurse. This essence was expressed as a "fragrance.... coming from a

being that is centred upon giving and caring." But such caring attitudes were not seen as the sole property of the nurse, although, it was the opinion of this informant that they should be found in the nurse. In fact, another informant who volunteers in an extended care setting confirmed that the recreational therapists there were, likewise, very caring individuals.

Some informants suggested that nurses enter the profession in response to their own needs. Such nurses were motivated by a "need to be needed...the need to be appreciated." Another informant described this motivation, as the nurses' need to care:

> If you don't have that innate need or wish to really care for people, then you wouldn't be in this profession...All the nurses that I had any experience with at all, all had that. All wanted to do the best for me....Nurses seem to need to do that and as a patient that's exactly what you want is someone who needs to do that. Not someone who's just sort of putting in time, not someone who's working towards the pension or...just doing this as a, "Well I'm doing this because I don't want to work in an office." You have to do this job because you want to care for people and you want to help people...that's what's clear to me.

A nurse who remained after his shift to wash an informant's hair was thought by her to be motivated by his need to be certain of his patient's personal well being before he left the ward. Having observed several nurses who she thought exemplary, this participant recognised that they were different from other nurses. And while she did not expect that all nurses would or should be the same, she viewed these model nurses as uniquely motivated by their love of their work and their love of people. She stated, "They were probably just really passionate about their job...they just probably really loved it and really loved people."

It seems that these exemplary nurses are motivated by their view that they can make a positive difference in some area for their client. And it is this that they value. These nurses accomplish what they set out to accomplish. In fact, Pask (2003) reports that the nurse's professional identity is "intrinsically linked to and dependent on their capacity to see good in

the work they do" (p. 166). She goes on to suggest that nurses must perceive value in their work before they can become fully engaged in any client-focused encounter.

This is closely aligned to the view expressed by another informant that the nurse has the interests of the client at heart. Unfortunately this participant shared several stories where the nurse was not seen to be functioning in the best interests of the client. And so, she lacked confidence in the nurses, remained hyper-vigilant for herself and her family members when they were in treatment and care situations, and regularly intervened to prevent errors.

Other participants commented on nurses whose attitudes and behaviours demonstrated a willingness to go the "extra mile" where the client was concerned. Such nurses went beyond duty or their job description and exceeded their client's care expectations. While it was not anticipated that every nurse would exhibit such attitudes, informants saw this particular approach as a distinguishing feature of exceptional or memorable nurses. And so, from the informants' perspective, seemingly small things were quite profound and were offered as examples of their exceeded expectations. For example, the youth clinic nurse who gave her home phone number to her young client exceeded that client's expectations. The informant explained, "The fact that she had given me the number meant more to me than anything...just that she'd really gone beyond...the normal call of duty."

Another informant described another such small thing--having his hair washed by the RN in the ICU—as "a very nurturing, perhaps loving thing to do....for another [person]." Had the nurse made excuses or said "No," he would have accepted it. But instead his expectations were exceeded because of the RN's care.

But another participant told a disturbing story about a situation that occurred in the nursing home where her husband was taken for terminal care. Because of his functional and physical decline, he had spilled the contents of his urinal. His wife called for assistance so that it could be cleaned up before visiting hours. The nurse responded that it was "not my job to clean it up" in front of the patient and his wife. His wife answered that *she* would clean it up, but was told that housekeeping would be called. The spill still had not been attended to when, sometime later, the patient's physician arrived. That doctor reportedly stormed out and said, "Where do you keep your mops because I'm going to clean that up...if you can't do it, then I will." In this case the nurse's attitude was thought by the informant to demonstrate a lack of care, and perhaps even a lack of professional pride, because this informant believed that nurses would want their patients and their families untroubled by their physical environment.

And so, informants saw that the nurse's motivation was expressed in the nurse's attitudes towards others and demonstrated in her willingness to go the extra mile for her clients. Motivation, a response to either intrinsic or extrinsic components, was seen as an important aspect of what it means to be a nurse. These motivators were especially important since, having observed nurses working in extended care, an informant noted that "there's not a lot of fun things going on because it's pretty serious stuff caring for someone's health." As another subject stated:

> You could never pay me enough money to be a nurse because they just put up
> with the most ridiculous things....It's just not a fun job, so nothing pleasant
> about it at all...it was like all the not fun stuff that you know the doctor doesn't
> deal with necessarily. So they kind of do the aftermath stuff like the cleanup
> and eventually sending you off.

It seems evident that the nurse identified as going the extra mile has not succumbed to an "its-not-my-job" mentality, but has done something memorable for her client. What seems most noteworthy is that these unforgettable things are not huge. Most nurses will consider them quite small, even insignificant. But they are not so to their clients who recounted these events with such feeling and emotion. Accordingly, the nurse who provides a phone number to a lonely, pregnant teen, the nurse who washes a bedridden client's hair, the nurse who, having discovered that a dying client likes classical music, brings a tape recorder and classical tapes into that client's room, and the nurse who orders pizza for family members holding a death-bed vigil are all seen to have done something extraordinary. And so, if nurses really do love people, as is suggested earlier in this section, perhaps one way that it is manifest is in these seemingly small, loving acts which informants discern as going the extra mile.

In studying quality of nursing care from the patient's perspective, Fosbinder (1994) explores the nurse's interactive style with her patient. "Going the extra mile" is one component of her emerging theory of interpersonal competence. Perhaps going the extra mile arises from the nurse's fundamental attitude and is part of her *being*, although Fosbinder does not suggest this connection. In her study just over one-third of her subjects make statements explaining how the nurse exceeded their expectations. My informants similarly identified the infrequent occurrence of this experience.

Perhaps, it is *being* a nurse that requires the motivation which informants identify. If, as Ohlen and Segesten (1998) suggest, the feeling of being a nurse is quite different from working as a nurse, then working as a nurse may require different, less, or no motivation at all. One is also left to ponder whether the nurse's motivation changes over time. If the

nurse's professional behaviour is in keeping and integrated with her personal values and beliefs, then it is possible that the motivation that she has to become a nurse is the same motivation by which she remains a nurse.

Thus, to be a nurse was more than a job description because, as subjects shared, the motivation of the nurse was evident in her work for and attitude towards others. It was the nurse who was motivated by caring, whom informants described as providing extraordinary care. Nurses, whose motivation revolved around their paycheque or their desire not to do something else, such as work in an office, were suspected of being less caring. After all, it is because of those motivators that the day, which is just another day for the nurse, becomes a day that the client never forgets.

Nurses Live With Change

Whether or not the nurse simply accepts change or is seen as a change agent, informants recognised that to be a nurse involved a changing role requiring adaptation and accommodation on the part of the nurse. The addition of other paraprofessionals into the healthcare team contributed to the change process within nursing. Rather than seeing this as problematic, an informant saw it as a positive move, an opportunity that enabled nurses to do what they should be doing. He mused:

> The tasks of the nurse…[are] changing over time. There are more paraprofessionals and I'm pleased to see that these supportive staff to the nurse are taking care of a lot of things that the professional nurse doesn't have time to do…I don't pretend to understand all the tasks of nursing but I do think there has to be division of labour within the nursing profession and people working under the nurse.

His comments raise a key question,"What should nurses be doing?"

These informants encountered nurses in many clinical areas, including acute care, home care, public health, and clinical research. Several participants with a longer view of the

profession noted differences between nurses in times past and those they meet now. They suggested that the ways in which nurses were "trained" or "educated" influenced how the client perceived them. But not only has the manner in which nurses are educated changed, informants also commented on the changing content of that education, from treatments and drug therapy to advances in technology, which nurses now needed to know and understand. Although the nursing environment has changed dramatically, an informant proposed that the qualities and attributes required of the nurse remained the same. But it was not clear whether the mode of education (hospital-based diploma or university-based degree) was as much a factor in the client's perspective of the nurse's professional identity as was that nurse's age and years of experience--both nursing experience and life experience. For example, another informant commented on the connection and ease he felt with nurses who were close to him in age and parental experience.

The nurse's ability to respond to change continues from her student experience throughout her career. In fact, maintaining competence would seem to necessitate change. One informant, previously an educator, had a particular interest in life-long learning. Having written about life-long learning for a government task force in the 1970s, he reported that at that time, RNs ranked first at life-long learning and continuing education among all the professionals reviewed for that report. From his perspective this spoke to the professionalism of nursing and the importance that nurses placed on maintaining a current body of knowledge. He noted:

> It is an awesome responsibility for someone to take on the assignment of a
> patient and look after their best interest in the complex health system. It requires
> the best of training but more importantly it requires the best possible candidates
> ....it's so complex and important that nurses have a duty and an obligation to
> continue in their professional training even after graduation to keep abreast of

what's best and to grow with their profession because it's just an awesome responsibility that they carry. And I know circumstances and times change, conditions improve, but there's like a moral duty to keep that up...it's so important for nurses to keep abreast of their profession...and study and give that time required.

Even in retirement nurses were seen by informants to find ways to serve with their knowledge and skills, and continue to perform the essential nursing role of advocate. One participant mentioned parish nurses in this regard and also paid tribute to his wife, a retired RN, as a prime example of continued nursing involvement. Although retired from active nursing, she continued to care for friends and acquaintances. He reported:

I mean nurses just don't quit....[wife's] got all sorts of people that she phones every day to see how they are. She checks up on them, she goes and visits them ....she's an advocate for people who are having things to do with the medical profession. Everybody these days should have a medical advocate.

This is not unlike the informant who, although his wife had not worked as a nurse in 25 years, continued to recognise her as a source of nursing knowledge and action. When dealing with care issues, he described her as much more tenacious in obtaining information from medical personnel than he was. Another informant acknowledged a retired nurse who volunteered in a nursing home and offered healing touch to the residents. This informant reported that "[she] would come in and you sensed the professionalism that she still wore from her nursing career."

But perhaps most importantly, these nurses were seen to have retained their interest in the client's health and illness story. Another participant recounted how a retired nurse in his hiking club was particularly interested in talking with him about his "story of what happened and how this whole MI [myocardial infarction] happened and what were the symptoms and what kind of care I got." And so, even though the nurses' context for caring changed with their exit from the active workforce, that which had motivated these nurses from their entry

into nursing was thought to continue, prompting them to actively seek and maintain opportunities to express their caring attitudes.

The view that nurses never stopped being nurses was common. Although this investigator did not question informants further about this view, it does raise an interesting issue from a nursing practice perspective. While it is possible that a nurse may never stop being a nurse, does that necessarily mean that a nurse will never stop acting as a nurse? If it truly is a case of "once a nurse, always a nurse," then perhaps the continuation of service behaviour described by informants is simply a consequence of being a nurse. On the other hand, it may be that individuals with these tendencies toward social commitment and community service gravitate towards nursing. This raises questions about registration, continuing competency, and accountability within the profession on which it is unreasonable to expect informants to comment. Still, if the attitudes of informants are reflective of those held by the public, is the retired nurse responding in such a relationship simply as a good neighbour, a "Good Samaritan," or is she something more?

Difficult and Complex Role

Informants agreed that while being a nurse involved much more than the knowledge, skills, and abilities set out in a job description, there were inherent difficulties with the role. They thought that the nurse's role might be both rewarding and depressing, difficult because of the complex situations nurses are required to handle and the stressful environment in which that work takes place. Further complexity was identified through the diversity possible within the nurse's role. One informant expressed her view saying, "When I think about nursing I just like think those poor people [the nurses] must be exasperated altogether." She saw the nurse in a no-win situation, constantly struggling to perform her role with little

systems support. Another informant said, "I just understand how draining that [nurse's] job must be and how, almost thankless."

Although participants spoke of nurses working in the school system, the military, clinical trials, doctors offices, occupational health, public administration, cardiac rehab programs, and as prostate centre educators, the institutional setting was the most common point of contact for the participants. In fact, one informant claimed that he "didn't really have a lot of contact with nurses....[because he had] always been quite healthy and wasn't in the hospital for any length of time." For this individual, contact with a nurse would have meant that he was sick and in hospital.

But other informants provided a broader perspective of the nurse's role. These participants believed that the client's relationship with the nurse changed as the client's role changed. An informant shared her insight that she had a different relationship with the nurse as the spouse or caregiver or advocate of the client than she did when she was the client herself. Similarly, another participant reported that her needs from the nurse differed depending on her circumstances:

> For me, I needed emotional support when [son] was there. For my own thing I expected a little more cleanup, very basic. For my mom, I expected information in ways how we could help....and for me at the youth clinic I expected hard facts as well as emotional support.

And so, while informants saw the client moving between different roles and having different needs, they observed the nurse having different roles as well. Depending on the situation, they saw the nurse functioning as the leader, a colleague, or a caregiver. Positioning within the treatment hierarchy was thought to be determined by the education of the practitioner, but for some participants, there was a lack of clarity as to the responsibility incumbent with particular roles. While they viewed physicians as being at the top of the

hierarchy, RNs were thought to provide leadership to paraprofessionals involved in care, having more of a "voice" with physicians than LPNs. There was a perceived "pecking order," perhaps further evidence of the difficult and complex nature of the nurse's role.

The idea that to be a nurse is difficult is supported in nursing literature. Nursing issues have been linked historically with feminist or oppressed person's issues (Roberts, 2000). As well, Adam (1991) posits that nursing is difficult especially because the nurse's behaviour should be seen consistently and continually to offer evidence of her inner motivating attitudes.

Informants also saw the role of the nurse as complex and unpredictable because the nurse had new experiences every day, as well as the possibility of life and death dramas, which a participant called "life-defining moments." Even circumstances that might be thought routine became unique since the nurse was caring not only for the client, but also for those around--their family and friends. And so, dealing with drama, tension and worry were seen to be part of being a nurse.

It would seem that the lack of predictability within nursing is one of its greatest charms and perhaps its greatest curse. With each client a unique individual involved in a unique situation, the nurse is challenged to be flexible and adaptable, tailoring her interactions in such a way that they are particularly suited to the recipient. There is nothing easy about this. An informant explained the unpredictability of the nurse's role; "The day of a nurse is very different day to day...depending on ages, personalities, people's ethnic backgrounds, what they know about their medical condition. It must be...difficult."

In fact, informants saw the work of the nurse as emotionally demanding. An informant said, "I love nurses in general, they just seem to be such a needy bunch." As a

solution, this informant recommended the services of a "support team" for counselling or "debriefing rounds" thereby sustaining nurses in the profession by assisting them "to deal with the emotional side of the job" and preventing burnout.

These interesting comments leave one wondering whether nurses are needy before they enter the profession or whether their neediness is a by-product of their emotionally demanding work. Informants indicated that the nurse's emotional demands might come from several quarters. It was proposed that perceived monotony in the nurse's role could contribute to this stress. Furthermore, while they looked for and valued the relationship that the nurse built with them as clients, some participants spoke of the nurse's attachment to their clients as being a source of that nurse's emotional burnout.

However Schreiber (1999) suggests just the opposite. Although over-involvement with clients is to be avoided, she states, "When you don't get attached, that's when you burn out...the energy in nursing comes from those bonds" (p. 9). Perhaps the difficulty then is determining whether the nurse-client relationship has fostered a healthy or an unhealthy attachment. Certainly it is unlikely that "burned-out" nurses can rise to the challenges intrinsic to client-focused care.

Informants saw the jobs of all nurses as complex, stressful, and emotionally demanding no matter where they worked. Nurses working in the ER or ICU had very sick clients who came and went, but nurses in long-term care had different stresses. Because they got to know their clients over a longer period of time, informants thought that the passing of those clients was particularly difficult for their nurses. A participant commented on the nurse's stressful role:

> Nurses they say get used to all the horrible things they see and terrible
> situations they're in. But this is not...really true. I mean they're affected and

worry. It bothers them. I mean losing a patient bothers them....Look at the
emotional drain of being a nurse in the...palliative care...every one of your
clients or patients are going to die. And the skill that you need to make that
person go without fears is...stress-wise, I would say that would rate just about
as high as being in intensive care...But it's a different kind of stress....People
misjudge nurses and misjudge their role...they put the ICU nurse on pinnacle
and the emergency nurse on a pinnacle but when you come down to it...they're
all doing their jobs and all of the stress...comes in different ways.

And so, informants recognised the complexity and lack of predictability within the

nursing role. While this may keep the nurse's work interesting, informants saw it as stressful,

as were other factors related to the working conditions commonly experienced by many

nurses.

Nurses Work in Stressful Environments

Busyness. Overall, informants perceived that nurses were busy multi-tasking

individuals who had difficulty completing their work. Informants recognised that some of the

nurse's busyness was due to strained resources within healthcare. Staffing and client acuity

problems were apparent to them. A participant reported, "They [the nurses] don't get enough

time in a day to do what they should do all the time with a patient." Thus, the nurse's role

was seen as varied with multiple demands. One informant, a mother of young children, easily

related the role of the nurse to that of a mom. She explained the stress associated with the

nurse's role:

They're [the nurses] able to manage because it's so multi-tasking...its like a
mom. How do you know when a mom is stressed? You know, one more thing
and the back's broken...things get left behind and they find it hard to keep
that mental order. It's easy to burn out I would think as a nurse.

Staffing changes. Changes to staff mix with fewer RNs and more ancillary staff on

the ward did not go unnoticed. Informants told of paraprofessional staff responding first to

client problems even though they lacked the knowledge to provide answers satisfactory to the

client. Thus opportunities for client education were lost because, from the client's perspective, even though these ancillary staff were unable to provide satisfactory answers to client questions, they often seemed unwilling to pursue the client's concerns or needs with the RN. An informant shared his experience:

> The doctor came in one day and says, "Okay, we will release you when you've had a bowel movement." And I hadn't had one yet, and of course, I was just starting to eat. And then I went to have the bowel movement and blood is spewing out of the end of my penis. And I've got no bell and I'm yelling and screaming. And in that instance I don't even think it was a practical nurse or a LPN that came. It was just somebody who says, "Oh no, that's normal." And so...I think I finished and got back up and got back into bed and then somebody did come in...I asked the question and to me never got a satisfactory answer but I got an answer....Why didn't somebody tell me?

Systems problems. Systems problems were blamed for some of the work-related stress that both nurses and their clients encountered. But informants had different views on whether nurses had the power to influence systems changes. One participant stated, "The number of people that they were expected to be able to service just seemed unreasonable for the amount of staff they had...they were always going." Another informant corroborating this opinion reported, "I think their level of care that is expected, that **they** want to give, they can't do anymore because of the shortness of time and the lack of backup or other people to deal with and the fact that they don't have anybody to communicate themselves with."

Informants believed that political influences were at the root of systems problems within healthcare and were responsible for many difficulties directly affecting the nurse's practice. But political issues were not seen to be the focus of the nurse. Instead an informant saw political issues in healthcare as a distraction for the nurse focussed on caring for the client. She said, "Politics can get in the way of good nursing. They take the focus away from the things that draw people to the nursing career and cause conflict." But another

participant's comments implied that staff assignment, while a nursing practice, was related to

systems issues definitely falling within the political realm. She acknowledged:

> When [husband] had them [home care RNs]…the big issue was that it was
> seldom the same person and I needed stability in my life then and we didn't
> have it with the nurse. It wasn't their fault but that was somehow the way they
> were assigned.

Similarly, another informant told of linen shortages during her own hospitalisation

and staffing shortages during her mom's hospitalisation. She noted that there were few RNs

providing care in the immediate post-operative period after her mom's mastectomy. She

blamed the government (the system) and did not fault the RNs on the unit. In her view the

nurses "try so hard and [the government is not] setting them up for success." She described

this situation as disappointing for the nurses and frustrating for the clients:

> There was a huge cutback in linen so they couldn't replace my linen every day
> no matter how many times I threw up on it or went through fevers and different
> things like that. It was frustrating so my Mom had to bring linen from home….
> My Mom had a full one [mastectomy] and she was in there [the hospital] for
> twenty hours. And you could just see in the nurses' faces that they were…
> really disappointed and they would apologise constantly and just feel really bad
> that they had to send her home with a drain…they were really struggling at the
> time.

Occupational hazards. There are other difficulties associated with being a nurse. An

informant identified various occupational hazards to which nurses are exposed. In his

historical chronicle he noted that nurses have worked closely with polio and tuberculosis

patients. More recently, his daughter-in-law, while working as a nurse, sustained a needle

stick injury, contracting hepatitis. Another informant mentioned meeting a nurse in the

community and being impressed that this small nurse had been able to lift and move her

while she was a patient in ICU. While not recognising this as an occupational risk, it was

something that she found remarkable. Similarly, several informants commented on the

difficult adjustment associated with shiftwork, especially extended shifts (i.e. 12-hour shifts) which they thought were particularly arduous for nurses with families or those nurses over 50 years of age. As one informant opined, "Your life isn't really your own for a week...your whole life is revolved around shifts."

The lack of anxiety that seems to attend the informant's account of his daughter-in-law's needle-stick injury may be indicative of the general lack of awareness within the public of the many occupational hazards with which nurses are faced. Although the 2004 Canadian Severe Acute Respiratory Syndrome (SARS) outbreaks may have focused some attention on the hazardous environments in which nurses work, the scope of those risks appear vague to informants.

Even though the systems problems within healthcare are recognised by informants, they do not seem to see nurses as part of the solution. Perhaps this is justified. Whereas nurses are the most numerous of all health care providers (Canadian Institute for Health Information, 2002), their ability to influence the health care system has been limited. For example, to date nursing submissions to the 2002 Romanow Commission[3] seem to have had little effect on the current Canadian health care system. However, if nurses do not make some attempt in this regard, perhaps this says to clients, "It's-not-my-job." But such a view cannot be perceived as valid given the nurse's commitment to care. After all, exploration of the client's needs and then advocating and providing for those needs in an appropriate manner is fundamental to the role of the RN (RNABC, 2003). The classic rationale offered by both nurses and clients, to excuse nurses from involvement, is that nurses are too busy with all the

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[3] The 2002 Commission on the Future of Health Care in Canada, headed by Roy Romanow, Q.C. consulted broadly with Canadian health experts, healthcare workers, policy makers, and members of the public before making recommendations on sustaining a publicly-funded health system that balanced investments in prevention and health maintenance with those directed to care and treatment.

other things that they have to do. This is not a new defence. Nurses of that day, reviewing the synopsis of Holliday's (1961) work identifying characteristics that patients thought were part of their ideal professional nurse, report that time constraints make practising in a manner that would meet such patient expectations impossible. Holliday reports the nurse's view: "I know what is valued by *me* as a bed patient, but for time reasons I am not performing in this ideal manner for my patients" (p. 210). Is it unreasonably idealistic to suggest that nurses can never be too busy to care? For their clients' benefit it seems that nurses should address this difficult question.

Have a Place Within the Healthcare Hierarchy

All informants commented on the various roles played by nurses within the healthcare hierarchy. The nurse's role was seen as dependent, interdependent, and independent depending on the circumstances. Perhaps the most important feature, however, was the consistent presence of the nurse no matter how the healthcare team might be configured, or even if a team actually existed for certain clients. After all, as one informant reminded the investigator, "We are nursed back to health." While the nurse and client were described as being "in it together," there was no indication that informants saw this relationship as excluding other team members. In fact, successful integration of members and their services made an impression on participants because of the impact it had on service delivery. Even if the healthcare team was hierarchical, there was an expectation that there would be rapport among all of the staff. Rapport depended on communication between the client and all care providers. As an informant remarked, "I believe that anybody that's involved in the caring of that patient or that individual should have an important say in it [the patient's care] because

they're all looking at it from a different aspect." And so, communication was key and will be discussed later in this chapter.

A participant whose own experience as a social worker may have contributed to her understanding and acceptance of such teamwork raised the idea of multi-disciplinary teams. She noted that when her husband was a palliative care patient, the nurses and social worker were a team on that unit. Interestingly, she mused that the team may have meant more to her as the caregiver, than to her husband, the patient. Because all team members were aware of the unique care issues, that team contributed to the security she felt within that experience. And so, it seemed that successful teamwork was relational and required communication. She said, "We're a part of so many…there are so many parts of our body that work in harmony and so should the professionals then too." Surprisingly, not all participants identified themselves as part of the team.

There was no doubt among informants that the purpose of the nurse and the healthcare team was to care for their clients. The nurse was thought to have a primary role in ensuring that the team was appropriately functional. As an informant explained, "It takes a certain attitude to be able to do that [care for team members under them] …It takes an ability to be able to draw people to do their best and…to be a help and not put stumbling blocks in front of people." Another informant also emphasised the nurse's role in providing care and support for other team members, particularly those working under them giving the impression that the nurse's interest in these other team players might go beyond their common focus in the workplace. And perhaps this is so, if nurses really do love people as other informants claimed. After all, this linking of healthcare team members is an essential nursing function, utilising relationship and communication theory to care for the client and

the public (RNABC, 2003). The idea of the nurse as a link is discussed further in the next section.

While a healthy cohesive team was desired because of its positive impact on client care, informants noted that there were power differentials on the team. Several participants reported that nurses had little power relative to the physician. And, there was the sense that clients often did not know who had power or what policies guided nursing practice. As an informant explained, "Each level [of the healthcare hierarchy] has their own responsibility in ensuring that the populace is healthy, but I don't know how far each level should go."

Even though hospital stays are much shorter and the client's condition generally more acute during that time, informants wanted to know who was "in charge" and how the healthcare hierarchy was constructed because they were aware that these factors could impact on their care. They wanted to know not only the nurse who was directly responsible for their daily care, but also the nurse manager (or the current iteration of the individual who wears the mantle of the "head nurse"). Identification of the leaders was important because participants thought that those making administrative decisions could be detached from those either acting on those decisions or dealing with their aftermath. An informant explained that when she wanted to complain about her husband being moved to another ward without any communication to her, she didn't know to whom to address her grievance. In fact later, when the incident was discussed with the unit's manager, the informant reported that this nurse manager did not seem to know the players responsible for that decision-making activity in the hospital either. From the perspective of this informant, having knowledge of the nurse leaders promised some order, responsibility, and accountability within the organisation, fostering her trust.

A participant perceived that the nurse's lack of power was related to the nurse's own personality and "personal power." She stated:

> Do I think they [RNs] have power? No, not too much. I think they have power up to a certain point, but I think that policies and attitudes apart from the personal preference really alter a lot of the way things are done.

She further mused that she had observed that some nurses tolerated abuse from physicians while other nurses would not.

Still, another informant saw things differently. She saw the nurse's potential to influence the public as similar to that of a stay-at-home spouse who exerted both overt and covert influence on society through child rearing and community involvement. She remarked, "They [nurses] have power…tons of power. Nurses have as much power as a wife does who doesn't leave the house but is somehow so important to the world." But, she was the only participant to see the nurse as an individual in a position of power within the healthcare hierarchy, even though others mentioned that nurses had power over clients. For example, other informants reported that nurses might withhold access to information either overtly or covertly. The nurse might not share information with the client or they might fail to direct the client to the appropriate source of information. And unit managers could also wield power over staff, although clients were unlikely to be aware of this unless staff discontent increased to the extent that client care was affected.

Perhaps one way that nurses exercise power is by empowering their clients. An informant recounted how his ward nurse explained the concept of "patient-centred care" to him. He referred to this concept as a "scheme," which empowered him such that he was listened to and his views were respected. Exercising his power, he ate his breakfast while it was still hot and was not forgotten by those team members who would have previously

interrupted him for their own purposes, such as drawing blood or obtaining his daily weight.

The only problem came when he was out with the physiotherapist when his cardiologist

began her rounds. He shared his encounter:

> [The specialist said,] Where were you? Didn't that nurse know or that
> physiotherapist know I was on the floor?" I said, "Well, we're on this team,
> Dr. [name]." ...And she said, "Well, there is a certain hierarchy on that team."
> And I said, "Yeah. I'm the peak." She wasn't very pleased with my
> observations.

Obviously patient-centred care hangs on the idea that the patient is the reason that all

healthcare providers, including nurses, are there. Later in the interview this participant

reframed this concept from the perspective of his prior employment for a municipality, and

also from that of a cook in a mining camp. He saw it as quite simple. In the municipality

office, his job was to be responsive to the taxpayers who paid his salary, and the cook's job

was to feed the working miners. In both of these settings the focus of attention was clear. To

this informant, patient-centred care was an attitude or as he stated, "a frame of mind."

And so, informants understood that to be a nurse was to have a special role within the

healthcare hierarchy. The nurse might have multiple roles or multiple clients. And those roles

might be played out differently as was suggested by the various metaphors used to describe

the nurse. But no matter how that role was configured, it was the nurse's, because the nurse

was there.

Nurses Are There

All informants expressed the view that the nurse was the professional who was there--

being "present" for their clients. Recalling personal in-hospital experiences as well as the

hospitalisation of family members, participants observed that while the doctor visited, it was

the nurse who was continually there, whom they got to know, and whom they relied upon for

information. Even in community care settings, it was often the nurse who provided ongoing assessment and monitoring. An informant noted, "People depend on nurses a lot, at least I find…that because you're…the closer one to them in general…the constant that they see more regularly." Another participant reported, "They [the surgeons] come in, they take it out, and then…they go on to the next one…ninety percent of the care that you get after that is with the nurse." Still another informant explained, "When you wake up…it's the nurses who you deal with…[they're] running the hospital in a lot of ways."

Informants also had the impression that if a physician was present, so was a nurse. One participant shared information about an on-site doctor's office in a new assisted living complex where his mom was relocating. While impressed with this on-site service, he assumed that there would be a resident nurse in this large complex. He admitted, "I didn't inquire as to whether there'd be nurses there but if it's…a wellness centre and the doctor's office then I assume there would be nurses there."

With the nurse as a more regular point of contact, the informant's perceptions of the nurse were built on previous contacts with nurses. These perceptions are important because they influence not only what the client thinks of the nurse, but also what he looks for from the nurse. And perhaps it is those perceptions that influenced the variety of metaphors used by participants to describe the role of the nurse within the healthcare hierarchy.

As a descriptive tool, metaphors enlarge our understanding through the word pictures that they create. As informants' metaphors were noticed, the appearance of metaphors in related nursing literature was also observed. For example, the nurse is "the spider in the net" whose busy role is co-ordinating the work of other personnel (Odling et al., 1990) In Taylor et al. (1991), the nurse is the "glue" that keeps the hospital system together. Still, while some

participants viewed the role of the nurse within the healthcare hierarchy in different ways as expressed through metaphorical descriptors, they all saw the nurse as a continuous presence with the client. The nurse was also thought to be capable in moving between various nursing roles and clients. And so, in articulating his view of the role of the nurse within the healthcare hierarchy, an informant stated, "Nurses bind it all together." But within the healthcare hierarchy, informants also described nurses as "watchdogs," the "conscience of care," "humanisers of healthcare," and "bridges" or "links." Furthermore, nurses were seen to "orchestrate," a part of the nurse's *acting* that is discussed later in this chapter.

Nurses are "watchdogs." An informant referred to the nurse as the watchdog for the doctor in both the clinic and hospital setting. In his experience, it was the nurse who was the initial contact, took the history, found out the client's concerns, passed that information along to the physician, and then followed up with whatever the physician had suggested or ordered. He saw this as a very important role "because I may say something to them [the nurse] that I've forgotten by the time the doctor gets in there and if he doesn't know that I said this, then he's not going to be able to necessarily help me."

When this metaphor was presented to a subsequent participant, he disagreed. Instead he saw the nurse as the watchdog for the client because the client was the nurse's priority, the reason why she was there. In fact, he felt that both the doctor and nurse were watchdogs for the client since both of these professionals should view the client as their primary interest. He explained that in some circumstances the nurse might even challenge the doctor given that it was the client's best interests that were of foremost concern:

> You're the watchdog for the patient I would suggest and if you need to call the
> doctor in your professional judgement, you call him in or his alternate....I think
> that would be good, the role of the nurse to be the watchdog for the patient....
> The nurse...focusing on the patient...it ties into the advocate position in my

mind.

If the nurse was going to function as a watchdog, it was because informants believed

that nurses knew what to do. Nurses were identified as knowledgeable because of their

education and "accreditation." Being observant and responsive, they were also seen as

important conduits of information, offering reassurance and allaying concerns particularly

around conditions or events that are "normal."

Although one participant conceded that LPNs are now more knowledgeable than they

were many years ago, he valued the RN's more detailed knowledge and ability to answer

client questions. That RNs are increasingly university prepared was important to him, as was

the idea that the nurse had continuing professional development requirements. He placed

great value on his own university preparation, which he reported taught him a great deal,

although not necessarily how to do his current job. Viewing the degree-prepared RN in a

similar light, he voiced great respect for RNs, and expected competency. And because he

valued the RN's knowledge he would "listen and do what they tell me to do." Knowing that

the nurse was knowledgeable gave him confidence in the RN such that he felt comfortable

about having that nurse present in times of crisis. He explained:

> That's important to me…To deal with a LPN with twenty years experience or a
> nurse with ten years experience, I would feel that the nurse with ten years
> experience is better equipped to answer than somebody that's got twice as long
> of experience but doesn't have that knowledge base or hasn't gone that extra
> step to get the additional knowledge.

Nurses are the "conscience of care." In recounting how the nurses had intervened on

his mom's behalf and prevented her premature discharge home, an informant referred to

those nurses as the conscience of care. Among those later informants to whom this idea was

presented, there was some disagreement. A participant who supported it once again linked it

to advocacy on behalf of the client. He viewed the nurse's efforts to "read" the patient and their situation as bordering on the conscience of care, since he thought that it involved the nurse interpreting the patient's feelings in determining what was right for that particular patient. However, another informant disagreed. She felt that labelling nurses the conscience of care was placing a burden on them that was too big for them to bear. Rather, in her view this attitude was the responsibility of the entire healthcare system, including administrators, doctors, and clerks. She thought that all should be exercising a caring conscience.

Nurses are "humanisers of healthcare." Another informant suggested that nurses are humanisers of healthcare. Observing that there was sometimes a disconnect between members of the treatment team and the client, she referred to nurses as "humanised people who took care of you and dealt with the aftermath...the surgeons came and did their thing and then the nurses kind of helped you along the way."

But when seeking comment on this idea from other informants, again there was disagreement. One participant was of the opinion that this process was spread across the healthcare domains, or should be. Concurring with this view, another informant noted that saying that the nurse was a humaniser of health care suggested that "humanity" needed to be added back into something that should already be "humane." Informants hoped that nurses were not the only humanised people that provided care, since humane care should be the rule, rather than the exception.

Still, Rogers, Karlsen, and Addington-Hall's (2000) work with palliative care clients addresses the dehumanisation that can take place when clients are treated stereotypically and their care approached in a mechanistic fashion. They propose that the application of the

values central to palliative care will enhance the client's perspective of their care, no matter where that care is provided.

Nurses are "links" or "bridges." That the nurse is a link or a bridge was a metaphor used by an informant to describe the nurse's visible and constant presence with the client. This participant went on to ascribe particular importance to the individual who was the client's first contact. Along with other informants she placed considerable value on the nurse collecting and filtering client information. She felt that less information was forthcoming the more times the client had to repeat the story. Because some of that absent information might be quite critical; she thought it important that initial contacts with clients be a function of the nurse. She asserted:

> They're [nurses are] their only link. I don't know if that's reasonable or not but the nurse is the link. Doctors, you know, invisible, comes in, blows in, you know. The nurse gets everything, the nurse gets all the questions, all the responsibility....She's the most important person absolutely....He or she is the biggest link, it's uphill or downhill from there....The nurse needs to be able to recognise valid information...if they're the first person in the room with somebody a bridge often happens.

This informant saw the client as somewhat vulnerable without their link to nurses. But with complicated and irregular staffing schedules, that link may lack consistency and the bridge may not be as secure as this informant may hope.

Nurses Are Indistinct

Within the practice setting informants reported that individual RNs were often indistinct. When an informant told of the nurse whose "digs" humiliated a patient who was not being an ideal patient, there was the impression that in the acute care setting nurses tended to blur together as professionals. While the nurse was there, this informant suggested

that clients did not pay much attention to them until there was something urgent or critical happening. She explained:

> That's the thing about our memory about a nurse is that you don't register a time and a place and the face or the…you know…the atmosphere in the room but I only registered that that was a nurse who was pushing a person who wasn't doing well.

If such an encounter results in the client's diminished confidence in the nurse, reclaiming that assurance is difficult and it may result in transference of the nurse's offending attributes by the client to his next nurse. With 12-hour shifts, part-time and casual employment, clients rarely see the same nurse for an extended period of time. As such, while the disturbing attitude may be the responsibility of a specific nurse, the client has difficulty making distinctions between practitioners. And so, that nurse becomes part of a composite nurse in the client's mind. This composite might have the characteristics of the "bitchy" nurse, or conversely, the nurse who is "extraordinary."

In a similar vein, a participant voiced his impression that nurses lacked distinctiveness as a professional group:

> For many patients I think, it's the doctor…who we're waiting to see, the doctor who we're waiting to talk to, the doctor who's going to give us the information and no disrespect to the nursing profession but sometimes maybe the nurse becomes rather indistinct. Like…she comes in and she goes out and she does this and…then the next day perhaps another nurse…we just don't pay enough attention to the nurses you know. We seem to accept the care they give.

There may be many reasons why participants view nurses as indistinct. Nurses may not seem distinctive because they no longer look distinctive. And differentiation of the nurse from other groups by the particular tasks or functions they perform is no longer reliable since informants spoke of their difficulty in differentiating between nurses, full-scope LPNs, respiratory therapists, and social workers.

Still, while the role of the nurse was seen as vital and demanding, informants were clear in their view that the nurse did not do it all or work alone in caring for clients. One participant was quite determined in articulating her view that nurses could neither assume a comprehensive role in the client's care management or education, nor keep on top of the client's emotional needs and those of their family. Rather, she envisioned a more involved role for a psychologist or social worker, which she described at length and for which she saw her psychology studies as preparatory. She was keen that nurses collaborate using such a "middleman" as a touch-point for client interaction and information.

Since informants recognised that nurses needed help, the role of ancillary staff and paraprofessionals was valued. While there seemed to be some expectation of collaboration within the healthcare team, there was persisting confusion about these roles and who actually did what. It sometimes seemed that nurses were victims of their ability to go about their work in the background without drawing attention to themselves. This was especially observed in the Labour and Delivery areas where several participants commented on the nurse who "quietly went around doing what she was supposed to do." Another informant concurred, "I don't recall the nurse being actively involved although obviously they must have been....The nurse must have been there and handled everything okay although I don't recall."

Summary of Being a Nurse

Clearly informants seemed to be of the opinion that to be a nurse was more than a job description. To be a nurse was to be open to change, influenced by one's innate personality and attitudes, and yet sharing the experience of being human with the client. Being a nurse involved motivation. While the education and workplaces of nurses have changed greatly, the altruistic attitudes, which informants viewed as prime motivators for being a nurse, remained

unchanged. Those nurses described as born nurses or natural nurses displayed qualities seen

to be the result their upbringing, previous experiences, and interactional style with people.

Although some of those qualities were taught or built on during the nurse's education, most

were thought to be an inherent part of her being, which she brought to the practice of nursing.

Even though the nurse was thought to be doing something naturally in keeping with

her own attitudes and aptitudes, informants thought that nursing was fraught with difficulty.

To be a nurse was difficult because of the unpredictable and complex quality of the nurse's

work. Both physical and emotional stresses were related to the nurse's busyness, variable

staff mix in the workplace, various healthcare systems difficulties and identified occupational

hazards.

For participants, the nurse's place with the healthcare client was indisputable. Still,

the nurse's position within the healthcare hierarchy was variable, changeable in response to

the needs of the client and the other members of the hierarchy. Although the nurse was

always there, being present, perhaps as a watchdog, a conscience of care, a humaniser of

healthcare or a link, the nurse was also indistinct. Informants found that nurses were

sometimes indistinct as individual practitioners and had difficulty in distinguishing them

from other groups on the healthcare team.

To "Act" as a Nurse, From the Client's Perspective

In this section, the client's perspective of how the nurse demonstrates those attitudes

thought to be intrinsic to the nurse's being is presented. It portrays the nurse's *doing,* which

is comprised of how the nurse behaves and what she does with and for the client. Because the

act of nursing occurs in the context of the nurse-client relationship, to act as a nurse

incorporates both the display of a professional bearing and approach, and the performance of duties in a professional manner.

Display a Professional Bearing and Approach

Although informants commonly used the term "professional" when speaking of the nurse, they did not succinctly define this term. Suffice it to say, participants thought that the nurse with professional "presentation" would display a professional bearing and approach.

An informant expressed his view of the importance of professional "appearance" stating, "They're not somebody that is just there. They're a professional and they have to somehow indicate that in every aspect including dress." In fact, the nurse's credibility depended on the nurse being dressed "appropriate for the profession." Participants recognised the nurse's professional attitude in her dress, grooming, and deportment. They thought that the nurse's work attire reflected the importance that she attached to her work and would be in keeping with the standard set by her professional colleagues.

But while the nurse's professional attire was important, informants claimed that the look of the nurse involved more. Several exemplary nurses impressed a participant with their good posture, confidence, poise, and the fact that "they made good eye contact." And so, it was important that attributes linked to the nurse's being were evident. For example, informants anticipated that nurses would be pleasant, calm, and able to instil confidence in their client.

Nurses Look Appropriate

Informants admitted that, to them, what the nurse wore in the course of her work mattered, particularly on initial meetings with the client or when that encounter would be brief. However, as the client's relationship with the nurse progressed, the nurse's

professional look was less critical because the client had other indicators by which to

evaluate the nurse's professionalism. An informant explained:

> The uniform I think is **really** important for that first hour or two where you see
> someone for like a two or three day period 'cause you're just kind of looking
> for external cues in order to put confidence into them 'cause you don't know
> what their quality of care would really be like. So for social influence or
> impression management I think the really professional look of a uniform is
> key.

The nurse's uniform worn in times past was an instantly recognisable identifier. An

informant described the uniformed nurses from this by-gone era as "glamorous,"

"impressive," "person[s] with a mission," "important," "gleaming and looking efficient," and

"a beacon." To him, those nurses inspired confidence, but to other participants, the

conventional uniform was an unwelcome symbol of authority.

That traditional nurse's uniform included a nursing cap, which advertised the nurse's

status and school of nursing. Another informant told of recently encountering a staff person

wearing a traditional nursing cap. She thrilled, "I know a cap...I know what that means."

When the informant asked where the wearer had trained, that individual disclosed that she

could not work as a RN in Canada, although she was a foreign-trained nurse. The informant

later asked a RN on the unit about this apparent misrepresentation and that nurse said, "You

know it means a lot to her to be able to have that because... nobody else wears them

anyway." From this encounter, the informant learned that she could no longer depend on this

previously trustworthy, obvious identifier.

Even informants who felt that uniforms created "the wrong impression" and "make

people feel uncomfortable" because the professional was presented as "some authority figure

with the starched uniforms" expressed surprise that nurses had abandoned their "identity"

and the symbols associated with that identity. A participant clarified:

Over the years it's also been a little surprise for me to see nurses not wearing the cap, not wearing the starched white uniforms...being much more relaxed, still...very neat and tidy but...wearing a blue sweater or wearing a pair of beige slacks....They still have the little thing that says...RN on their lapel but that... firm strict dress code is no longer in effect. And I think that's a good thing... I think it puts us as patients a little bit more at ease to see someone who...comes in and sort of says..."Hi. How are you? My name is Sandy and I'm going to be your nurse for the day." And she's dressed like somebody who might come into your home.

While it was important that the client feel comfortable with the nurse, the client also wanted to have confidence in the nurse. Even if the confidence-inspiring uniform had largely disappeared, the client's need for confidence in the nurse had not. And so, an informant told of identifying the nurse by her nametag, which also showed her status. But because there was not universal compliance in wearing identification badges, this participant also found it difficult to identify the RN unless he asked. He remarked:

I don't know, going visiting for an hour and a half or two hours whether its an LPN or it's a care worker or it's a RN now because some of them, they don't wear their pins; they don't advertise that, "Hey I'm this."

And so, for the client unable to confidently identify the nurse, the initial encounter was problematic. Some informants suggested that the nurse's paraphernalia, such as stethoscopes, might serve as indicators of the nurse's status. But when this strategy was unsuccessful, the client was wary and unsure. As another informant declared:

I can come to you [the nurse] with anything... I know what you're going to do is going to be done right because I know you are [a RN]. Now its, "I don't know who you are. I don't know what you are...I wonder if you can do the task correctly....Now...you go looking for a nurse but you have no idea ...who's a nurse and who isn't. You don't know who any of them are anymore because they're not identified as such....I don't know who you are. I don't know what you are...I wonder if you can do the task correctly....The people who clean the floors have the same clothes that nurses do.

However, a young informant expressed the view that nurses invested in their profession demonstrated that investment through their dress as well as their action. It was

these nurses in whom she had confidence. Relating this to her own experience in the workplace she noted that when she dresses in casual rather than business attire, she feels that her customers at the bank see her as less credible. Consequently, she reported giving careful consideration to what she wore to work, noting that she "takes on the role of the job as she puts on her work clothes."

If the nurse also put on her role when she dressed for work, it is unlikely that she would present, as did the nurse described by this informant. "We were horrified by her….She kind of came looking like she was in her pyjamas or her house cleaning clothes…just sweat pants and like a t-shirt. It didn't really differentiate her from anyone else at all." Participants, who likewise commented on nurses with sloppy workplace presentation, suspected that nurses with so little personal regard would extend similarly slipshod attention to the client. A less than professional appearance was thought to be distracting, with the RN and her message not seen as credible, and therefore ignored, that information lost, or not taken seriously.

On the other hand, one informant declared that he had "never met a sloppy nurse". The well-groomed nurse was thought to demonstrate the nurse's pride in herself and in her professional role. The status-indicating badge also demonstrated the nurse's pride in her position, as another informant opined:

> A lot of them [nurses] will have tags…that says RN because…I think they're like anybody else, they're proud of what they've accomplished and they want to show…people that they are educated and they know what they're talking about.

And if the nurse looked healthy, another informant was confident that the nurse could handle any hardship associated with the stressful work at hand. She elaborated:

> She [the nurse] was clean…had a bit of colour in her face to show that she was still healthy…These are just things that you can identify like…does the person look healthy, are they acting healthy? These are important characteristics for a

nurse. The burden is so huge that if...they are healthy it just comes across and
it puts the patient at ease. And I'm not talking slim....I just love to see a
healthy nurse because I know they're doing a good job and they're well taken
care of.

As another participant confirmed, the nurse's workplace presentation should give the

"impression of someone who's proud to be there as a caring person...in the nursing

profession."

But, according to informants a work-ready presentation included more than the

nurse's uniform. It involved grooming as well as attitude. A participant suggested that the

nurse's neat grooming indicated a less casual, more conscientious approach her work. The

nurse's attention to her personal grooming indicated her readiness to care for the client and

reaffirmed that the client mattered. She described this nurse:

Hair's probably tied back, that's another way I kind of judge somebody
who's really ready and willing to work. You know some of the girls wear it
down and they're usually the ones that linger over the conversation just that
much longer.

And no matter where the nurse was employed, informants felt that the nurse's

workplace attire should be in keeping with the community standard. That standard might be

more casual in some settings such as community health or street nursing, but even so,

informants thought that there was a prevailing "standard of decency within the profession"

which must be maintained.

Although an informant suggested that "nurses gave up their identity by getting rid of

their hats and their uniforms", identifiable uniforms have been a source of controversy in

nursing for a long time (Houweling, 2004). Now the nurse dresses like everyone else in the

workplace and this may not be a good thing. As Houweling says, "The uniform that once

distinguished trained nurses from the untrained and elevated the profession now hides them

and obscures their role in healthcare" (p. 48). In fact, she goes on to suggest that this homogeneity of look among personnel in hospitals may disguise the fact to clients and their families that there are fewer RNs present to care for them, since everyone looks the same.

These sentiments are echoed in current nursing literature. Curran (2004) tells of accompanying a friend to the ER of a Chicago teaching hospital where the triage nurse was unidentified, wearing sloppy and soiled attire, and indifferent to the client. The lack of attention to and communication with the client was also missing in other nurses they encountered. Although the author had been an ardent defender of the view that professional practice was not influenced by what the nurse wore, her friend, a lawyer, disagreed. She said that if one of her partners had looked like the triage nurse she would be sent home because, "we feel our clients deserve attorneys who are professional in all aspects of their practice" (¶ 8). This attorney suggested that this lack of professional presentation might be contributing to the nursing shortage, because "what smart person would want to join a group that looks messy, is unfriendly, and unhappy" (¶ 8)?

Interestingly, in the summer of 2004 several large hospitals in Atlanta, Georgia introduced a dress code, which requires all their RN staff to wear white uniforms. Reportedly, this change is mandated to address the problem patients have with identifying the RN and also to satisfy the "nurses own need to dress in a way that reflects their professional status" (Centre for Nursing Advocacy, 2004, ¶ 2). Similar changes are taking place in hospital systems in Texas and Illinois to name a few (Linn, 2004). And for other nurses, the American Nursing Association is spearheading a grassroots movement to have a visible "RN" patch--red letters on a white background--worn on nurses' scrubs and lab coats (Mason

& Buhler-Wilerson, 2004). It seems that the variety of solutions being attempted points to the seriousness of the issue.

Perhaps it is time to reopen the debate about professional presentation. Other occupations such as police officers and flight crew continue to wear distinguishing uniforms as symbols of pride, responsibility, and authority, with no apparent ill effect to the public psyche. Mark Twain said, "Clothes make the man. Naked people have little or no influence on society" (Twain, 2005). Perhaps if nurses see themselves as influential members of society, increased care and attention will be paid to their outward presentation. Otherwise it is possible, as an informant predicted, that the nurse's lack of attention to their appearance would eventually result in a loss of respect with their public.

And so, to act as a nurse requires a recognisable, appropriate look. It involves not only the nurse's attire but also that nurse's demeanour. The professional attributes that the nurse exhibits are also important components of the nurse's professional bearing and approach.

Nurses Display Professional Attributes

As informants explained their view of the attitudes which nurses held, they shared examples of professional attributes that they had seen displayed or which they felt should have been displayed. Nurses were seen to display competence and accountability, attentiveness, reliability and responsiveness, as well as assorted "people skills." Informants described nurses as approachable, respectful and sensitive, flexible and calm, and as possessors of practical, common sense.

Competence and accountability. While there was recognition that the education and knowledge base of the nurse had changed, several informants specifically mentioned that

having "standards" ensured the adequacy of the work and the competency of the nurse. One informant compared the "accreditation" process within nursing to the training standards practised in her business world where knowledge, competence, standards, and attentiveness were all related to "doing things right" for her client. Doing things right meant that she was responsible. And so too was the nurse. Informants thought that the RN would see that "whatever it is that's supposed to be done, got done, whether she did it, he did it, or they had somebody else do it". In this way, as previously mentioned, "the nurse has to bind it all together."

One way that informants assessed the nurse's competence was by the nurse's attentiveness to and focus on the client. A participant remarked:

> Competence is the first thing I expect...I assess competence by speed, attentiveness, lack of distractedness when I'm giving my details, and the speed and apparent concern with which they seem to respond to my complaint, even if they don't agree....These are things that give me confidence...[in] a nurse.

This informant also felt that there was a direct correlation between a nurse's pleasantness and competence. She asserted:

> I've never found a very pleasant nurse that wasn't competent...sometimes you can find nurses that are very unenergetic and you don't know if they're competent or not, but I'm leaning towards not. I just feel like the ones that are attentive, upbeat a little bit, they don't seem to make mistakes, they seem to always be where they need to be.

Perhaps this was not that different from the nurse who was described as "comfortable with her knowledge such that she could make us feel comfortable with leaving." That nurse knew she was competent and knowledgeable and therefore could share her confidence with her client. And so, the nurse was seen as secure in her knowledge and practice. She engaged with her client for a particular reason and had a plan for how to complete her task. Another informant described such nurses:

> It was the confidence that they came into the room....that they knew where everything was, that they seemed to have some sort of thing that they were geared to doing....They didn't seem like, "Oh, I'm in a new environment and I feel unsure of myself" like they just walked right in and took a look and they weren't afraid of...anything.

Of course, in this instance, the nurses seemed to be in charge of the agenda and confidant with the client because they had something specific to do. But what if the nurse was simply *being* with the client, not "in control" but rather, open to that client's agenda?

Participants emphasised the idea that nurses should be accountable even though this accountability was not always evident. One informant told how her friend tried to address the negligence of the nurse who made the same medication error on two occasions. He was unable to achieve satisfaction, and accountability, in this instance, seemed lacking. The informant recalled:

> It was like a circling of the wagons so to speak for that particular nurse. And although I can appreciate that to some degree, if somebody does something wrong then, as in any profession, if they're not made accountable for that error, then they'll keep making it.

Even though this informant pointed out that the incident had potential to affect other clients, she seemed unaware that one mandate of the nurse's professional body is protection of the public. If nurses are practising in accordance with their association's "Standards of Practice" (RNABC, 2003), they will be responsible and accountable.

But other participants spoke with respect of nurses who returned and admitted errors to their clients. One such informant arrived at the hospital to find her terminally ill husband in the process of being moved to another unit. Even though this possibility had previously been discussed with the nurse and they had reached a verbal contract that her husband would not be moved until both she and he had been notified; she was not informed. Not only was it upsetting for this couple, but it also "destroyed a great deal of trust that we both had."

Nevertheless, some of that trust was restored when the head nurse came and apologised for the distress and confusion they had experienced. This was perceived as accountability.

Another informant shared her postoperative experience. After her surgery, she was surprised to have what appeared to be dried blood on her abdomen. It was the residue of the iodine skin prep used prior to surgery. When she voiced her dissatisfaction while asking for a facecloth with which to clean herself, she received not only the cloths but also a rude retort. One of the nurses said, "Oh we're not your…personal body technician"…kind of being rude…like "We're not here to clean or sponge bath you"…. I think they should send you off as close to the way that you came as possible." To this informant, sending a surgical patient out of the OR clean demonstrated the nurse's accountability, or lack of it. This informant shared how she was working to instil accountability in her child, describing this trait as the idea that each one in their household was responsible for the mess that they made. But during her hospitalisation, it seemed that the surgical nurse did not even recognise that the client's lack of cleanliness was a problem for this client. Sadly this was the second time that this participant had not been "cleaned up." She shared that after her 18-hour labour, she wasn't cleaned up either. From the informant's perspective, the nurse's competence, as well as her responsibility and accountability were necessary.

Attentiveness, responsiveness, and reliability. Informants saw attentiveness as part of the nurse's professional personae. These nurses paid attention, asked appropriate (not scripted) questions, and were responsive. A participant reported that on the one or two occasions during his hospitalisation when he pushed the button to call for the nurses, it was his sense that they were there instantly. And, from his perspective, such attentiveness was not an isolated occurrence. The nurses had been just as mindful during his mother's more recent

admission. Furthermore, in the cardiac rehab program he attended, attentiveness was demonstrated through the continual assessment and monitoring carried out by the nurse and was interpreted as caring and concern on the part of the nurse. Similarly, Radwin's (2000) informants describe attentiveness as a characteristic of excellent nursing care, which is both caring and helpful, the antithesis of abandonment and neglect.

The importance of the nurse focusing on the client was again confirmed in the story told by an informant whose baby died at birth. Certainly the majority of births are happy events. However, nurses should to be able to care for clients with unhappy outcomes as well. This mom asserted that she would have welcomed somebody to talk with, somebody to distract her. Instead, she was left alone to cry. An attentive nurse would have noticed.

Various systems failures are sometimes associated with the occurrence of serious medication errors. But the participant whose friend was twice given a medication to which he was allergic suggested no such explanation. Inattention on that nurse's part seemed a key factor in this repeated mistake. She declared:

> They didn't once see the write...they never told [friend] they were giving him Penicillin or he obviously would have...it was big, in big red print on his chart. **Penicillin Allergy**. And yet I don' t know how it happened but they did it more than once.

This was not the experience of the participant who saw attentiveness going hand-in-hand with other admirable qualities--being personable and doing things right. She shared, "There was one nurse...she was attentive to mom and she was making sure that things were done right for her, very personable and very attentive."

In addition, informants saw nurses as reliable in the sense that they kept commitments and did what they said they would do. In other words they were trustworthy. A participant referred to the assurance she felt from the verbal contract she had with a nurse. Other

informants reported that it was safer to give information directly to the RN than to less qualified individuals, such as LPNs. They expressed some concern that information given to the LPN might be lost. They thought that the nurse was more dependable.

Having observed the nurses caring for his mom during her hospitalisation, a participant commented that the attentiveness and reliability of those nurses meant that her care was very good. The obvious conclusion seems to be that very good nurses are attentive and reliable. And so, it is little wonder that attentiveness and responsiveness are often linked to quality of client care (Oermann, 1999; Radwin, 2000; Schreiber, 1999).

Using "people skills." Informants made numerous mentions of the nurse being "nice," "pleasant," "friendly," "courteous," and having "people skills." In other words, these individuals were personable. They liked people and it showed. They talked with their client, explained what was happening, provided information and treatment options, and asked what the client would like. For example, it was a "nice" nurse who talked with a participant and asked her what name she wanted to assign at her dying baby's baptism.

Pleasant nurses were the opposite of those nurses whose lack of fulfilment in their role was evident, and who were seen as "miserable," "rude," "scary," or "bitchy." Informants did not take pleasant nurses for granted. Rather pleasantness was an extra, as this informant explained:

> As an added bonus then they're pleasant but usually with those things
> [attentiveness, speed, apparent concern] come extreme pleasantness...I find
> these people really put themselves out, they're not burnt out, they find their job
> rewarding....But the other end of the spectrum...probably an equal balance on
> the other side where the nurses don't seem to be very fulfilled in their job....
> I'm always nervous about meeting those nurses but I'm also very cautious
> with them...I walk in and I just don't know what I'm going to get.

Another participant agreed that not all nurses began with these people skills which included the ability to be "reassuring, giving [their clients]…confidence…that they're dealing with somebody that knows what they're doing…These people skills…they're learned as a nurse". It was these people skills which tempered the nurse's "bossy" or "take charge" tendencies when dealing with clients, as this informant noted, " they do it in a sort of way that you figure, 'We're doing this together.'"

And so, just as the nurse's people skills facilitated their success as nurses, an informant suggested that these skills would contribute to the nurse's achievement if she left the profession and pursued other career options, like real estate. In fact, any search of the Internet (i.e. www.google.com) will yield millions of references to "people skills." Generally, they speak of interpersonal skills such as understanding people, influencing them, and improving communication. These are invaluable traits no matter what one does.

Approachability, respectfulness, and sensitivity. Approachability has a great deal to do with communication, which will be discussed in a subsequent section. Informants spoke of how important it was that the nurse was open and approachable, so that the client would go to the nurse with their questions. And so, nurses who were seen as approachable and not nervous were able to engage clients with confidence. Their presentation helped the clients feel at ease because these nurses were not distracted or in a rush when dealing with them. Approachability was a valued attribute as this participant explained:

> …Approachability because they are kind of the expert or the professional and you're not, so just being able to come in with a sense of confidence. And I think eye contact is really key 'cause when they don't look at you and they're talking to you or if they're looking around or they're really nervous that really makes you wonder what's going on like that there's something else that makes you feel insecure. So…someone who just seems to be with an air of confidence when they walk in the room and they're not scatterbrained…they're more organised in their thoughts and what they're doing. So they're not wandering

around the room looking for something or kind of talking to you and kind of doing something else at the same time. Or seeming to have a huge list of things that they have to do in the day and they just have to rush in and out.

While the nurse should be approachable, when that nurse was approaching or interacting with the client, respectfulness was desirable. Besides communicating in a respectful manner with the client, it was suggested that the nurse displayed respect for that client by maintaining "professional distance" and protecting his privacy. Informants spoke of overhearing nurses chattering about other clients. The potential for divulging personal information was not thought respectful, nor was it in keeping with the participant's understanding of confidentiality.

An informant, whose family doctor had previously divulged her personal information to her parents, went to the youth clinic because she knew that this was a service where her privacy would be respected. And it was. She was not disappointed. She reported:

If I would have just had somebody who was more biased...pushing their ideas on me, I might have made a different decision. But she [youth clinic RN] never in any way tried to influence me, only gave me the resources, only gave me the knowledge and the facts.

From her perspective it was important for the RN to keep the client's values and beliefs foremost and to relate in an unbiased fashion. It seemed that the youth clinic RN did this. Later, the Labour and Delivery RNs were less generous in dealing with this informant. She felt judged by the attitude, facial expressions, and expressed comments of the staff. For example, she was told things like, "It would be in your best interests" and "How old are you." To her, the inference was clear--"Could she care for a child on her own?" She recalled staff "grabbing the baby out of my hands, [seeming to say] 'You don't know what you're doing.'" The lack of respect for and sensitivity towards this young mom seemed overwhelming.

Several informants stated that they did not want the nurse being "too familiar" or "too friendly," for example, calling them by their first name initially. One of these participants explained, "They interact with you in a professional way because they are, in fact, strangers to start with…I also respect a professional distance with these people, I wouldn't want to call them by their first names immediately at least." He suggested that there was a professional "line," which was drawn, that allowed the nurse to demonstrate a caring and professional behaviour, and gave the client confidence in the nurse's ability to care for him. This professional distance was respectful to the client, and the client reciprocated by being respectful to the nurse. This was interesting because later, this subject spoke warmly of a nurse who seemed to be in a much more intimate relationship with the client and his family. Rather than being seen as an intrusion, or a disrespectful crossing of the line, the familiar connection between the nurse and the client highlighted the personal bond that now existed with this nurse. And the family was comforted by the knowledge of that relationship.

Informants saw nurses as respectful not only to their clients but also gracious and inclusive towards other team members. As previously reported, collaboration and rapport among all staff was important to the informants. The participant who witnessed the nurse treating other team members with respect felt that she would be valued and that the same courtesy would be extended to her as a client. This informant reported, "I really admire the nurse who can speak with respect to the cleaning staff as much as they would to a doctor and that there be good congeniality among the nurses and among the aides."

And so, while circumstances may change, informants assumed that the sensitive nurse would recognise this and respond accordingly. In their view, they would always experience this respect as non-judgmental and unbiased.

But in the experience of another participant sensitive, empathetic nurses were the "minority." Although it was not clear whether informants could distinguish between empathy and caring, they thought that empathy was an innate quality that should be present in nurses. It was seen as another of those unique descriptors, which would separate those who were nurse material from those who were not. An informant stated:

> You must have that kind of empathy within you to want to help....A great degree of empathy....that's a natural drawing card for nurses because if you don't care about people and if you don't care about people's health, then you wouldn't...be willing to go in this profession.

Flexibility, calmness, and practical common sense. Informants also reported that nurses were known for the flexible and calm attitude they brought to the nurse-client encounter. These nurses were relaxed and didn't get flustered. The client was not the nurse's "enemy" or viewed as a "disruption." The adaptability of home care and palliative care nurses was particularly remarkable, seen as a consequence of their being organised and knowledgeable. Such adaptability was impossible for a "burned-out" nurse. A participant observed:

> Somebody walks in with a new thing, they can adapt to that person quite readily ...you really see it, you know, they look you in the face when you're talking to them; they don't keep their eyes on their paper. When you come to see them... they don't keep talking to their colleague about the donut or the party....they're not disrupted by the patient. They don't behave as though it's a disruption to have somebody new to take care of or have a need...they react positively to the spontaneity of a patient's need.

Similarly, a particularly kind and responsive nurse was commended for her "common sense," while another informant described such nurses as "practical people," concerned with all that is going on around them. He said, "Nurses, because they're involved with life and death and health, they're much more practical, down-to-earth type of persons."

And so, the presence of these many and varied attributes in the nurse was important to the informants. These qualities did not form an exhaustive list, nor were they ranked in any particular order of importance. Rather the participants identified these attributes because they were evident in their experience with nurses. The informants did not seem to see these attributes as stand-alone traits, but as qualities often expressed in conjunction with one another. Along with a fitting visual presentation, they comprise the nurse's professional bearing and approach, which are seen as fundamental to acting as a nurse.

Perform in a Professional Manner

The idea that the nurse performs in a professional manner might seem obvious, however, when it was absent, that omission was glaringly evident to informants. From their perspective, the nurse's professional performance hinged on her abilities to communicate with the necessary parties, in addition to the capable performance of the specific task at hand. Moreover, evidence of the nurse's communication skills seemed to take precedence with participants interviewed for this project.

Nurses Communicate

That the nurse was seen as a skilled communicator was an important thread common through all the interviews undertaken for this study. In fact, several informants focused almost exclusively on this aspect of the nurse's role. The nurse's approachability and organisation in both thoughts and actions often set the stage for successful client-nurse communication. Participants described communication as a people skill, utilising both verbal and non-verbal means.

Being a good communicator involved more than simply being able to make conversation. In the absence of outward identification, such as a distinctive uniform, cap, or

pin, informants claimed to identify the RN by the skill with which they interacted with their

clients and answered questions. They saw the nurse's excellent communication skills

permeating all aspects of that nurse's practice, producing interactions that were tailored to

and meaningful for the individual client. An informant explained:

> You can be a good communicator and you talk to people and they understand
> you and enjoy listening to you. And it's being able to size up that person you're
> talking to and to be able to get through to that person on his level whether its
> down, up, or whatever it is…I think sometimes it's…a skill you're given by
> God kind of thing.

Such communication was respectful, as between equals--one human being to another.

Informants asserted that respect was communicated to the client through the language that

the nurse used in her interactions and in sharing knowledge with that client. And conversely,

a lack of appropriate effort at communication signalled a lack of respect for that individual,

as expressed by this informant:

> Nurses maybe know they know what they know and they know that other
> people don't know, so they have to manage their judgement of other people in
> a way…prejudice…preconceived ideas of what kind of a patient that one's
> going to be…one of the signs you can see is that they almost seem to start to
> lack respect for the patients, the vocabulary changes, the language indicates a
> lack of respect for people.

Several participants questioned the use of endearments by the nurse when speaking

with the client. They viewed such terms as "demeaning." One informant reported that the

nurse who was thoroughly professional addressed the client by name and did not use these

familiar terms. He shared:

> One woman [the nurse] was saying… "Do this, dear, and that, dear." And I said,
> "Dear, like in the…dear, it costs a lot of money" or "deer that lives in the forest."
> And she laughed. She said, "D-e-a-r." I said, "Well, you're not my dear and I'm
> not your dear." And so she called me Mr. [P] after that. I mean I'm not that
> way, but I don't think it shows too much professional pride when you…call
> people "Lovey" and "Dear"…It's demeaning actually in some respects.

> Especially when you get older…she figures I'm an old codger, that I need to be
> jollied along. And I **am** an old codger.

Yet these terms are commonly heard, used by both nurses and physicians in the course of the workday. Perhaps this is because these caregivers can't remember the client's name. Suggesting that this would be equally uncomfortable if roles were reversed, this informant mused with great sincerity that he thought that nurses wanted to be addressed by name as well--not as "lovey" or "dear." The implication was that his calling the nurse by name was a sign of his respect for the nurse, one that he thought she would value. He went on to tell of a hospital unit where at the foot of his bed hung a whiteboard on which his nurse for that shift wrote her name. Since participants often reported that they did not know whom their nurse was, this seemed a novel means of keeping track of the nurse responsible for the client's care. It reflected a level of responsibility and accountability that should be present in a professional standard of practice. It promoted mutual respect.

Using non-verbal techniques. Informants spoke of the importance of the nurse's body language--direct eye contact, proximity to the client, and touch. These all contributed to communicating the approachability of the nurse and were used by the youth clinic nurse to communicate her concern and support to this informant. She shared:

> I had seen the way she'd called other people in and then…she called me. Right
> away her arms around me and…I guess because it was a little bit more traumatic
> aspect that we were dealing with, it wasn't just, you know, a birth control
> pick-up.

The energy the nurse brought to her client encounter was also noticed. An informant discerned that attentiveness toward the client was communicated through the nurse's pace and responsiveness to that client. It seemed that a smile from the nurse spoke volumes. As well, contextually and culturally appropriate touch confirmed that the nurse was paying

attention to the client. Another informant explained how the touch of the nurse was "normalising" and validated the client as a fellow human being:

> She would touch my shoulder....It always kind of drew my attention and it always made me realise that she was paying attention to me....[it] makes you aware that the person is aware of you and acknowledges you as a person and that you're touchable.

And so, nurses communicate not only by what they say but also through what they do and what they fail to do. Although this informant's story was previously told, because it clearly illustrated the impact of the nurse's non-verbal message, it is presented again. Although the client drew her soiled postoperative state to the nurse's attention, she received no assistance. By telling the client to go get dressed, the nurse communicated that any cleanup was the client's responsibility. The client understood the non-verbal communication clearly, "You're on your own from here on in. We've done our part. Good luck."

Another participant, telling the story of her baby's perinatal death, reported that when the baby died, the nurse having collected mementoes (photos, foot and handprints, bracelets, hat, and a lock of hair), had the chaplain give them to her, along with the birth, baptismal, and death certificates. While this seemed appropriate, given this informant's spiritual inclinations as evidenced by her request that her baby be baptised immediately, it did not seem to meet all of this client's needs. She was told that the door of her room on the maternity ward would be closed so that the other babies would not "bother" her. However, as she shared, she gave the impression that this action left her feeling isolated and ostracised. She would have welcomed further conversation with the nurse. Instead she was left alone-- "locked" in her "prison" to think and to cry. Perhaps this lack of interaction met the nurse's needs, rather than the client's.

Informants stressed the importance of initial encounters between the nurse and client. If the nurse spoke to the client from the door, this suggested the nurse's lack of availability or interest in dealing with the client. But if the nurse approached the client with that non-verbal confident air, participants opined that the client would return trust and responsiveness to the nurse. As this informant explained, "When she [the nurse] comes into your room…you look at her and she…in most parts they give you a feeling of confidence and…the rest of it's up to them…the way they handle it." Informants seemed to be saying that if the nurse reached out to the client, the client would respond.

Introducing the nurse. Participants had difficulty differentiating between nurses and other health care providers. Given the lack of uniformity in dress among nursing staff, a verbal introduction was a strategic and necessary way of making the nurse clearly identifiable. An informant described an introduction and its importance to her:

> The nurses I liked would always introduce themselves and…say, "How are you doing. How are we this morning? I'm going to do this." And just kind of tell me what was going on which is nice 'cause it gives me a locus of control…just because they've informed me it gives me the confidence to feel that I can give them authority or I can respect them or trust them in whatever they're doing.

Participants appreciated the inclusion of appropriate humour. One informant recounted how the nurse prepping him for surgery introduced herself as "Ms. Bobbit."[4] While this informant obviously found this reference very funny, the use of humour can be complex and depends on what the individual finds appropriate. Therefore a careful assessment of the client will help the nurse choose remarks that the client will respond to positively.

It was important to informants that the nurse-in-charge be recognisable. This

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[4] Mrs. Bobbit was a notorious American wife who, in 1993, cut off her husband's penis.

identification was seen as a hallmark of good communication, reassuring the client. But, informants reported that the onus to inquire was often left up to the client because these basic introductions were not initiated. While the more sophisticated client may have no difficulty asking questions or demanding answers those without the same confidence or communication skills might find themselves uninformed.

Exploring needs. It is impossible to respond to the client's unique needs unless they have first been recognised. Informants reported that by exploring their clients' needs and finding out what they know, the nurse could provide appropriate information that would support the client and empower the client's decision-making. The client also needed to be given time to process this information and to make decisions.

This area of communication was particularly problematic for one informant. While talking about the difficult circumstances surrounding the perinatal death of her baby, she reported that the marital conflict she was experiencing affected her decision-making abilities. But the nurses did not know this. They naturally presumed that she had the support of her husband. She shared:

> The nurse came in and she said to me that she [the baby] was gone and if I
> wanted I could go down and see her...I somehow wished that she had stayed
> and talked a little bit more 'cause I didn't go....I guess maybe the nurses...
> don't want to get into grief counselling or any of that kind of stuff....I needed
> ...someone you could talk to, somebody you could ask questions to, someone
> who would be able to say...."You could see the baby now" [without the tubes,
> etc]....I needed somebody to talk to...somebody to...essentially help me
> decide what I wanted to do.

Even under other circumstances, this informant felt isolated and excluded from the health care process when her needs were not explored. She also suspected that staff were withholding information or were not respectful of what she already knew because of her laboratory science background. As a result, she presented as hypervigilant when discussing

her contact with nurses and other health care professionals because, as she disclosed, "I'm talked down to because of my knowledge. They don't treat you for what you know....they don't treat you like an equal, they treat you like an idiot." This theme was played out again with a nurse in a local travel clinic where this informant went to get the shots necessary for a trip to Asia. She had researched the immunisation requirements but the nurse disagreed. This time the informant "phoned up the government number and I said to her, "Here. We don't have to guess about it. We have to have it."

But another informant shared a positive exemplar. A nurse, recognising that his young patient needed cheering as her hospitalisation progressed, explored her needs with her. He asked her, "What can we do to make you feel better?" He might have presumed that any number of interventions would yield some positive outcome. But his question demonstrated the utmost respect for the client and allowed her some of the control over her circumstances that she so desired.

Still, as informants reported, often contact with the RN only occurred when the nurse had a particular task to perform. Benner (2004) explains that in caring relationships, such behaviour arises from "the fallacy of thinking that what can't be counted doesn't count" (p. 349). But the client is hoping that the nurse will do more than dispense medications and perform prescribed treatments, as important as those are. They are looking for the nurse to talk with them and to explore their needs. While nurses may sometimes appear psychic because of their powers of observation as discussed in the next section, this study's participants assumed that a discussion of their issues and needs would be part of a regular assessment conversation reflective of the changing nature of their condition. It was this conversation, informants reported, to which clients felt "entitled" and that confirmed to the

client that they were the focus of that nurse, less vulnerable in an environment where they perceived themselves to have little control.

Listening and observing. To learn about the client involves not only questions and answers, but also active listening to and observation of the client. Informants spoke of nurses who were observant and attentive to detail. An informant explained, " Nurses have…the power of observation. Nurses don't look at a person as just Joe Blow from down the street. [They say] 'Joe Blow down the street looks a bit peaked today…he's got funny colour.'"

Perhaps nurses begin their education with powers of observation that are further developed during their schooling, or perhaps this is a clinical skill that is taught. In combination with the nurse's ability to understand and interpret the client's non-verbal communication, such as physical signs and symptoms, and body language, it is a powerful tool. Still, participants noted that some nurses interpreted these non-verbal signals of the client's pain, discomfort, or anxiety better than others did. An informant recounted, "I'm pacing back and forth and I think that second nurse really picked up on that because she kept coming over, "Are you okay?"

The importance of listening, as a component of communication, in addition to responding and acting was compared and contrasted in this informant's post-op story. She was having discomfort and called the nurse for help. Her first nurse was abrupt when she responded and moved the drain reservoir on which the client was laying. Later, this client again asked for help. The nurse who responded this time listened, as the client explained what the previous nurse had done, and then responded in a manner that displayed respect for both her colleague and the patient. The nurse's kind explanation satisfied the client, and left her feeling "there was a nurse that I could ask directly." This informant further described her

view that when the client was speaking with the RN, she would not have to repeat herself. In this way, the client was not "wasting" her breath or energy giving information to an intermediary whom might then have to get the RN. This was seen as particularly important when the patient was in a compromised condition, such as in the postoperative period, when breathing was difficult and energy conservation was a priority. In her view, the nurse had the ability to make judgements on the situation, and could act or answer questions immediately.

But not all participants encountered nurses who listened. An informant stated that nurses "don't listen. I feel they think I'm a threat." She told of being asked to repeat a 24-hour urine collection when she was hospitalised during her last trimester. Trained as a lab technician, she questioned the nurse about the need for this and offered an alternate solution. The nurse, however, rather than following up with the lab, brought in the intern to try and get this difficult patient to comply with the doctor's order. It would appear that it was easier to follow the "order" than to listen to the client and explore options. But the client was adamant and eventually the solution she had provided was proved correct, although she was dismayed that her expertise was not recognised from the start.

Nurses ensure that clients are comfortable through observation, assessment, and interaction. Feedback from the client is essential because different clients want different forms or levels of interaction. A participant noted that he had always sought "information or reassurance through verbal communication." Communication with the nurse was one way that client comfort was achieved because, as he reported "the doctor has moved on....the nurse is the one that's left to deal with the patient." And so if communication is a means to comfort for the client, the nurse who is communicating successfully will be meeting the clients emotional and physical needs. As Benner (2004) maintains, "comforting a patient

includes providing social, emotional, physical, and spiritual support for the patient. While these terms sound soft and tend to get trivialised in a setting focused on highly technical curative techniques, they are life giving and valuable in their own right" (p. 348).

The importance of listening to the client cannot be emphasised too much. The nurse may be good at explaining what she wants to explain, but unless she is good at listening to what the client has to say, that interaction will most likely be pointless. After hearing informants' stories of nurses who listened to the client and those who did not, it seems that perhaps the quality of listening done by the nurse depends on the importance they place on what the client has to say. While informants valued the nurse's ability to listen without judging, they also wanted the nurse to exercise professional humility, and to recognise and accept the knowledge and expertise of the client. They are the experts about their own situation and circumstance. That expert may be the mom who knows her child, or it may be the lab technician who knows how testing is conducted in the lab. Successful communication requires all participants to be active listeners--the nurse as well as the client.

Building relationships. Informants remarked on the nurse's ability to connect with clients and build relationships even if the encounter was relatively brief. Some of these relationships were a result of the nurse "being there," but other such relationships were built and maintained over an extended period of time. An informant shared, "I thought, 'Boy she [the nurse] seems to have attained this relationship with my Dad in a short space of time'...she'd only had one day with him...I was very impressed....and he felt warm and fuzzy as we walked out."

Although the forming of a relationship did not happen with all nurses, when it did, it was something particularly wonderful. Another participant spoke of a special alliance forged

over months of visits with a youth clinic nurse. She felt that she "could say anything" to this nurse. She proclaimed:

> I believe in building relationships…she knew the story. I don't want to have to
> go in and explain it all over again. Yeah, they can read a file but it's not the
> same as hearing it from me, what I think.

This participant had valued this relationship so much that she self-scheduled her visits at the clinic so that she could maintain contact with that particular nurse. This connection was so special that this client returned after the birth of her child telling the RN, "Look! This was the product of our visits."

Having the nurse share from her own experience, or personal story, sometimes contributed to this sense of connection with the client. For example, having a nurse who shared from her experience as a breast cancer survivor, was a positive encounter for one informant. The caveat, while not mentioned by participants, is that care must be exercised so that there is no shift in focus from the client to the nurse. The interaction always has to be about the client.

And so, the idea of building a relationship with the nurse seems important. But informants noted that it was often difficult to achieve, especially in situations of home care, where scheduling was often a problem and it was not unusual for a different nurse to make each home visit.

Providing information. The ability to share information and provide explanations was seen by informants as an active demonstration of the nurse's knowledge and skill, important because it empowers the client. Providing information and enough time so that the client can come to understand the healthcare plan and make related choices supports client decision making. It helped an informant achieve some "locus of control," alleviated her

uncertainty, enabled her to consent to treatment, and increased her respect for and trust in the

nurse. What was required was the honest sharing of information from the nurse, sometimes

even in the face of the nurse's own uncertainty. Unfortunately, this did not always happen.

She reported:

> I wasn't really told what was going to happen and I came out with three feet of
> tubing and it's so strange. They didn't tell me that I wasn't going to have
> anaesthetic and go under. It's really just important to inform you.

While it was not essential that the nurse immediately respond to all the client's

questions, it was key that the nurse commit to finding out the answers to those questions

beyond her knowledge base and report back to the client with that information. And,

informants thought that the nurse would take initiative in obtaining more detailed information

if necessary. An informant explained:

> When a person asks a question, they have to be able to answer the question and
> not seem vague....Not brush you off and if you want an answer that maybe is
> a little bit more in depth to not be hostile if it's inconvenient, to go call the
> doctor.

As a participant reported, "People need the information, [but] not everyone knows where to

find it." Information needs are uniquely individual. Some participants reported greater needs

for information from the RN, while others required very little. Still, participants were nearly

unanimous in seeing the RN as a source of information, sometimes meeting the client's

information needs by default because she is the practitioner who is there.

While the provision of information may be routine for the nurse, for the client this

information is often new. An informant referred to the routine discourse that occurs with

some nursing tasks as a "script." As a long-term client, she was so familiar with some of

these routines that the extent to which such a scripted interchange might be termed an

interaction was suspect. She explained, "There's such a social script that you're used to

hearing like "I'm going to be...taking your blood with the needle and look this way"...It's just going through the process of it." And so, informants emphasised the nurse's ability to communicate using language that the client could understand and answering questions appropriately, particularly those of a general physiological nature.

Some information can be successfully communicated non-verbally. One informant's positive experience attending the death of an uncle in the ER was due in part to the information about the dying process shared by the palliative care nurses during the terminal care of another relative and supported by a document on the stages of dying. But another informant who appeared to have minimal knowledge needs, disclosed:

> I don't think I was one of those patients that's sort of demanding, "What's going to happen next. What's going, what am I going to do now...tell me about this." There was some brochures brought in, dropped on the little table beside my desk and I think probably by a nurse about..."What is a Myocardial Infarction" and "What You Need To Know About It"....Read those and that sort of seemed to satisfy my knowledge base about what's happened to me.

This information was provided in a rather generic fashion without either exploring this client's unique needs or following-up to answer any questions prompted by the literature. While this client expressed no concerns, it might be difficult to determine that a client's knowledge needs had been met unless feedback was solicited. But another informant suggested that this was a shared responsibility, not one owned by the nurse alone. And so, he felt that the client was responsible for ensuring that his questions were answered satisfactorily just as the nurse was responsible for answering them.

Nurses who responded to specific questions positively affected informants. For example, a RN provided information about resources for post-mastectomy women. The additional impact of this RN's sharing from her own mastectomy experience was particularly meaningful in this situation and offered another perspective. Similarly, another informant

described home care nurses who provided information, explained what they were doing, and showed her how she could do it later. This meant that a family member could safely provide some personal care for the client when the nurse was not present. As well, the nurse provided pamphlets about additional resources. Because the nurse did not filter the information, making choices about which options might be right for the client, the family were able to use the information to make their own decisions, aware that some of the options were beyond their financial means.

Several participants spoke of how they valued information provided by the RN because it stemmed from the nurse's knowledge of what was normal. These participants reported feeling reassured by the nurse's encouraging words --"Oh it's perfectly normal and you're doing great." But this informant also shared a negative exemplar in which she felt that the nurse offered information on which she was not authoritative, answering a question that the client had not even asked. This informant recounted:

> We were horrified by her...she would tell us information that we didn't need to know or that was actually kind of speculative and would mislead us or be just dishonest. Like she didn't know about the situation and we didn't ask the question...she would just say random things about, "Well in your surgery this probably happened" or "Well this will probably happen to you."

This nurse was seen to be sharing misinformation. And so, rather than alleviating any element of surprise, the informant seemed to become sceptical of the nurse as a credible resource. Several other informants also questioned the credibility of some RNs, and suggested that nurses were less forthright with knowledgeable clients. They thought that if clients were thought to have no knowledge, nurses were more willing to interact and offer explanations. Given the increasing access to information for ordinary individuals via the

Internet, this may pose a problem for those nurses who are threatened by clients they perceive to be especially informed.

Informants also thought that nurses shared information with their peers or other colleagues such as physicians. Nurses were seen as conduits of client information to the doctor which might not be forthcoming simply because the physician's contact with the client was more limited. And so, it isn't only the client with whom nurses share information.

Having arrived to visit his elderly uncle hospitalised with pneumonia; an informant found his uncle's bed empty. Thinking that he had been moved to another room, he was surprised to be told by the nurse that the uncle had been discharged. Because of his deteriorating condition, it had been determined that he would need a higher level of care on discharge. And so, family members had been organising his transfer to a new institution. Even so, this patient was discharged from the hospital without the family being informed. Equally distressing was the idea that the nurses did not express concern or regret that this information had not been relayed. This informant stated, "They just shipped him around like a parcel."

The lack of collaboration in this scenario is disturbing. It is surprising that this informant does not seem to expect the healthcare institutions to be collaborating around the transfer of this patient. He seems to accept that this is his responsibility, and perhaps that is another factor in his distress when the process goes off the rails. The idea of being "shipped like a parcel" speaks volumes in the current healthcare climate where clients are often sent to alternate service locations, whether acute care hospitals or extended care locations. While the reasons may be well founded, communication with the clients and their families remains very important. This informant thought that the nurses would be informed and would then share

this information with the family, other staff, and other facilities as necessary. It did not happen.

Some participants spoke of missing the opportunity to talk to the nurse. The nurse communicating information provided comfort and reassurance to the client. An informant recounted, "More contact would have been better and somebody to sit and say, 'Okay, here's what's happened. Here's what you can expect.' And then I... wouldn't have been unprepared for that bleeding episode." In fact, this individual had clear views about the nurse's responsibilities to provide him with information about his progress. From his perspective, if the nurse had not taken the time to say to the patient, "Everything's fine," they had not done all that they should be doing.

Giving advice, follow-up, and direction. Nurses not only give advice; they follow up with the client. Recalling childcare advice given by community nurses during home visits, an informant reported that the nurses followed up on subsequent visits and learned that their recommended treatment had been successful. And palliative care nurses continued to offer advice even after the death of the family member who was their client. In that case they reminded this informant that she needed to take her mom's personal belongings with her, the nurse having suggested that her mom's jewellery could be removed and replaced at the funeral home.

However, a participant who was married to a nurse recounted with some glee that nurses do not always follow their own advice. Although his wife, a public health nurse, had recommended that women not be pregnant during the hotter summer months, two of their three children were born in the summertime.

Nurses were also thought to provide direction about where to get specific information if they were unable to provide it for the client. And in the interim, nurses offered a step-by-step approach--"This is what you have to do for now." Nevertheless, sometimes it seemed that nurses gave direction instead of care. Another informant described regular visits with a friend hospitalised for an extended period after an accident. She reported that the nurses were pleasant and accommodating. Although they were too busy to provide the personal care that might have been expected, they showed her where things were on the unit so that she could wash her friend's hair. She stated:

> The nurses didn't have time to give my friend the type of care and...things like washing his hair....I was the one that was helping....Somebody needed to do it, 'cause he couldn't sit there for three...for months without having his hair washed for example.

This informant did not fault the nurses for this lack of physical attention. Still, recalling what this simple act meant to other informants, the care that these nurses provided for a long-term client seems less nurturing, less exemplary.

Advocacy. The advocacy of the nurse in the nurse-client encounter was important to nearly every informant. Perhaps it should not be surprising that the one informant who did not comment on this aspect of nursing practice saw the nurse as someone who primarily performed tasks. This individual sought his information from his physician. Every other informant recalled an instance where a nurse advocated for her client.

Nurses can advocate at the client's request, or as a professional, without their knowledge, but in their best interests. For example, an informant appreciated the professional, gentle, and humorous way that the nurses approached the physician who had restricted her activity and mobility on the unit. In her case, the nurses prepared the physician

by mentioning the client's desires and needs, and the client negotiated her request for

increased activity directly with him. She described this important function:

> The nurses did advocate for me…in a gentle way, but in a very professional
> way and I really appreciated you know this professionalism that…they kind of
> cleared the ground for me. They did it in a light way.…That was a good
> example to me of the professionalism and being able to…be an advocate…
> because the few minutes that a patient has with a doctor…is really ineffective
> …you're mostly listening or answering their questions.

Being a watchdog, described and discussed in an earlier section of this chapter, was

linked to the advocacy role of the nurse. An informant asked the OR nurse to make sure that

her fallopian tubes were cut and cauterised during her tubal ligation. She was anxious that

others in the OR know of her desire. She recounted, "I remember telling her, telling the

nurse, I was starting to fall asleep and telling her, 'Listen, make sure he doesn't only cut my

tubes but I want them cauterised as well. This has **got** to be permanent.'" In this instance, it

was the nurse as a watchdog who advocated for the client's best interests. This nurse went

beyond consulting with the physician, confident in her advocacy because she was aware of

the client's desires.

When another informant's elderly mom fell and fractured her patella, the surgeon was

ready to discharge her shortly after her operative repair. The nurses intervened and said that

she could not be discharged home. They insisted that she be sent to an assisted living site

where she could have continued assistance and rehabilitation. He recalled:

> The nurses are the ones that are saying, "No, we're not going to release you."
> The doctor says, "Okay, she can go home." The nurses were the ones that knew
> that she lives alone…it wouldn't be good for her to go home because she couldn't
> handle walking…even with the brace on. And she had steps that she would have
> had to climb and she was alone.…So they [the nurses] were the ones that were
> saying, "No…you'll stay here for the week." And they're telling the doctor that
> she's going to stay there for a week. And then what happened is she got put into
> one of these transition houses and she could stay there for…six days to forty-two
> days or…until the cast comes off.

Communication of client needs to other staff is also a form of advocacy on the client's behalf. An informant recounted that when her infant son was hospitalised she brought diapers from home to protect his sensitive skin. Although she asked the primary nurse to have other nurses use them in her absence, they did not and his skin quickly reacted. In her view, this was a communication failure, and it was quite serious to her given the importance she placed on the role of the nurse as a communicator.

Another participant spoke of the difficulty she had controlling the number of visitors when either she or her husband was hospitalised. With many friends in the community, they were inundated with well wishers. She had difficulty admitting that she was exhausted and drawing the line because she was busy "performing"--being a good patient. She shared that she would have welcomed the intervention of a nurse who having recognised the client's fatigue, would have discussed her needs with her, and then interceded on her behalf and with her permission.

An informant, who repeatedly expressed her view that she had to look out for herself and her family as they interacted with the healthcare system, also offered a scenario where the nurse was an advocate. This seems a difficult and perhaps controversial vignette because it discusses clinical indications for investigations, which are still the prerogative of the physician. In this instance the nurse came to the informant and presented the case to her, rather than interceding with the ER doctor. The informant felt helped and empowered by that nurse's explanation, encouraged by the sense that the nurse had "joined her in her corner." And perhaps the nurse played it safe by not discussing the situation with the physician in a collaborative manner, instead urging the informant to insist on what she wanted. This informant, interpreting this interaction positively, reported:

"The nurse came to me and she said, "Don't let him get away with that [postponing the CT scan]...She's been out of it too long not to have the CAT scan done. And so she really helped...by explaining to me....It was nice to know that somebody backed up what I wanted.

And so, it is clear that informants viewed advocacy as a function of nursing practice, which their clients valued and of which nurses should be proud. The nurse was seen as the natural advocate for the client because she spent the most time with him and should therefore be best acquainted with his needs and preferences. As an informant explained:

> Ensuring that everything was done right for that person, even to the point of quizzing the doctor or questioning what was going on here....It was right there among the highest attributes....We all need our advocates....I think it is so important that there be one firm advocate. I'm not sure that the doctor can play that role because of the number of patients that he deals with. But the amount of time that a nurse spends in the healing process or in the recovery process with a patient, she would be the natural advocate...."I'm going to do the best I can for you while I'm here. Advocate for you."

Another participant spoke of the importance of having an advocate as one navigates the medical system. He saw his wife, a retired nurse, filling this role for various acquaintances. Others have also identified this need. In fact, a Vancouver-based company has recently begun marketing this service for a fee (Fayerman, 2004). RNs are used to help clients navigate the healthcare system because "they have malpractice insurance, they are highly trusted members of society and they know the healthcare system well" (B7). This again highlights a fundamental problem that well-intentioned former nurses may have in continuing to assist others. Although still seen as knowledgeable and competent advisors, they may lack the legitimacy of continued regulation through their licensing body.

Emotional support. Communication is one way that client comfort is achieved and emotional needs are met. As previously discussed, participants felt that feedback from the

client was essential because different clients would want different forms or levels of interaction.

As a pregnant teen, one informant felt emotionally supported by nurses at the youth clinic. If the opposite of support is abandonment, then the nurses who offered non-judgmental and unbiased support assured her she would not be abandoned thus relieving some of her anxiety. She was encouraged to make the decision that was right for her and told of community resources to help her if she decided to continue with the pregnancy and keep the baby. She recalled, "They [the youth clinic RNs] were great in the sense of, you know, listing your options, making sure that there was emotional support, at any time you could phone." This was quite the opposite of the post-partum nurse who left the bereaved informant alone in her room.

In reviewing the data, it seemed that the emotional support offered by the RN empowered and informed client decision making because it was offered along with information and resources. As this informant reported:

> She was very clear in telling me, "You're the one that lives out this life. Your parents will tell you they'll help you and they may or may not. But you can't go making decisions based on other people's words or other people's actions or other people's experiences. You have to do what you feel is right for you." And those words rang over and over in my head and I thought for me, I knew what was right for me.

Another way that informants saw the nurse offering emotional support was as she shared from her own real-life experiences. While this might be problematic if the exchange becomes more about the nurse than about the client and her family, in the instances shared, participants felt supported and encouraged by the nurse's revelations. As previously recounted, a nurse shared about prosthetics from her own experience as a breast cancer

survivor. A nurse told another informant how much she had learned about the process of

dying from her patients. This informant shared that nurse's words:

> "Just when you think it'll be over, she'll breath again….I know. And that was
> hard for me at this job," she explained. "Originally I wasn't sure, you know,
> what the hell was going on."…She was there for us more than she was for my
> mom.

And so, *acting* as a nurse required that the nurse utilise both verbal and non-verbal

means to communicate with the client. Such communication required that the nurse introduce

herself to the client and enter into a relationship with the client. Within that relationship, the

nurse listened and observed as client needs were explored. The nurse also provided

information, gave advice, became an advocate for and offered emotional support to the client.

Nurses Respond to Physical and Emotional Needs

For participants, it was a foregone conclusion that the nurse would complete physical

tasks, providing personal care as necessary for the client. It was not enough to simply explore

the client's needs. Participants described acting on information, making decisions and

solving problems, in response to the physical and emotional needs of the client, as a salient

part of the nurse's function. The nurse was organised, working with efficiency and

resourcefulness, following the doctor's orders, and delegating tasks appropriately. It required

knowledge, insight, and understanding, as an informant revealed, because "I don't expect

them [the RN] to do everything. I expect that they have the knowledge to understand what is

happening." And so, informants described the nurse responding to each client as an

individual; reassuring them, and making them feel safe. For example, although it is not

unusual for parents to be anxious when their child is having surgery, the nurse who

recognised and responded to this informant's needs was memorable. She shared:

> She saw my emotional unsteadiness…[and] went beyond the call of duty. I'm

sure it didn't say in her job description, "Must phone ORs and…update patient's parents"….But still she did that because she saw that I was upset…and I'll never forget that…just really cared to calm me down.

This participant later recalled that during her mom's terminal illness, the home care nurses not only collected information, they also acted on it. And so, they continued to assist her mom and eventually used their information to appropriately seek hospitalisation for their client.

A story shared by another informant focused on an industrial nurse's concern for him during the 1950's polio epidemic. He had stayed off work because of the "flu." The nurse checked in on him multiple times through his first symptomatic afternoon and night. The implications of his illness, and the possible consequences within the community did not dawn on him until later. When asked whether the nurse had shared her concerns with him, he responded, "No. She didn't alarm me or anything like that…[but] she came back and she came back."

And so, some nurses were responsive to the client's physical and emotional needs, while others considered the client a ""disruption" or their "enemy." The difference was palpable as another participant remarked:

> Sometimes you walk in and the patient is almost the enemy. Sometimes you walk in and they're just happy to have you there. "What can I do?" Its not that they are different looking people or anything like that so much…there's just a feeling.

But, this informant also told a powerful story highlighting the lack of responsiveness that she saw resulting from the absence of this vital aspect of the nurse--care. During her fourth delivery, she had a fever and was given antibiotics. Although she verbalised her concerns about her baby's condition, she was unable to get the nurses or physicians to respond. Therefore, in her estimation, "They just didn't care." She recalled:

The nursing situation was, I was in a room very far away and nobody would take me seriously, I said, "He's not well," and **nobody** cared...I could not spark an interest.... His eyes were all yellow, his body was skinny, he didn't want to drink....He would cry but nobody sparked, they were so disassociated, blasé.... The nurses weren't alert....I was trying...I said absolutely enough to gain some interest....The only missing piece of the puzzle to having stopped all this from happening was me knowing baby should be paid attention to....They knew that or they didn't. What do I know what they knew or didn't know...(pause) They should have known (softly).

But nurses who care do respond. Another informant reported that without the ability to provide otherwise for her mom, the nurses helped the family "work with the resources that we had." This spelled "relief" for her because she was not left to care for her mom alone. She recalled, "She [the nurse] took a load off me because if we didn't live in a day and age where we had that system where somebody comes and looks after you...we would have been screwed."

Responding to client's needs requires the nurse's observation, assessment, interaction, and intervention. And all this must be done in a timely manner with feedback obtained from the client to confirm the benefit or evaluate the outcome of these efforts. But, with fewer nurses working either on the wards or in community settings, this may not happen. If the nurse is unable to respond to the client's needs in a timely manner, then the nurse may not be meeting the client's needs at all, as the informant noted when he expressed his anxiety and dissatisfaction with the nurse's late response to his episode of post-op bleeding. In fact, Ponte et al. (2003) comment on the adversarial nature of some provider-client relationships. Certainly this is what has happened if the client feels that he is the nurse's enemy.

Performing physical care. Some informants were confident that they could identify the RNs by their actions, functions, or duties. They assumed that a nurse would do such physical tasks as taking blood pressures, dealing with stitches and wound dressings, ensuring

that medications were taken as prescribed, in addition to providing comfort for their client. In fact, several participants expressed the view that the nurse's priority was taking care of the client's physical needs, not their psychological needs. An informant stated:

> Basic prototypes [of the nurse] were…someone who comes out and cares for you and checks on you, makes sure you have your meds….He [the nurse] would sit on the floor with me and hold my hair back. And if I cried he would just sit there and wait 'til I was done. And he was never pushy or overbearing at all….As a nurse…number one is physical needs…why are you there at the hospital, probably a physical need. So, I wouldn't necessarily expect them to psychologically care for me over time or to take on that burden necessarily.

This informant, viewing the nurse as primarily a task-directed individual, felt that the nurse was either incapable of or unwilling to assume a more comprehensive role in care management or patient education. Even though she had received emotional care as a client quite outside the parameters set by her expectations, she did not see the nurse as a provider of holistic care. For example, her nurses went to considerable lengths to cheer her up, recognising her demoralised state as a young person hospitalised long term. In one instance, providing for her emotional well being involved the very practical task of washing her hair. It is hard to imagine how another professional, like a social worker or a psychologist might have addressed this problem. It is unlikely that they would have taken a hands-on approach. Rather one suspects that they would have either asked a nurse to do it, or suggested that the client book an appointment with the hospital hairdresser.

Most informants expressed their desire that the nurse focus on them as individuals. In their view it was important that the nurse's clinical skills be so solid that the nurse could then pay attention to the "human side" of the work. As this informant explained, "Skill has to be so in place that the personality can just be what it's supposed to be and deal with the people aspect of it." Still, as previously mentioned, some informants were not aware of all that the

nurse was doing because she unobtrusively went about completing her tasks. Therefore, they took the nurse's clinical expertise for granted because she was focussed on doing those tasks associated with her job. But it is possible that the nurse is focusing on the task because she is unsure.

In reviewing the data, it seemed that participants who were hospitalised for serious injuries or conditions came more readily to the conclusion that nurses were primarily concerned with responding to the physical needs of their clients. Other informants, who had witnessed the care of clients with chronic conditions like diabetes or cancer, or geriatric clients, seemed to ascribe a broader, more encompassing role to the nurse. For such clients, informants seemed more aware that the nurse had offered support and provided instruction in addition to performing the specific tasks, which were the reason for the nurse's attention in the first place. Although informants did not use the term, it seemed that they were describing holistic care. In reflecting on this, it seems that some nurses are so busy doing important things, at least from their perspective, that they do not have the time, or take the time, to provide those comfort measures or emotional connections which are valued by their clients.

Providing holistic care. Nursing as the "caring profession" is a concept well supported in nursing literature. As a layperson, caring was the first thing this informant associated with nursing. He stated, "When I think of nursing...I just thing of care. That's the first thing that comes to mind...that nurses do and act for the patients for whatever they need and...try to fulfil those needs." Not only was the nurse charged with caring for the client's physical needs, the nurse provided reassurance and responded to his emotional needs as well.

Participants also spoke of the nurse's role in creating an environment that supported the client, promoting his wellness in the foreign and strange hospital setting. This was

important for the very same reason that verbal communication was valued. It was seen as another of "those professional things that gives the patient confidence that they know they're being looked after properly." This informant summarised this as being "nursed back to health...[with] nurses...promoting the process."

For most informants the ideas of "caring" and "responsiveness" were closely linked, just as Radwin (2000) alleges. As a pregnant teen, a participant had little family support. It was not surprising that the nurse's concern for her, as expressed when the nurse shared her home telephone number, had particular meaning. Perhaps it was even more meaningful because the nurse told her that this was not something she did routinely. This informant shared, "[the nurse] said, 'You know, normally I don't do this but I just feel like you have nobody and I'd hate to see you make a decision just out of...not having the proper information or not having that emotional...support system.'" Nursing interactions continued with clinic nurses coming to this informant's home. "Because I was so young I think they were extra worried." With limited family resources, she welcomed their concern and attention, and did not find it intrusive. Similarly, after her mom's death the palliative care nurse expressed the concern that she felt for this participant. She recalled, "The nurse, I guess, saw the kind of look on my face lugging all this shit [her deceased Mom's personal belongings] and she's like, "Are you going to be okay?"

It might be suggested that the ways by which the nurse provides care demonstrate the extent of her caring attitudes. This display of attributes, which were not a generic expectation of all nurses, was what made the nurse particularly noteworthy for informants. Unlike those nurses who quietly went about their work, this informant did not need to guess what the nurse was doing or why she was there. He described the nurse:

Nurses who I was very impressed with…really cared and were there to show empathy for what was happening to me. I felt secure because of their manners, their professionalism around the bed and…the way they paid attention and showed that they really wanted to help you and assist you in whatever way and encourage you through this…period of time…they were there for comfort and they showed that.

Of course, other nurses were memorable because of their lack of caring. As previously discussed, this same participant saw the nurses who participated in shipping his elderly uncle between care facilities like a "parcel" in this light. But, the client-focussed ER nurse, who provided this client's final care, was a sharp contrast. The informant shared:

She released him, you know, and looked after him just as a daughter would and showed great sensitivity to the family in what was happening.…It's always hard to lose somebody but when you know what's happening and there was a nurse who really cared and treated him with great respect and actually told him it was okay. "You can leave, you know, you can go now" type of thing and it was… just a wonderful experience for the family to see that happen.

And so, even though times and circumstances changed, it remained important that the care that the nurse provided dealt with more than the client's physical needs. One informant compared and contrasted his two surgical admissions, which had been at the same hospital, although six years apart. He was quick to point out that while his care was different for several reasons, he viewed the primary reason to be changing RN-to-LPN-to-client ratios. During his more recent hospital experience, his contact with the RN was "task initiated." He reported, "I had very little contact except when somebody had to come in and change the dressing or look at the drip or that sort of thing. I was basically left in that room alone." While he expressed no complaints with his physical care, his comments indicated that emotional care and support were missing.

Offering reassurance. Informants saw the nurse offering reassurance to them when they were provided with information of all sorts. A participant told how the nurse informed

her that her mom was near death and shared information about physical signs that might be witnessed during this time. This was reassuring for the participant because she thought the nurse knowledgeable in these matters. Later, when her mom died, her younger sister became hysterical. At first it seemed to this informant that the nurse did not know what to do. But then she offered calm reassurance to the older sister and did not leave them, but made the necessary calls to the morgue from the hospital room. That nurse said, "Just give her a minute. This is very normal….she's young. That's her mother." The reassurance and kind support was unforgettable for this informant.

Some informants were reassured when they learned that what they wanted had been done. The participant who asked her OR nurse to ensure that a permanent tubal ligation was performed was pleased when that nurse reported back that the surgeon had both cut and cauterised during the procedure.

Other participants spoke of the reassuring presence of the nurse not only when the nurse was caring for them personally but also when they witnessed other nurse-client interactions and were assured that the nurse's attention extended to those individuals as well. The early visit by the home care nurse was seen as "definitely reassuring" when an informant's mom was discharged on her first day post-mastectomy. This reassurance came from the understanding that providing care was not the sole responsibility of the family who lacked both medical knowledge and expertise. This informant shared, "Your life just changes so much in that one day…having someone come right after was definitely reassuring."

In a similar vein, another informant commented on the sensitivity that ICU nurses displayed in their treatment of other patients in such close and exposed quarters. The nurses reassured her about her own condition as well as that of her neighbours in the unit, something

which had obviously been a source of some distress for her. She commented, "How sensitive they were to the fact that the man in the next curtained area was in a very different physical position than I was and they were reassuring me that they were taking care of him."

"Orchestrating," taking charge, organising, and delegating. An informant spoke of the role the nurse played in "orchestrating" the move of her mom when her condition declined. The informant recalled:

> We didn't find out until later from her because we talked to her later, that' she [the nurse] was the one that initiated a change for mom because she could see how mum was deteriorating…she was the one that insisted that the one private room on the floor would, when it became vacant, mom was to go in there and she worked that out….She just orchestrated everything….She just orchestrated everything and things kept falling into place."

For this family, this nurse personified care. While this may be similar to advocating, this nurse was seen as the initiator of the change, and perhaps that makes this scenario slightly different. This nurse was an arranger with attributes surpassing some clearly defined expertise, who provided what informants seemed to want as "someone who can value and connect with others, using the multiplicity of experiences of the client and team members to develop adaptive and creative solutions" (Managing identities, 2002, p. 33). This is a continuing challenge for any practising nurse.

Accordingly, because of their knowledge and their people skills, nurses were seen as "take charge" individuals who, when necessary, could act quickly because they had learned to make decisions. An informant suggested that "calling a code" would be illustrative of such a situation and behaviour. And being able to make decisions was essential for nurses involved in trauma or rescue operations. Another informant told how his wife rescued a drowning victim from a lake and performed cardiopulmonary resuscitation (CPR) on him, as well as how she provided emergency support to a pedestrian struck by a car. Expressing his

confidence in her abilities, he disclosed, "Whenever there's a problem like illness or somebody getting hurt...I know [wife] can do it, you know, because she's a nurse, eh?"

The quick response of the nurse was thought by participants to be a sign of the nurse's organisational skill and efficiency. For example, the speed, with which an informant was admitted into the ER, the morning he was having his myocardial infarction, amazed him. The nurse "spun around the corner...got me into emergency and laid me down and attached all those different things to my chest wall and the clips to my fingers and took a blood sample." To a nurse who works in ER and admits countless clients with chest pain, this may sound routine and predictable. Yet, this individual, unfamiliar with that environment, was impressed with the efficiency with which these tasks were accomplished.

Similarly, another participant spoke of efficiency as one of the hallmarks of the professional nurse. During her extended stay in the ER, she felt safe because someone was always popping in and responding to the bells and whistles. When transferred to the ICU the nurses continued their diligent monitoring and quick response. She reported:

> I was very aware of the efficiency of the whole operation....They [the nurses] were very professional....I was hooked up to all these bells and whistles and there was a bell going off it seemed like every time I moved. And I couldn't figure out who was setting off the bells...(the nurse) would come running over ...how quickly they acted.

Informants commented, not only on the organisational abilities of individual nurses, but also on the impact that the organisation and co-ordination of nursing services had on their care. An informant shared how the services provided by the youth clinic, as part of the community health clinic, were organised. She appreciated the continuity of care, and was impressed with the comprehensive service. Not only was prenatal counselling and care offered, but home visits were also arranged after she has the baby, and her baby's

immunisation was begun through that office. It meant that she did not need to continually retell her story to new nurses. Rather, by being organised and informed, the nurse says to the client that she is ready to give that client her undivided attention.

Several informants spoke of the value of having paraprofessionals to assist in the care of the client, freeing the RN for other responsibilities. Although these informants displayed no real understanding of how the job descriptions of such individuals might differ from that of the nurses other than by the degree of difficulty accorded certain tasks, informants saw nurses as maintaining responsibility and accountability. And so, these informants were comfortable with the RN's role in decision making, problem solving, and delegation of function to paraprofessional staff because of the nurse's knowledge base. But, delegation must also be done appropriately. When this informant was a teenaged hospital volunteer, a "candystriper," she was sent by a nurse to tell parents that their baby had died. This seems entirely unsuitable and professionally indefensible. A volunteer should never be sent to do what the RN should be doing.

Still, as previously mentioned some informants were puzzled as to what the nurse should be doing. Perhaps this was indicative of the continuing confusion and blurring of professional boundaries as understood by these informants. They expressed surprise at the suggestion that the LPN's "full" scope of practice might allow the LPN to do some tasks previously done only by RNs. How this might compare with the expanded practice roles envisioned for some nurses was not mentioned by the participants. This was not surprising, since none of them spoke of encountering nurses in genuine advanced practice roles. And so, it is not just that nurses do these tasks for their clients, but how they do them that is

important. Informants also saw nurses solving problems and effecting change using efficiency, organisation, and resourcefulness.

Solving problems and effecting change. Problem solving may require creativity, persistence, and sensitivity. Several informants described the importance of having their hair washed while they were in hospital and unable to do this for themselves. One informant had no problem with the nurse not shampooing his hair immediately. The nurse had priorities and explained them. After completing those tasks, the nurse came back with all the necessary equipment and washed this informant's hair. This informant explained:

> He said he had some other things to do that morning but he'd be back. And about an hour and a half later he came back. And he had this very curious kind of stainless steel bowl thing that had a curve in it that fit around your neck so you could lay back...a pitcher of warm water and some shampoo. And I put my head back and he soaped up my scalp and rinsed it off and...gave me a really nice shampoo...and gave me a towel...it felt so good. I'll never forget that.

Another participant also remarked on the resourcefulness and problem-solving abilities that the nurse demonstrated in accomplishing this same task. Because her shampoo wasn't a standard over-the-sink or in-the-bed shampoo, it required creativity on the part of the nurse, which this client recognised and appreciated.

The tenacity that her nurses displayed in locating and tracking down her physician at the Vancouver Airport impressed a participant. Another informant recounted how the palliative care nurse, perhaps seeing the state of the informant, offered a solution to the immediate problem of returning the equipment which had been obtained "on loan" for her deceased mom. The nurse assured her that she would call the companies and arrange for them to pick it all up. This was very practical, sensitive, and welcome support.

Only one informant suggested that nurses might be agents of change. He shared a vignette about nurses solving a problem in their small hospital. Their matron had set ideas

about an appropriate dress code, which at that time included nurses not wearing pants at work. However, a television crew had filmed her nurses transferring a patient into a helicopter. Wearing dresses, they were quite exposed on the film footage that was broadcast later on television. A delegation of these nurses challenged the matron, compelling a change in the facility's dress code. These nurses were described as people who made things happen.

Protecting the public through safe practice. Even though informants thought that nurses had a certain level of knowledge and understanding, they also saw the nurse doing what the physician said. By following doctor's orders and practising in accordance with clinical guidelines, informants thought that nurses protected the public and helped their clients feel safe. In addition, the continual presence of the nurse, monitoring and reassuring their clients, promoted a sense of safety and security for those clients.

In discussing the cardiac rehabilitation program he attended, an informant reported that the kinesiologist ran the program. The RN had an "adjunct" role, which involved monitoring participants. This informant observed that each client had unique reactions to their myocardial infarction and to their participation in the program. Some were worried and others did not appear overly concerned. Still, when these clients were being assured about the safety of their participation, the on-site RN was the major plus. He recounted, "They really went through great pains to reassure them that "It's okay. You're under a controlled environment here. There's a nurse…right here." Interestingly, this informant knew that the kinesiologist had a Master's degree. He had no knowledge of the RN's educational preparation.

In other settings, informants saw the nurse as in charge of the patient because she was there, a consistent presence in providing client care, even though the "doctor calls

occasionally to talk about your instructions." When an informant's elderly mom was relocating to a new assisted living complex, one of the complex's selling features was an in-house doctor's office. The informant assumed that "there'll be a nurse assisting the doctor." RNs, rather than LPNs, were thought to be able to provide more comprehensive explanations about what was being done, why it was being done, and to possibly elaborate on information the physician had either provided or omitted.

Nurses were known to have policies and procedures that guided and assured their safe practice. When one participant was showing signs of pregnancy even though the urine tests were negative, the nurse sent her for blood work. From the client's perspective, this was standard protocol at the youth clinic. Practising in accordance with clinical standards, that nurse was able to make a clinical assessment and act on it without needing a specific physician's order.

Safe practice was seen as the responsibility of each nurse. An informant commented on the need for the nurse to "behave appropriately." Having experience dealing with an impaired employee, she mused that nursing was likely no different from any other profession. And so, nurses were thought to responsibly monitor their colleagues, thus protecting clients from the consequences of impaired practitioners whether that impairment was through poor judgement or something contagious. Of course, similar monitoring had not protected the patient who was twice the victim of a nurse's serious medication error. In that instance, not only was there a lack of personal accountability on the part of the RN, there also seemed to be a lack of corporate ethic in providing protection for that particular client and for the public. Instead, that informant, using the western analogy whereby vulnerable pioneers

were protected, spoke of the organisation "circling the wagons" and protecting the nurse, rather than the client.

Overall, informants agreed that the presence of the RN made them feel safe. A participant told of the gratitude that her father expressed when he was being discharged from the hospital. She recalled, "As we were leaving…he stopped to thank the registered nurse for making it such that he could leave and in his mind saving his life. She was…his 'angel' 'cause she got him out of the hospital." While it sounds somewhat insignificant, it is important and in keeping with recent magnet hospital research conducted in both Canada and the United States. Those researchers report that morbidity and mortality rates decrease as the ratio of RNs providing direct client care increases, irregardless of the practice setting (Searle, 2004). Perhaps this elderly client knew this intuitively.

Unfortunately, policies, procedures, and orders are not always enough when faced with the ethical issues that can be part of the client's experience as well as that of their nurse. An informant shared stories about such difficulties from both perspectives. She spoke of the palliative care nurse who showed compassion and understanding when she told the informant that "its [death] always worse for the family that's watching it." Although her mom had not wanted any morphine administered, this daughter was asked how she felt about this. While she did not want her mom to have an uncomfortable death, she was surprised that her mom's wishes could be "overpowered." As well, this informant commented on a situation she observed in a hospital's pre-op holding area. A RN was doing a pre-op check on a patient with limited English skills. Although it seemed obvious to the nurse that this patient had no idea why she was coming for surgery, that patient's son said, "Don't worry about her [his mom]. We know why she's here and that's all that matters." Apparently this nurse did not

agree and stated, "I feel she needs to know why she's here." To this informant, it seemed that this nurse was trying to provide safe and ethical care.

And so, even though the nurse's actions were seen as consistent with her knowledge base and guided by professionally informed policies, the nurse was not immune to ethical issues. Nurses wanted to do the right thing. It is unresolved problems such as these that result in the moral distress nurses experience and commonly report in nursing literature.

Summary of Acting as a Nurse

According to participants, to act as a nurse was to display a professional bearing and approach and to perform in a professionally competent manner. This required not only proficient clinical skills, but also excellence in communicating with the client and others involved in the client's care. It was important that nurses exhibit a professional attitude in their dress, grooming and deportment and that they were recognisable, displaying such professional attributes as competence and accountability, attentiveness, responsiveness, and reliability. Nurses were further described as using people skills, demonstrating approachability, respect and sensitivity, flexibility, calmness, and practicality in their approach to client care.

Informants insisted on the importance of the nurse treating each client as an individual. The nurse's responsiveness to the client's physical and emotional needs was related to the personal, holistic care that the client received. The nurse's reassurance was also important because the nurse was perceived to have knowledge and understanding. The nurse was seen to "orchestrate" client care by taking charge, organising, and delegating appropriately. Nurses used their knowledge and creativity to solving problems and bringing

about change for the client, and the larger community. Through engagement in and promotion of safe practice, nurses were seen to protect the client and the public.

The ability of the nurse to communicate by both verbal and non-verbal means was described as a pivotal part of *acting* as a nurse. As informants explained, treating each client as an individual began with personalising the client-nurse conversation by using the client's proper name, and individualising verbal exchanges so that those interactions were not perceived as scripted encounters.

Conceptualisation of the Findings

Reflecting on the substantial data obtained from this study's informants, it is apparent that understanding the professional identity of the nurse from the client's perspective is complex. In keeping with Fagermoen's (1997) work, informants offered positive and negative exemplars to support their view of what it means to be and act as a registered nurse. This is appropriate because concept clarification is achieved not only by reviewing model exemplars, but also by considering those of a borderline or even contrary nature (Shattell, 2004).

From the informants' perspective, *being* and *acting* are not equal facets of the nurse's professional identity. Nor do they seem to be two sides of the same coin--the nurse. Rather, the nurse's *being* is central, providing structure to and influencing the way *being* is operationalised in the nurse's practice as *acting*.

To *be* a nurse is to be intrinsically motivated to care for another person. The nurse's desire and ability to care is the unique descriptor separating those who should or should not become nurses. This innate trait was described by an informant who said, "Ideally we see compassion and love...when there's no care...you can't create that in somebody, they have

to have it in them…it has to be a part of them, intrinsic to the way they do their nursing."

This motivation may be expressed in a uniquely individual manner, the result of the nurse's

upbringing, previous experiences, and natural talents. But those identified as born nurses give

evidence of their motivation, as part of their *being* through their interactions with others, long

before they begin their nursing education.

It is this motivation which sustains the nurse in a complicated and often difficult role

requiring intellectual, emotional, and physical capabilities. Not only does it support the

nurse's work in the client-nurse relationship, but it also contributes to the nurse's dynamic

collaboration with the entire healthcare team. Being a nurse is a relational venture, not a

solitary occupation, imbued with great responsibility because the nurse is the most consistent

presence with the client.

To *act* as a nurse is to be identifiably involved in a client-focused endeavour, which

requires knowledge that is uniquely the nurse's. How the nurse *acts* is seen as a consequence

of the nurse's *being*. The attitudinal traits associated with the nurse's being are witnessed as

professional attributes demonstrated through the nurse's actions.

Within the nurse-client relationship, communication is viewed by clients as an

extraordinarily important element of being and acting as a nurse, since some sort of

communication takes place every time human beings encounter one another. As Watzlawick

(1967) claims, "all behavior is communication; no matter how one may try one cannot *not*

communicate" (cited in Adam, 1991, p. 50). From the client's perspective, the nurse, who is

easily recogniseable and identifiable through her bearing and approach towards the client,

communicates pride in her professional knowledge and her ability to care for client needs.

Although clients value nurses' knowledge and believe that all professional nursing

practitioners will be proficient in the performance of specific nursing competencies, without excellence in verbal and non-verbal communication something vital is missing in the nurse's *acting*.

It is possible that *acting* can influence *being*. If one simply considers the relationship between being and acting from a growth and development perspective, the nurse, responding to all that is experienced in her environment both professionally and personally, may experience some shift throughout her professional lifespan in response to her professional activities. However, it is also possible that those intrinsic motivators, by which the individual is drawn to become a nurse, are the motivators by which she remains a nurse--simply becoming more of what she already *is* throughout her professional career.

In studying and reflecting on the viewpoints expressed by these informants, it was remarkable that they so closely resembled those expressed in the works of Sr. Gabriel (1935), Holliday (1961), and Tagliacozzo (1965). Although the work in which nurses engage has become increasingly technical; the client remains the nurse's point of care. While context and societal changes may have altered the client's needs or the way that we, as human beings, approach one another, the things that seem to matter to individual clients in the client-nurse relationship remain those of a most personal and interactive nature. And this is why it is vital that the nurse not simply performs those tasks and responsibilities incumbent with the role, but that the nurse's action is seen to occur as a reflection of and in response to her *being*.

Summary

This chapter contains the findings of my research project. Using informant interviews, the client's perspective of the nurse's professional identity is explored and the client's perspective of what it means to be and act as a registered nurse is suggested. These

findings are also discussed in light of related research and are the foundation of the

conceptual summary.

CHAPTER 5: SUMMARY, CONCLUSION, LIMITATIONS, AND IMPLICATIONS OF THE STUDY

This chapter contains a summary of this research project. A description of the investigative process, an outline of findings, and conclusions of the study are presented. In addition, implications of the study findings are discussed and limitations of this research project are acknowledged.

Summary of the Study

This study explored the professional identity of the nurse from the client's perspective. Although there was considerable nursing literature devoted to the investigation of the nurse's professional identity from the nurse's perspective, the perspective of the client was rarely considered. But the client's perspective is important and must be acknowledged. If nurses are going to recognise the importance of the client's perspective, they must know and take into account the knowledge, beliefs and values of that client or family. With the increasing use of industry and business terminology within healthcare, the perspective of the consumer should be considered; the client's voice should be heard.

A broad literature review laid a foundation for this study. Various perspectives of professional identity were presented because "professional identity" was found to be a rather amorphous concept, difficult to both understand and define. Having evolved through the centuries, interpretation of this idea remained varied. While one's professional identity was achieved through socialisation in and identification with one's profession (Addis, 1996; Kandel, 1993; Merton, 1982); it was also an evolutionary construct, influenced by those with whom the professional was in contact (Connelly & Clandinin, 1999). And since individuals who were outside the profession were found to assign specific attributes to practitioners

within the profession, acknowledging and identifying those traits was meaningful, particularly when considering the client's perspective of the nurse.

Within nursing literature, the professional identity of the nurse was described by Fagermoen (1997) as the nurse's personal philosophy of nursing--"what it means to be and act as a nurse" (p. 435). She further explains that the nurse's personal philosophy is comprised of that nurse's values and beliefs and that it is these that guide the nurse's thinking about, response to, and interaction with the client. Clearly, the nurse and client have an interactive relationship. And so, it is the client, complete with their own values and beliefs, who gives meaning and definition to the nurse's professional identity.

But rarely was the client's view of the nurse's professional identity presented in nursing literature. Rather the focus seemed to be on seeking the client's perspective on various aspects of nursing practice and on assessing quality of care and client satisfaction. While these facets of professional practice may be related to the professional identity of the nurse, that this was the client's perspective was not clear. In fact, Chapple et al. (2000) report that the client's view of the nurse is thought to be influenced by various factors including the client's prior encounters with a nurse, interactions with other people, and notions about healthcare and nursing that have been obtained from other sources. Even so, the construct of the client's view about the nurse's professional identity was not apparent. Therefore, using Fagermoen's (1997) description of the professional identity of the nurse, this study explored the client's perspective of what it means to be and act as a nurse.

To guide this query, a qualitative study employing interpretive description methodology, as delineated by Thorne (1991) and Sandelowski (2000) was used. Following the philosophic tenets of naturalistic inquiry and focusing on individual informants, in-depth

narratives were gathered. Because informants shared their perspective using their customary language and grounded in their own experience, the informants' perspective was not only clear, but also richly detailed.

Using purposeful theoretical sampling, 10 informants (six women and four men) representing all of the decades from 20 to 80 years of age, participated in unstructured, open-ended interviews, which were audiotaped. In keeping with the inductive nature of qualitative research, data collection and analysis proceeded concurrently as the verbatim transcriptions of the interview became available. Data analysis was guided by Omery's (1983) adaptation of Giorgi's strategies. The basic components or units identified within each interview were constantly compared to those identified in subsequent interviews. Thus, common categories, which described the client's understanding of what it means to be and act as a registered nurse, emerged from the data.

It is apparent that informants in this study were in agreement with Ohlen and Segesten's (1998) view that being a nurse involves much more than simply working as a nurse. From the client's perspective, being a nurse is more than fulfilling the duties listed in a job description. Each nurse is seen as unique, influenced by her individual attitudes and personality, even though some of these attributes are held in common with other nurses. That the nurse shares the client's human experience, and is also a member of a collegial group with a unique history, contributes to the client's perspective of the nurse. To be a nurse requires unusual motivation. Even though informants remark on the change process and its effect within the nurse's education and workplace, they see the prime motivator for being a nurse, that nurse's altruistic attitude, remaining unchanged. Whether intrinsic or extrinsic, informants perceive that what motivates the nurse is obvious in the nurse's attitude towards

others and the work. Some of these nurses are described as "going the extra mile" in the workplace, perhaps lending further support to the client's impression that the nurse never stops being a nurse, even though retired from the active workforce.

To be a nurse, from the client's perspective, is a difficult career choice not only because it involves so much more than a job description, but also because of the complex nature of the work itself. Informants think that being a nurse is emotionally demanding since it may involve unpredictable drama, tension, and worry as the nurse interacts with clients. And so, not only do informants see that the nurse's basic work is stressful, but also that the nurse's working conditions promote stress through strained resources within healthcare, changes to staff levels and mix, and increasing client acuity. Various occupational hazards to which nurses are exposed are recognised, although informants are not aware of all the risks that may be present in the nurse's workplace.

From the client's perspective, to be a nurse is to have a multi-faceted role within the healthcare hierarchy. The nurse is variously described as a dependent, interdependent, or independent member of the healthcare team where, depending on the situation, that nurse may be a colleague, a leader, or a caregiver. Just as the nurse has multiple roles, the nurse also has multiple clients. And so, informants recognise that their relationship with the nurse may change depending on whether they are the client or the spouse, the caregiver, or the advocate for another client. To better describe their view of the role of the nurse within the healthcare team, informants used a variety of metaphors such as "watchdog," "conscience of care," "humaniser of health care," "link," "bridge," and "orchestrator." Even though the nurse's role is expressed in assorted ways, it is valued because informants recognise that the nurse is the practitioner who is the consistent presence with the client. Therefore, the nurse

integrates services for the client, and maintains rapport with other professional and non-professional caregivers, thus facilitating a functional, cohesive team whose focus is the client. And so, informants see the nurse working in concert with ancillary and paraprofessional staff, even though they express some confusion about the nurse's roles, and blurring of both intra-professional and inter-professional boundaries. Informants speak of nurses being indistinct, sometimes indistinguishable from other nurses or from other caregivers.

Within nursing literature, individual beliefs and values, which are a fundamental part of the nurse's being, are thought to influence that nurse's behaviour and response to the client (Fagerberg & Kihlgren, 2001; Fagermoen, 1997; Tashiro, 2002). Since the act of nursing invariably occurs within the context of a nurse-client relationship, informants identify attributes which they think are intrinsic to the nurse's being.

To act as a nurse, from the client's perspective, is to display a professional bearing and approach. Informants contend that the nurse's professional presentation demands a recognisable, appropriate appearance in keeping with a professional and community standard. In care situations, it is the nurse that clients trust and want to approach. Therefore, they want the nurse to be visually identifiable so that they are not confused and mistakenly approach other ancillary or paraprofessional staff. Whether or not the nurse is wearing a distinctive uniform, informants suggest that nurses will be identifiable and inspire confidence by their demeanour because they will be neat, well groomed, and wearing nametags. This look is also thought to demonstrate a more conscientious approach to the nurse's work with the client and to be a sign of personal and professional pride on the part of the nurse.

Informants identify professional attributes displayed by the nurse, which are seen as important components of that nurse's professional bearing and approach. They link these attributes to the nurse's attitude, part of the nurse's being. From the client's perspective, to act as a nurse requires that the nurse be accountable, approachable, attentive, empathetic, respectful, responsible, and reliable. Such a nurse is seen as client-focused, engaged in competent, confident practice yet maintaining a calm and flexible demeanour. In addition, the nurse is personable, practical, and physically able to do the job required.

From the client's perspective, performing or "orchestrating" in a professional manner is fundamental to acting as a nurse. Since communication takes place every time individuals encounter one another, the nurse communicates not only through what is said, but also through what is done. It is presumed that the nurse is knowledgeable and will have proficient clinical skills, so that the physician's instructions can be followed and any task for the client that is the nurse's responsibility can be capably completed. In this way, the nurse is seen to act on information, make decisions and respond to client needs, demonstrating organisation, efficiency, and resourcefulness. These actions are thought to demonstrate the nurse's concern for the client and so are reassuring to the client since they help to create a safe environment and offer a sense of security to the client and to the larger public. Such a nurse provides care in keeping with the ethics of the profession. Such a nurse does not treat the client as a "disruption" or an "enemy" because the nurse and the client are not protagonists; their goals with respect to the client's health issues are shared. And so, because clinical skills are so secure that they appear to come naturally, the nurse can concentrate on the "human side" of the work, providing truly client-centred care. And that human side involves communication.

In addition to having proficient clinical skills, the ability of the nurse to display excellent communication skills is a critical aspect of professional performance. In fact, for informants in this study, the nurse's ability to communicate takes precedence, perhaps because competent practice is taken for granted. In the absence of visible identification, nurses are thought to be identifiable by their ability to interact with clients and to respond to their questions. Communicating non-verbally, the nurse's body language and responsiveness announce approachability, attentiveness, respect, concern, and support. Verbal communication begins when the nurse is introduced to the client and commences conversation with that client, demonstrating respect by not using endearments but addressing the client by their proper name. As the nurse continues speaking with the client, needs are explored, advice is offered, and information is provided, particularly about what is normal. Actively listening to and observing the client are also essential components of communication, since they aid in building a valued relationship with the client whereby the nurse can advocate with and for the client, as well as provide comfort. This requires that the nurse communicate not only with the client but also with other members of the healthcare hierarchy. Because each client is a unique individual, it is stressed that the nurse use language understandable to the client, not "scripted" discourse, and that feedback from the client be elicited so that their emotional and physical needs can be met.

Form the client's perspective, being and acting are not equal or independent facets of the nurse's professional identity. Rather, the nurse's being is central, providing structure to and influencing the way that being is operationalised in the nurse's practice as acting.

Conclusions of the Study

This research study contributes to nursing knowledge about the client's perspective of the professional identity of the nurse. Informants spoke about what they were looking for in the nurse, and described what they experienced, what they saw, and what they heard in personal encounters with nurses. The specific conclusions based on the findings of this study include the following:

1. From the client's perspective, to be a nurse involved more than fulfilling the demands of a job description. As such, being a nurse was seen as a difficult career choice requiring accommodation to many potential sources of stress and the ability to handle a multi-faceted role within the healthcare team.

2. From the client's perspective, to act as a nurse required that the nurse display a professional bearing and approach whereby the nurse was easily identifiable and displayed particular professional attributes. While acting as a nurse also involved the nurse performing the requisite clinical skills with proficiency, excellent communication skills of all types were identified as an even more important aspect of professional performance.

Limitations of the Study

As with other qualitative studies, the findings of this study are tentative. They are not generalisable or considered representative of other individuals, even though they may be. It is an exploratory work limited by the method of inquiry. Because of the small sample size it is impossible to account for the wide variety of factors which might impact on the findings. For example, the sample is English speaking and predominantly middle class, residing in an

urban setting. Nor does the sample take into consideration the possible implications of cultural diversity on the phenomenon of interest.

Implications of the Study

The findings of this study suggest many implications that warrant thoughtful consideration. These are discussed as they relate to nursing research, nursing education, and nursing practice.

Implications for Nursing Research

Other researchers comment on the need to investigate discrepancies in perception of the nurse's professional identity and its effect on nurse-client interaction (Lehna et al., 1999; Tashiro, 2002). As an exploratory study, this investigator is well aware that there are further areas that warrant exploration. For example, the client's cultural background may influence his perspective of what it means to be and act as a nurse just as the nurse's cultural background may also have some bearing on the client's perspective of the nurse's professional identity. These are issues that should be addressed as Canada's ethnic diversity continues to increase. In addition, a larger sample is needed to study variations in perception that may be age specific, or perceptions that might change over time.

While some informants commented on their perception of the nurse as an agent of change in regards to the client's care, nurses were also viewed as defenders of their own status quo. Does the nurse's attitude depend on whose behalf the nurse is working, or whose interests are being protected?

Increasing awareness of what the client needs, expects, and wants cannot help but have an impact on any nurse's practice. An informant in this study suggested that the media portrayal of specific nurses, such as union activists, might influence the client's perception of

the nurse. This seems to imply that image might influence the way the client perceives the nurse's professional identity. With respect, and acknowledging the historic work of Kalish and Kalish (1983) on nursing image, perhaps it is time to explore this question from a Canadian perspective. Image and identity are not the same, and there may be a cultural component to how these ideas interface as well.

The nurse whose practice reflects the underlying tenets of Henderson's theoretical framework does not display callous or cavalier attitudes towards the client's needs, whether those needs are expressed or left unexpressed. But based on the comments of informants, it was plain that they perceived that there just were not enough RNs to meet their expectations. And so, the importance of taking the time that the client needs to address his issues and concerns, is another issue that proceeds from this study. If the RN is not there, who will meet the client's needs or will they be ignored?

Implications for Nursing Education

Demographically, nursing as a profession is in a precarious position. Not only is the nurse workforce ageing, but there is also an increasing demand for nurses. Recruitment into the profession is urgently needed. But even though the need is huge, it will be important not to be so blinded by the need that there is a failure to recruit and screen for applicants who will find the profession rewarding and remain in it once they complete their education.

Providing care for clients in the acute care environment has become increasingly complex and technical. Consequently, individuals being recruited into the profession will need to be academically gifted so that they can understand the disease entities as well as the treatment modalities brought to bear on them. But informants in this study have highlighted other attributes that are also required. Sometimes for students the technological aspect of the

work is stressed, and it is some time before they come to understand what a small part of their identity as a nurse this entails. This is not meant to demean or fail to recognise the important necessity that each nurse demonstrates technical skill. The nursing student wants to be successful in this area because it raises that student's confidence and self esteem. And, after all, clients expect competent practice from their nurses. But technology is a tool, and not the main focus of the nurse. Caring for the client is the main focus of the nurse. And if nursing is really about the client, than it is essential that the profession be responsive in providing practitioners who have the qualities and traits that will satisfy the stakeholders, who are clients similar to informants in this study. Fosbinder (1994) also found that clients valued the nurse's interpersonal skilfulness and stressed that nursing educators should place as much value on it as they place on the student's technical proficiency.

Informants spoke of some nurses being "born" nurses or "natural" nurses. These nurses were thought to have particular attitudes and attributes, which they brought to the professional practice of nursing. But born nurses were not all identical because their inherent traits were expressed in uniquely individual ways. Informants suggested that born nurses or natural nurses were displaying attributes that were the result of the nurse's upbringing, previous experiences, and how they interacted with other people. Some of these can be taught or built on during the nurse's education, but many are thought to be unalterable, already present in the student and an inherent part of that individual's being that they bring to the practice of nursing. And so, informants recommended that these natural or born nurses be targeted and their natural attributes developed and strengthened. Fagerberg and Kihlgren (2001) assert that the student's prior knowledge, skills, and interests are enriched in the educational process but that the attitudes brought by the student to the learning experience

are not easily altered or changed. If personality is so important to the RN, independent of setting, how might nursing school applicants be screened? If it is important to have basic elements present in the character of those individuals who are to become nurses, then it is essential that educators be selective on the basis of those qualities that are important but which are unlikely to be taught. While this may appear to deny students individual choice and right of access to education, it may be prudent to wisely dispense the limited seats available in schools of nursing to candidates who are known to be suited to the profession and likely to remain in it.

Perhaps an innovative way to look at the recruitment of new nurses into the profession is needed. In an article that proposes some ways of beginning to solve the nursing shortage, Toto (2004) reports that the Gallup organisation has studied talented nurse professionals for more than 30 years and has developed a selection tool based on that research. The idea is that hospitals can be helped to identify the nurses with desirable talents or traits. These facilities then teach the nurses what they need to know to work successfully in a specific area, such as the OR. Recognising that nursing involves innate talents, just as informants in this study articulated, this web-based tool, the Gallup Nurse Index, is designed to help facilities select the best candidates from new two and four-year nursing schools graduates by evaluating their "attention to detail, empathy, self-confidence, and whether those candidates are the right fit for the job" (¶ 14). If it can be used to identify suitable nursing graduates, perhaps there is a need for a tool such as this to screen those who will be the most suitable candidates in the beginning. After all, how much time and effort is spent teaching empathy, accuracy, or communication skills to students? And yet, these were attributes that informants in this study valued.

Nurse educators can promote the recruitment of students already exhibiting the traits which informants identify as valued, and can continue to stress the importance of professional practice that meets the client's expectations in every possible way. From the very beginning, those entering the profession should be taught the importance of the client's perspective in the articulation of the nurse's professional identity. Being attentive to the client's view also serves as a reminder that the nurse is involved in a service industry whose focus is the client. In a sense, the consciousness of the nurse is raised by making her aware of and responsive to the client's perceptions of her role as a registered nurse. As was pointed out, being a nurse involves much more than simply working as a nurse. And so, students who are helped to understand this essence of nursing practice may engage in that practice in a more client-focused way because their personal and professional identities are more integrated.

Given the complex and difficult aspects of the nurse's role, which the client recognises, how can nursing be presented as attractive and appealing to those with a bent for service to their fellow humans and possessing the attributes that informants identified? Based on the literature and the data, it is important that nursing be seen as an attractive profession. At the end of the day, this may have more to do with the professional identity manifested by nursing's current practitioners, than the labour benefits for which, with respect, nursing unions persistently lobby. After all, as Curran (2004) reports, an attorney who was an ER patient noted the unkempt, unidentified, and indifferent individuals who were that department's RNs. That lawyer suggested that prospective nurses might be dissuaded from entering the profession because they would not want to join or be identified with such a slovenly group? Taking a positive approach, Johnson and Johnson's 2005 American

television advertising campaign, which promotes nursing as a profession, spotlights diverse individual's proclaiming "I am a nurse." What is universal, is that each person in that ad looks neat, happy, and healthy.

What are nursing faculties teaching about professionalism? Without a doubt responsibility and accountability are highlighted, and rightly so. Some informants also thought that instruction on deportment, grooming, dress, and attitude were part of the nurse's basic education. With the increasing admission of mature students into nursing is this reasonable, or would the rigorous screening previously mentioned ensure that students enter with these qualities already established? Of course, if there is a standard within the educational facility, then it is important that it be in keeping with the community standard so that it is reinforced in the workplace. Newton and Chaney (1996) confirm that nursing faculty can positively influence students in adopting appropriate professional attire, but that the nurse also needs to "think and behave as a professional" (p. 244). This sounds remarkably close to being and acting which are explored from the client's perspective in this study.

Ensuring that nursing students are familiar with nursing's proud history may be important in developing their professional identity. Several informants commented on the value of traditional nursing uniforms, caps, and pins in helping them identify the RN and her educational background. Another participant spoke at length about the local community marking and celebrating traditions that were such a part of the formation of the nurse – from entry, through capping, and on to graduation. These rituals were rites of passage that helped to solidify the student's professional identity and invested that identity with a serious and committed tone. The fact that they were recognised by the community showed those students that they had a place in a special profession. While this may be dismissed as what life is like

in a smaller centre, it does raise the question of how tradition might be incorporated into the life of the nursing student as a means to both establish and develop professional identity and professional pride.

Without a doubt, being a RN involves drama, tension, and worry just as informants described. Given that students may have limited opportunities to get comfortable with some of the stressful events they might expect to encounter as RNs, how can their transition as new graduates be eased so that these stresses and burdens are not overwhelming? This is one of several implications for nursing practice, which should be given consideration.

Implications for Nursing Practice

If recruitment is an issue related to nursing education, retention is an issue related to nursing practice. While recruiting suitable personnel will go part of the way in overcoming chronic personnel shortages, job satisfaction once those nurses have been hired will go a long way to retaining them. Informants commented on the differences they noticed among nurses working in different areas of patient care. Of course, the work was different depending on the unit or speciality, but to informants, nurses in different settings had unique traits and approached clients differently. With chronic personnel shortages, organisations often seem intent on simply hiring to fill vacancies. Use of a tool such as that produced by the Gallup organisation (Toto, 2004) might help position nurses on units where their attitudes and talents can be appropriately engaged. Suitable placement is important because, from the client's perspective, the nurse's professional identity is linked to the nurse's interest in the client and passion for the work.

In this study some informants stated that by abandoning the uniform and other professional symbols, nurses have given up their identity--who they are. Perhaps RNs should

take a serious look at the meaning of symbols and how to recapture them in a meaningful way both for themselves and for their clients. As a nurse it is important that positive associations are attached to the nurse and the profession. When the nurse comes in contact with the client or others in the community, that nurse should present as someone with whom potential recruits would wish to be identified. This is an important and timely point to ponder. As a nurse, who wants to be like me?

Informants in this study echoed several of Clark's (2002) suggestions about ways that nurses can continue to develop their professional identity as a collegial community. Because the nurse enters a complex profession with basic education, continuing education is essential if the nurse is to remain credible with clients and demonstrate professional commitment. Participating within the community not only extends the nurse's sphere of influence, but it also raises the nurse's professional identity and builds professional pride. While this may all be carried out as part of the nurse's effort towards continuing competency, the client needs to hear about it because it provides assurance that the nurse is both accountable for and enthusiastic about her nursing practice. Informants spoke with praise of nurses whose love of people and their work was obvious. Enthusiasm is contagious. Sharing this enthusiasm with clients tells them that nurses are passionate about their work and value it. If nurses do not value their own work, how can institutions and the general public be expected to value it? Imagine the change to the nurse-client dynamic if the client senses that the nurse loves the job and loves being a nurse.

And so, informants recognised and spoke about the need for role models and mentors within the profession as a way to promote the nurse's job satisfaction. Such individuals should be positive exemplars of what it means to be and act as a nurse. Perhaps this is one

way to care for and support the nurses whom an informant described as "needy" presumably because of the nurse's multiple job demands. Often the focus for newly hired nurses during preceptorships is on technical expertise, but it is the interpersonal skills that once again should be emphasised and modelled in the workplace. This form of leadership sustains and guides novice and experienced practitioners, and, it reassures clients by demonstrating what Clark (2002) calls the "soul" of the profession at the bedside.

Still, informants recognised that the nurse's work was complex and difficult. In reflecting on the comments of informants around work-related stress, this investigator wonders whether the importance of debriefing as a stress management tool--even daily stress--is given the serious consideration that it deserves. Today, nursing staff is so stretched that the opportunity to engage in team conferences seems a thing of the past. But as a patient safety initiative, nursing rounds are recommended in which the charge nurse and educator go to the bedside of every ward patient and review care options with that patient's nurse (RNABC Leaders Conference, 2004). Perhaps this is another way of debriefing. At the very least it makes the nurse-in-charge visible to the client, something that informants in this study desired. It also provides an important opportunity for peer consultation, which is another way to circumvent workplace stress.

The importance of excellent communication skills cannot be emphasised too much. Based on the findings of this study, nurses should identify themselves to clients through verbal and visual means, demonstrating their accountability and responsibility as professionals (RNABC, 2003). Lange and Polifroni (2000) state that this is "social responsibility and a moral mandate" (p. 513). The implication is clear. Nurses must identify themselves because clients have a right to know who and what their caregivers are. Santo-

Novak (1997) calls the absence of such visible identification "product ambiguity." Several

innovations have been suggested in recent American nursing literature. Some facilities there

are mandating all-white uniforms for RN staff; others are designating certain colours for

particular staff (Center For Nursing Advocacy, 2004). And the American Nurses Association

is promoting a special RN patch, which can be affixed to the nurse's uniform or lab coat

(Linn, 2004; Mason & Buhler-Wilerson, 2004). In the American market-driven system, it

seems that some of these actions are in response to clientele who have complained that the

nurse is not visible. Since there is no consensus within the nursing community about how the

profession should best present itself visually, it falls to institutions to mandate how they

would like their nurses to represent their facility. Pride needs to come from somewhere.

Ultimately, clients benefit because they know who the nurses are, something that not all

informants in this study expressed with confidence.

According to informants, what one sees does influence what one hears. There are two

mantras that might describe what the client is looking for in the presentation of the nurse.

First of all, informants had greater confidence in nurses who "walk the talk." These nurses

communicate by look and demeanour that just as self care is practised, so too will client care

be discharged. Informants also understood that an individual "dresses for success." Societal

assumptions are often made about an individual based on how that person looks. Whether it

is right or wrong to make such judgements, informants spoke of questioning the competence

of nurses who did not present well.

Informants also expressed their desire to feel that they are individuals on whom the

nurse's knowledge, skills, and abilities are focussed. Even though client-centred nurses may

perform technical tasks, they are not mechanical in the proficient performance of those

functions. The care these nurses provide is not perfunctory because they realise that the client is much more than the task at hand. An informant in this study recounted his nurse's explanation about patient-centred care, calling this terminology "jargon." This might have been a valid assessment had his nurse not offered an explanation of the terminology, which the client understood and proceeded to use in further discussions with his specialist. Based on his nurse's explanation, this client understood that he was the focus of all the members of the healthcare team, or should have been. But other informants were less confidant of their status in this regard.

Nursing literature and the findings of this study give credence to the idea that clients and nurses perceive the professional identity of the nurse differently. It is important that the nurse listens and responds to what the client has to say about the nurse and the practice of nursing, engaging clients in a continuing dialogue about their expectations of nurses. For example, several informants in this study expressed appreciation at being included in the care of their loved ones even though they were surprised when the RN's care extended beyond the individual to the client's family members. This occurred in such diverse settings as paediatrics, acute care, home care, and palliative care. Similarly, another informant directly associated contact with the nurse with illness.

Obviously there is a need to inform clients about the breadth of the nurse's role in healthcare, which extends beyond the interventions performed in the acute care setting and includes assisting with wellness, prevention, and health maintenance. While there is support in the literature for the idea that the client knows what he wants the nurse to know, do, and be (Radwin, 2000), the possibility persists that the nurse will be under-utilised because the client lacks real understanding about the nurse's professional identity and scope of practice.

Watson et al. (2003) claims that "a narrow and unbalanced view of nursing may prevent the patient getting the best out of the nurse" (p. 142). They go on to suggest that the client's perception of nursing be included in the nurse's patient assessment so that the client can be encouraged to recognise the nurse as a visible and available source of knowledge, enhancing nurse-client interactions.

Just as it is important that the nurse understand the client's perspective, it is important that the client learn the nurse's perspective of what it means to be and act as a nurse. But where should the nurse begin? Informants suggested that client advocacy, caring, and teaching comprised the core of the nurse's professional values and behaviours. Therefore, perhaps the nurse should begin by reflecting on his or her own practice and confidently communicating to the client the values that are held at the core of the nurse's professional identity.

Educating the client about the professional identity of the nurse could begin by communicating Henderson's (1966) conception of the nurse as one who "assist[s] the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the…strength, will, or knowledge" (cited in Houweling, 2004, p. 48). Such a nurse-client conversation would be individualised, not scripted, a meaningful interchange because it involves reciprocity with the nurse knowing and understanding the client, and the client knowing and understanding the nurse.

The professional identity of the nurse influences how the nurse functions as a client advocate, a function described by informants as integral to nursing practice. Shorr (2000) suggests that while nurses take and act on physician orders while observing and recording

client response, advocacy, as expressed through the application of the nursing process, is not routinely exercised. While this may have something to do with the leadership void in some practice settings, it may also reflect the lack of power that is presumed as part of the nurse's professional identity. But if the nurse is powerless, how can the nurse be a successful advocate? Informants looked to the nurse as an advocate and in British Columbia such advocacy is a clearly stated responsibility of the nurse practising in accordance with the profession's standards (RNABC, 2003). Perhaps advocacy is a way of exercising the nurse's "power."

In addition to advocacy, the nurse may express power through influencing or empowering the client. There is a subtle difference between influence and empowerment. Perhaps influence is more of a suggestion while power takes charge in a situation. An informant told of being encouraged by the nurse at the youth clinic to make her decision about her pregnancy based on "what was right for me." This nurse did more than suggest that the client "make up [her] own mind." This nurse empowered client decision-making by providing information and resources that supported the decision-making process.

Perhaps the palliative care accounts shared by informants in this study are most moving because, in these circumstances, it seems that families were also empowered. The nurse's focus on the client and the family and effort to maintain their dignity were unfailingly evident. Rogers et al. (2000) challenge nurses in all areas of healthcare to adopt principles of palliative care because of the positive impact on client satisfaction. With the care and attention given to the client, it is easy to imagine that there might be a positive impact on the nurse's satisfaction as well. And that will affect the retention of nurses in the workplace.

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Summary of the Study Findings:
When the project is completed a Summary of the Study Findings will be available. Please check on the line below if you would like a Study Summary sent to you.

Yes I would like a copy of the Summary of the Study   _____

Appendix C – Guiding Questions for Informant Interviews

1. From your (my) perspective, what does it mean to be and act as a registered nurse?

2. Thinking about specific nurses in the different settings where you have encountered them, how did that particular nurse model what you think it means to be a RN?

   Why was/is this important to you?

3. Were there nurses who failed to model what you were expecting? How?

   Why was/is this important to you?

4. How does what you value/believe about the nurse influence your view of the nurse?

   Do you think this might be how others think as well?