



**Submitted in part fulfilment of the
degree of Master of Science in Nursing,
Royal College of
Nursing Institute, London.**

**Akureyri, Iceland
April 1999**

**What is the Theoretical and Practical Framework which
Shapes the Nurse – Patient Relationship?**

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ABSTRACT

Aim: The aim of this descriptive ethnographic study is to explore culture in one hospital unit in an urban area in Iceland, focussing on the constraints and circumstances experienced by nurses and especially regarding patient-oriented nursing.

The Research question: What is the theoretical and practical framework which shapes the nurse-patient relationship in a medical unit in urban area in Iceland?

Method: The approach I used toward answering this research question is ethnographic, but I did participant observation and wrote extensive field notes at the medical unit; furthermore, I intensively interviewed one female nurse, my key informant, applying a mixture of semi-structured and in-depth interviewing as a data collection method.

Data analyses: My data was analysed according to the Ethnonursing Data Analysis Model developed by Leininger (1991).

Findings: The findings and themes emerging from my research strongly suggest that there are severe and considerable constraints within hospital culture against the nurses' ability to be 'patient-oriented'. According to my study the central, critical issues are time and communication. At the unit where I did my research and between ca. 9:00 and 10:30 nurses had to be, as they expressed it 'at two places at the same time'. I argue and my findings show that this overlap of time hinders the teamwork which is fundamental part of patient-oriented nursing. In order to create and preserve some type of coherence in the hospital culture nurses are socialised into being an oppressed group, individually communicating with other professionals, especially those ranked above them, as subordinates. Hospital culture should be described as dissonant since there seems to be a striking mismatch between espoused values and organisational goals, also because of the competitive spirit between nurses and nursing auxiliaries and the double standard for behaviour, but no formal systems exists for addressing conflict, just an

informal one. I argue in accordance with the findings of my research that the theoretical framework that shapes nurse-patient interaction is fundamentally task-oriented and also oppressive in nature.

ACKNOWLEDGEMENTS

I will thank the nursing director and the staff manager at the hospital, the head nurse at the unit and all the nurses at the unit who participated in this study for their contribution. I will specially thank my key informant for giving me the most important informations and so much of her time. I would also like to thank Mrs Thorarinsdottir, Mrs Karlsdottir, Mrs Skuladottir, and Mrs Bergs for their support and inspiring conversations and my dear friends Mrs Olsen and Miss Þorhallsdottir for their help, support and understanding. Dr Einarson and Dr. Ingimundarson for their support and guidance while doing this study. I will thank my housband for all his help regarding the computerwork and him and my daughters for their support and patience during the last two years.

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CHAPTER I

1.1. Introduction

The purpose of this qualitative study is to gain understanding of nurse's situations in one hospital unit. I am personally interested in the new philosophy in nursing called 'new nursing' that emerged in the early 1970s. This philosophy sought 'to redefine the nurse's role in order to assert its unique contribution to healing, leading to claims for greater status, while the women's movement began to challenge assumptions about nursing's subordination to medicine' (Salvage, 1992, p.11). This new philosophy requires different relationship to patients, moving away from the medical model, which views medical interventions as the solution to health problems, towards a holistic approach (Salvage, 1992). I argue that this new philosophy, and the change in the nursing frame of reference as a caring profession (Leininger, 1986) and accordingly to see the patient's situation from their own point of view (May, 1995; Tanner, et.al., 1997), has created difficulties for nurses regarding their role and status in hospitals. I am interested in whether the emphasis in the new nursing philosophy can survive in a medically dominated hospital culture that shapes the nursing practice in many hospitals. How are nurses coping with their situation there? What influence has the environment on the nursing practice and nurses professional identity?

This is a descriptive qualitative study using an ethnographic research approach and a participant observation, field notes and informal interview and applying a mixture of semi-structured and in-depth interviewing as a data collection method. The aim is to explore culture in one hospital unit in an urban area in Iceland, focussing on the constraints and circumstances experienced by nurses and especially regarding patient-oriented nursing. The research questions I am attempt to answer with my thesis are:

**What is the theoretical framework that shapes nurse-patient interaction?
Is it practically possible for nurses to give nursing care according to the
new shift in nursing, from task-oriented to patient-oriented, in hospital
units?**

1.1.1. Background of the Problem

I have a special interest in culture because I believe it has a big influence on our work and life in general (Goffman (1961). The medical model shapes the culture in many hospital and units (Ashley, 1976; Johns, 1989; Mackay, 1993; Gottlieb and Gottlieb, 1998). I believe it is difficult to change the focus in practice, to be more holistic and patient-oriented, in a culture so old and strict as the hospital culture is. That is why I find it so important to study nurses experience and to focus on how they manage in the 'field' and how the educational program can better prepare them for their real work situation. I am interested in whether the culture in the hospital unit supports this new shift in nursing or if not how the culture hinders it. Are nurses able to nurse patients in the spirit of the new shift in nursing, which is emphasised in the nursing theories today?

Patient-oriented nursing is very much built on the relationship between the nurse and the patient, (Melia, 1982; Peplau, 1988). Does the culture in one hospital unit support this relationship creation or not? The last research question reflects that focus and the findings from my study will hopefully answer that question according to one hospital unit.

This field is much researched since there have been carried out many research on professionalism and socialisation (Leathart, 1994a; Leathart, 194b; Spickerman, 1988; Breda, 1997), subordination, oppression (Roberts, 1983; 1989; Leininger, 1991; Mackay, 1993), and autonomy in the nursing profession (Hancock, 1997; Hart, et.al., 1998) and the culture in hospitals units (Fleeger, 1993; Robinson, 1995; Jones, et.al., 1997). All these issues represent nurse's position in different hospital cultures. In all these research the purpose is to describe and understand the nurse's position and situations in today's health care systems and the influence the culture has on nurses and their practice. According to these research nurse's situations in hospital units are very complex. They are captured in the 'physician-nurse game' and have to struggle to be assertive and acting as an advocate for the patient. They are also captured in ethical dilemma regarding moral decisions in patient care and in relationship with the patient (Tuckett, 1998).

This field is not much researched in Icelandic hospitals. The culture in the hospital unit in this particular hospital, where this study was carried out, has never been

explored. Therefore I find it very interesting to compare the findings from this study to the existing literature. Also because most of the nursing students at the University, where I am a lecturer, carry out most of their clinical practice in this particular hospital. In my opinion it is therefore very important to explore this field because academics and nursing educators have to be realistic of what goes on in the 'field' and construct their education according to that. This is important if there are to be any changes and development in the nursing profession and practice there.

According to many scholars socialisation in the clinical setting is stronger than the socialisation in the educational program (Campbell et. al., 1994; Binnie, and Titchen, 1995; Kosowski, 1995). Therefore the nursing practice in the clinical setting, where the nursing students gain most of their practice, must be in accordance with the emphasis in the nursing educational program (Throwe, et.al., 1987).

I am very concerned about the patient role in today's health care system in Iceland. I observe that the patients needs are not important in evaluating the quality of the service in hospitals but rather the outcome of effective financial arrangement. I therefore believe that the culture that shapes hospitals in Iceland, which mostly emphasizes productivity and financial arrangement, and thus strengthens even more the patriarchal dominance of the medical model that has shaped hospitals for many decades. This merely emphasizes how many patients are 'running' through units but not how the patients are actually coping with their illnesses and/or health problems. The focus is as well on budget savings, that often means cuts in the largest budget items, that is the nursing workforce. My opinion is that hospitals have failed to respond in a caring manner to the suffering of patients and their families. Therefore I argue that the holistic focus nurses have in their nursing practice, or should have, has never been as important as it is today because of this emphasis in hospitals as cost-containment institutions.

In the future I see nurses in Iceland merely as an advocate for the patient. I see them emphasizing patients needs and legal rights, and help him/her to cope with illnesses and health problems. I see them protect them from being a victim of today's economical arrangement in hospitals. As well they will act as a co-ordinator of care for the patient while he/she stays in the hospital because of the holistic approach nurses have on patient's needs. I believe that positive outcome of good nursing care

is in fact cost saving for hospitals and therefore for the community. I suggest that nursing researchers should explore that field in more depth in the future.

According to the research questions I put forward in my research proposal I was at first going to study what the kind of relationship nurses construct with patients. When I started my observation in April 1998 my focus on the subject changed. I started to think more about oppression and oppressed behaviour and the socialisation of nurses in the hospital culture. According to Breda (1997), there is a strong link between professional socialization and patient-oriented nursing and therefore the relationship between the nurse and the patient. Regarding this I am studying the same phenomena but from another perspective.

CHAPTER II

2.1. Literature review

The aim of this descriptive ethnographic study is to explore culture in one hospital unit in an urban area in Iceland, focussing on the constraints and circumstances experienced by nurses and especially regarding patient-oriented nursing. When I started my observation in the setting and analysed my field notes I became interested in nurses in the hospital unit and their relationship with other members of staff. My discussion in the literature review is therefore on subjects like culture, oppression, and socialisation in the nursing profession.

2.1.1. Culture

According to Spradley (1979, pp.5) culture has been defined in hundreds of different ways. Uchida (1997, pp.46) discusses the development of the third culture, built through interaction or communication. He implies that culture must be seen as dynamic and emergent but not static and pre-existing as the traditional definitions where culture is equated with nationality or ethnicity. Schein (1992) defines culture as 'a pattern of shared basic assumptions that the group learned as it solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems' (p.12).

According to Becker (1975) 'the culture protects social action in two ways. By providing a strict code of social ritual, it makes available an adaptational device designed to prevent the contamination of social intercourse with private data. The more or less 'proper' thing to say in each situation is provided' (pp.66).

Holloway and Wheeler (1996) define culture as 'the total way of life of a group, the learnt behaviour which is socially constructed and transmitted. The life experiences of members of a cultural group include a communication system which they share. This consists of signs such as gestures, mime and language, as well as cultural artefacts-all messages which the members of a culture recognise, and whose they understand. Individuals in a culture or subculture hold common values and ideas acquired through learning from other members of the group' (pp.82-83).

Spradley (1979) uses the concept 'culture' to refer to 'the acquired knowledge that people use to interpret experience and generate social behavior' (pp.5). He implies that members of two different groups interpret the same event in different ways. He also claims that by restricting the definition of culture to shared knowledge we merely shift the emphasis from phenomena such as behaviour, customs, objects, or emotions, to their meanings. His ideas have much in common with symbolic interactionism, a theory which seeks the meaning in interaction and communication.

George Herbert Mead (1863-1931, cited in Robertson, 1977, pp.105) introduced first the concept of symbolic interaction. He himself did not publish his innovations and ideas but his students and colleagues, however, compiled and published his work from lecture notes and other sources. Blumer (1969) further invented the concept of symbolic interaction and analysed its three simple premises. 'The first premise is that human beings act toward things on the basis of the meanings that the things have for them. The second premise is that the meanings of such things is derived from, or arises out of, the social interaction that one has with ones fellows. The third premise is that these meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters' (pp. 2).

Considering the concept of the meaning in interaction is not unfamiliar to nurses because it is one of the fundamental issues in patient-oriented nursing and thus the creation of the therapeutic relationship i.e. to grasp the meaning of the situation from the patients point of view (Melia, 1982; Peplau, 1988; May, 1995; Tanner, et.al., 1997). I find it very important to focus on nurse's communication and interaction with other professionals and patients in the spirit of symbolic interaction. It is my opinion that nurses should begin to think more about the meaning of the communication they have with other professionals, like physicians, in correlation with their position in hospital units.

According to Handy (1993) culture in organisation can be defined according to 'the deep-set beliefs about the way work should be organised, the way authority should be exercised, people rewarded, people controlled. What are the degrees of formalization required? How much planning and how far ahead? What combination of obedience and initiative is looked for in subordinates? Do work hours matter, or dress, or personal eccentricities? What about expense accounts, and secretaries, stock options and incentives? Do committees control, or individuals? Are there rules and

procedures or only results? (pp.181-182). He also indicates that 'the values and traditions of the tribe are reinforced by its private language, its catch-phrases and its tales of past heroes and drama. The way of life is enshrined in rituals so that rule books and manuals are almost unnecessary; customs and traditions provide the answers'. He continues and says that 'cultures are founded and built over the years by the dominant group in an organisation. What suits them and the organisation at one stage is not necessarily appropriate for ever – strong though that culture may be' (pp.183). Handy defines four types of culture; power culture, role culture, task culture and person culture.

Handy implies that, the power culture depends on a central power source, with rays of power and influence spreading out from that central figure. 'The organization depends on trust and empathy for its effectiveness and on telepathy and personal conversation for communication. If the centre chooses the right people, who can think in the same way as it thinks, they can be left to get on with the job. There are few rules and procedures, little bureaucracy. Control is exercised by the centre largely through the selection of key individuals, by occasional forays from the centre or summonses to the centre. It is a political organization in that decision are taken very largely on the outcome of a balance of influence rather than on procedural or purely logical grounds (pp.184).

Role cultures relay more on the role or job description than the individual who fills it and 'will be found in organization where economies of scale are more important than flexibility or where technical expertise and depth of specialization are more important than product innovation or product cost' (Handy, 1993, pp.186). Handy claims that in role cultures 'individuals are selected for satisfactory performance of a role, and the role is usually so described that a range of individuals could fill it. Performance over and above the role prescription is not required, and indeed can be disruptive at times. Position power is the major power source in this culture, personal power is frowned upon and expert power tolerated only in its proper place. Rules and procedures are the major methods of influence (pp.185). He further indicates 'that role cultures offer security and predictability to the individual. They offer a predictable rate of climb up a pillar. They offer the chance to acquire specialist expertise without risk. They tend to reward the satisficer, the person concerned with doing his job up to a standard' (pp.186). He continues and points out that 'the role cultures is frustrating for the individual who is power-oriented or wants

control over his or her work; who is eagerly ambitious or more interested in results than method (pp.186).

According to Handy (1993) the character of task culture is that 'influence is based more on expert power than on position power or personal power, although these sources have their effect. Influence is also more widely dispersed than in other cultures, each individual tends to think he [she] has more of it. It is a team culture, where the outcome, the result, the product, of the team's work tends to be the common enemy obliterating individuals objectives and most status and style difference. The task culture utilizes the unifying power of the group to improve efficiency and to identify the individual with the objective of the organization. This culture is extremely adaptable. Groups, project teams, or task forces are formed for a specific purpose and can be reformed abandoned or continued. The net organization works quickly since each group ideally contains within it all the decision-making powers required. Individuals find in this culture a high degree of control over their work, judgement by results, easy working relationship within the group with mutual respect based upon capacity rather than age or status' (pp.188). Handy also says that the negative part of this culture is that control in these organisations is difficult. Vital projects are given to good people with no restrictions on time, space or materials. But little day-to-day control can be exerted over the method of working or the procedures without violating the norms of the culture. These culture therefore tend to flourish when the climate is agreeable, when the product is allimportant and the customer always right, and when resources are available for all who can justify using them. Top management feels able to relax day-to-day control and concentrate on resource allocation decision and hiring and placing of key people (pp.189). 'Task culture is the culture which most of the behavioural theories of organizations point towards with its emphasis on groups, expert power, rewards for results, merging individual and group objectives. It is the culture most in tune with current ideologies of change and adaptation, individual freedom and low status differentials' (Handy, 1993, pp.189).

The fourth culture Handy describes is the person culture. In this culture the individual is the central point. If there is a structure or an organisation it exists only to serve and assist the individuals within it. Furthermore its structure is as minimal as possible, a cluster is the best word for it and control mechanisms, or even management hierarchies, are impossible in these cultures except by mutual consent.

Influence is shared and power-base is usually expert power, i.e. individuals do what they are good at and are noticed are taken on their opinion (pp.190).

According to Fleegeer (1993) cultures in hospitals are valued on the ground of whether they are consonant cultures or dissonant cultures. The character of a consonant culture is that there exists a collective spirit, golden rule norm, one superordinate goal, frequent management/staff interaction, clinical expertise valued, professional and organisational goals similar, goals same across work units, high cooperation between units, primary care model promoting autonomy and independence, formal and informal systems to address conflicts, match between values and outcomes, all nurses seen as members of the same occupational group, all members seen as working toward same goal and behaviour norms are the same for everyone (pp.40).

The character of a dissonant culture is that there exist a mismatch between professional and organisational goals, stronger union affiliation than organisational, little staff representation on committees, low staff participation in decision-making, do not have primary care models, competitive spirit, them vs. us norm, low staff/management interactions, staff feel undervalued, mismatch between values and outcomes, nurse managers seen as outside occupational, double standard exists for behaviours, groups feel others not working toward common goals and myths, stories, symbols not caring or positive (pp.40).

According to the above description, hospitals and units can be seen as cultural settings with their own customs, and rules. In my opinion the task culture is the cultural form that should shape hospital units. It is a team culture, where the outcome, the result, the product, of the team's work is the main purpose. I believe that in each hospital and/or unit are many forms of cultures, especially mixture of role culture and task culture, and therefore the power used to control is mostly positional power and/or expert power.

Schein (1992) emphasises that the foundation for cultural formation is group formation. Shared patterns of thoughts, feelings, values and beliefs that results from shared experience and common, learning should characterise the culture of the group. Staff members in a hospital unit could form a group, according to the artifacts i.e. 'the visible products of the group such as architecture of its physical environment, its

language, its technology and products, its artistic creation, and its style as embodied in clothing, manners of address, emotional displays, myths and stories told about the organisation, published lists of values, observable rituals and ceremonies, and so on` (Schein 1992, p. 17). This is in accordance with Handy's definition of task culture.

However, do nurses, nursing auxiliaries and physicians, have the same patterns of thoughts, feelings, values and beliefs? Schein (1992), implies that these thoughts, values and beliefs must be shared on a day-to-day basis if the group is to achieve its goals and to fulfil its mission as prescribed in the organisational chart for the unit or the hospital.

According to Schein (1992) it is helpful to bring the group together to have congruence between espoused values and basic assumptions. Internal debate must take place if members do not share the priorities among the different functions, forcing the group to confront what collectively it has assumed to be at the top of this hierarchy. Otherwise the group may splinter and even dissolve (Schein, 1992).

This description is in resemblance with the description of therapeutic team (Johns, 1992) which fosters autonomy and responsibility in nurses where the focus in nursing is patient-oriented. If nurses want to be part of the working group they must themselves take action and be active in the health care team and free themselves from the subordinate position in the health care arena (Paviovich-Danis et. al. 1998). To be active in a group is one way to increase self esteem, because we all define ourselves in relationship with other people, 'as a members of a role set with a role in that set' (Handy, 1993, pp.153). Handy implies that most people bring hidden agendas to a group which may have nothing to do with the declared mission of the group. This hidden agenda is almost always a set of personal objectives and sometimes unconscious, but has much to do with the role we have in the group. Other influential factors are f. eks. who else is in the group, one's previous behaviour and reputation in the group (Handy, 1993, pp.161-163).

I also argue that the positivist paradigm shapes the organisational structure of many hospitals because they are divided into medical unit, surgical unit and orthopedic unit grounded on the special medical treatment offered there. Therefore, the patient is 'split in to parts' according to what body part needs medical involvement and attention and therefore 'belongs' to a different unit according to that (Mackay, 1993, pp.10). The physicians focus is mainly on the body part(s) that needs

medical care but does not focus on the whole person, but see them merely as an object of clinical practice (Ashley, 1976; Mackay, 1993). Allen (1985) calls this medicalization where specialists rooted in technical science attempt to define some human actions as pathologic and hence subject to their control. This is also in accordance with Zola (1975) but he implies that physicians 'medicalize' much of daily living, by making the labels 'healthy' and 'ill' relevant to an ever increasing part of human existence i.e. pregnancy and death (pp.170).

The new philosophy in nursing called 'new nursing' emphasises holistic perspective in nursing and patient-oriented nursing. Therefore, the nursing profession and the medical profession are rooted in different paradigm and do not uphold the same values and belief systems and look at the patient from a different point of view.

2.1.2. Characteristics of Oppressed Group

Roberts (1983) wrote an interesting paper about oppression and nurses as an oppressed group. According to Roberts (1983) 'groups can be said to be oppressed because they have been controlled by forces outside themselves that had greater prestige, power, and status and that exploited the less powerful group' (pp.21-22). Roberts also claims that the oppressor looks in most cases different than the oppressed i.e. white vs. black, men vs. women, act differently and that the characteristics of the oppressed becomes negatively valued. 'The need to deal with negative feelings about one's culture creates the need to reject and/or hide evidence of its existence because it represents a sign of difference and inferiority' (Roberts, 1983, pp.23). The oppressed group thus internalises the norms and values of the oppressors and believes that to being like the oppressors will lead them to power and control (Roberts, 1983). Therefore they act towards other people in an oppressed way and for them 'the man' is an oppressor (Freire, 1988). According to Roberts (1983) this process of internalisation of values of the dominant group leads to marginal group formation, where self hatred and low selfesteem develop, which further stimulates the cycle of domination and subordination. This process is one of the most thwart in emancipating the oppressed from their oppressors. 'Functionally, oppression is domesticating. To no longer be prey to its force, one must emerge from it and turn upon it. This can be done only by means of the praxis: reflection and action upon the world in order to transform it' (Freire, 1988, pp.36).

Roberts (1983) states that another character of an oppressed group is the submissive aggression syndrome. This syndrome develops because the oppressed person is not able to express aggressive feelings against the oppressor. This aggressive feelings originate in the fear that the subordinated group can be destroyed if they attempt to revolt. 'This aggression within oppressed persons may be vented in an even more self destructive way' (pp.23). Roberts (1983) also points out this aggressive feelings can create internal conflict often referred to as 'horizontal violence' which is often given as a proof that the oppressed persons are unable to organise themselves or be 'civilised'.

2.1.3. Nurses Socialization as an Oppressed Group

Nurses have for many years been educated and trained in the hospital culture and most of them work in that culture (Ashley, 1976; Johns, 1989; Mackay, 1993; Gottlieb and Gottlieb, 1998). Many scholars look at nurses as a subordinate group in hospitals (Ashley, 1976; Cohen, 1981; Roberts, 1983; Leininger, 1991, Mackay, 1993; Conway, 1996). Specially socialised as physician's handmaiden and therefore they have taken for granted beliefs and worldviews of the dominant group i.e. physicians basic assumptions (Roberts, 1983; Freire, 1988). Mackay (1993) studied the conflict in care between nurses and physicians and claims that these professionals are captured in the doctor-nurse game. These conflicts are partly grounded in aspects like different educational backgrounds and emphasis in education and socialisation in hospitals. Physicians are socialised in their educational program and in the clinical settings to be independent and their clinical judgement is reinforced by the competitive spirit necessary to survive in medicine (Mackay, 1993, pp.44). Although the nursing educational program emphasise that the purpose of practice is to enhance wellness and to ensure holistic care, nurses are still being trained to 'fit into' a system or culture which is often antagonistic to academic knowledge (Mackay, 1993, pp.41). She also states that another difference exists between these two professions. The medicine is science and physicians are seen to be scientists, but for the nursing profession science may be a preferred subject to studies in nursing. Nursing is a practical skill rather than a skill based on theory and science (pp.42). Mackay says that this lack of scientific and theoretical basis is one of charges laid against nursing by some members of medical profession. In my opinion it is important that nurses are

aware of and emphasise the theoretical base of the nursing practice that underpin their practical skill.

Pavalovich-Danis (1998) implies that critical thinking were not encouraged in nurses but instead nurses often sought gratitude, praise and approval from physicians which superseded the need to be competent professionals. Freire (1988) states that oppressed groups are educated in one characteristic way called 'the banking concept of education' where the teacher makes regular deposits into the students minds, information communicated in one direction and the teacher makes all the decisions about what is to be learned. Hedin and Donovan (1989) further discuss this banking education method and compare it to the education nurses get in their educational program. The main character of 'the banking education' is that students remain passive recipients of a multitude of facts, the teachers image is 'I am in control', 'I have the answers', 'I talk, you listen', students are not responsible and must be told everything what to do, conformity is expected and control of emotions, heavy course work is assigned that students can't reasonably do and are therefore set up for failure, exhaustion and resentment (pp.9).

Schein (1992) defines culture as 'a pattern of shared basic assumptions that the group learned as it solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems' (p.12). Basic assumptions are like theories in use and old world views that are unconscious to us and therefore difficult to change. It is not until problems can not be solved that these basic assumptions come into the debate or are confronted (Wade, 1998 and Mezirow, 1981). Freire (1988, pp.39-40) implies that in order to liberate themselves, the oppressed must confront reality critically and must unveil the world of oppression and through the praxis commit themselves to its transformation. Lutz et.al. (1997) says that in order to expand the practice, debate challenges nurses to consider the emancipatory possibilities of clinical inquiry within both interpretive and critical paradigms. If nurses never question these basic assumptions according to their profession these assumptions will continue to dominate the nursing practice.

According to Freire (1988) the liberation from the oppression must come from the oppressed themselves. They are the only ones who know the effects of the oppression and can understand the necessity of liberation. But instead of struggling for liberation they become oppressor or sub-oppressor themselves. Their idea of

humanity is oppression because 'at a certain moment of their existential experience, adopt an attitude of 'adhesion' to the oppressor' (Freire, 1988, pp.30). This is in good correlation with Schein's discussion about internal integration of basic assumptions from the dominant group. This is probably the reason why changes in order to emancipate nurses from the subordination are so difficult and evoke much resistance in the nursing profession.

Roberts (1983) implies that the ways to preserve the dominant-subordinate relationship is to reward by monetary or positions for proclaiming the values of the dominant culture. Also if the education is controlled by the powerful and limited to the curricula that support their values. It also occurs when there is a threat of change or revolt and involves the giving of token appeasement of rights or rewards to the oppressed.

Not all nurses share the same perspective and do not subscribe to an independent role for nurses, but believe that nursing is just an appendage of medicine (Gottliebe and Gottlieb, 1998). Meissner (1986) discusses this topic in her paper 'Nurses, are we eating our young ?' and says that too many nurses seem to be waiting to smash the novices' rosy view of nursing and trample their sensitivity to patient concerns. In the educational program they are taught to respect the patient's individual response to pain and illness. They are anxious to give the best personal care but discover that most plans speak to medical diagnosis and procedural concerns (pp.53). This is in correlation with findings from Ekman and Segesten (1995) study about deputed power of medical control and the hidden message in the ritual of oral shift reports, where little attention was paid to nursing needs and measures. The nurses clearly demonstrated that they were caught in a system dominated by a medical paradigm that effectively obstructed the progress of nursing as a professional discipline in its own right.

According to Weiss (1984) changing these basic assumptions or values calls for perspective transformation and role transformation in the nursing profession. That emphasises education for autonomy and responsibility more than any other education. It is one way to empower nurses to be more autonomous and assertive and practice patient-oriented nursing, emphasising cognitive, knowledge-based communication style when interacting with other member of staff.

I believe, that most nursing educators and academics emphasise patient-oriented nursing, according to the new philosophy in nursing, and ensure that students

are empowered to see that the purpose of practice is to enhance wellness and to ensure holistic care. However, 'it is in the clinical setting where students come face to face with their education-based ideals. It is here that the students believe that 'real' nursing takes place so they may believe that nurses in clinical practice are 'up to date' while teachers are not (Clare, 1993, pp.1035). 'It is through professional socialization, student and graduated nurses learn to think and act in ways which are defined for them by the traditionally dominant groups within the health system (such as doctors, administrators and policy makers) and which they accept as natural, common-sense views of social reality' (Clare, 1993, pp.1034).

According to Cohen (1981) socialization is a process 'that encourage and allow neophyte to interact successfully with the field's professionals, so they can learn how professionals feel about clients, their fellow practitioners, and the problems involved in practice. The end product of professional socialization must be person who has both the technical competencies and internalized values and attitudes demanded by the profession and expected by the public at large (pp.14). Cohen (1981) implies as well that socialization occurs in four stages according to Erikson's developmental model.

Stage I is dependence stage. Cohen claims at this stage the neophyte nursing student relies on knowledge of the instructor and mentors and possibly relies also on glamorized stereotypes picked up from the media. Cohen also states that to help the student to progress through this first stage, the entire curriculum must be familiar and make sense and the student must realize the relationship between the knowledge presented in beginning courses and the usefulness of this knowledge in professional practice (pp.33).

Stage II is called negative/independence stage. 'During this critical cognitive stage, negative/independence, students start to test the limits of the professional environment. They discover new behaviour patterns that must be exhibited and old behaviours that must be revised or ignored' (pp.33). According to Cohen it is at this stage that students may develop the leadership traits and the educational structure must provide climate that allows students to express their questioning and resistance freely without fear of reprisal.

Stage III is the independence/mutuality stage. At this stage students learn the limits of the role, how to distinguish the most important information and to fit the information into theoretical framework, how to set priorities, how to maintain a

professional façade, make a prediction, and take action based on that prediction. Opportunities must be provided for the student to test their knowledge and analytical skills by making decisions about actual problems (pp.35).

Stage IV is interdependence stage. Cohen proclaims that in this stage 'the conflict between the need for independence and commitment to mutuality is resolved. The student takes leave of the student role forever and accepts responsibility for her or his decisions and actions. The apprenticeship ends and the evaluation now come from clients and colleagues' (pp.36).

I feel that the problem nurses are facing today is that they can practice nursing grounded on the physician's basic assumptions in the hospital environment, and thus never question the assumptions and belief system that should underpin their practice. As a matter of fact it is more convenient for the stability of this culture that nurses don't question these assumptions. Furthermore, nurses, as a group, also have to survive and adapt to external environment and every cultural group seeks stability and coherence (Schein, 1992).

According to Freire (1988, pp.39) oppression is dehumanisation. Therefore the nursing practice becomes depersonalised and task oriented. Nurse's tend to treat their patients in dehumanised way as cases but not as human beings with unique personal experience (Jarvis, 1992; Leathart, 1994a). They become oppressors or sub-oppressors themselves as Freire (1988) implies. To perform nursing practice in that manner is in good coherence with the depersonalised and positivistic culture that shape many hospitals today.

2.2. Summary

Culture can be defined in many different ways as Spradley implies, i.e. on the ground of communication (Uchida, 1997; Becker, 1975), knowledge (Spradley, 1979), shared values and beliefs (Schein, 1992; Holloway, and Wheeler, 1996) and how the work should be organized, the way authority should be exercised, people rewarded and people controlled (Handy, 1993). Cultures are also valued as consonant or dissonant cultures (Fleeger, 1993).

Many scholars look at nurses as a subordinate group in hospitals (Ashley, 1976; Cohen, 1981; Roberts, 1983; Leininger, 1991; Mackay, 1993; Conway, 1996).

They are specially socialised as physician's handmaiden and therefore they have taken for granted beliefs and worldviews of the dominant group i.e. physicians basic assumptions (Roberts, 1983; Freire, 1988). Therefore the nursing practice becomes depersonalised and task oriented. Nurse's tend to treat their patients in dehumanised way as cases but not as human beings with unique personal experience (Jarvis, 1992; Leathart, 1994a) and they become oppressor or sub-oppressor themselves as Freire (1988) implies. The emancipation and liberation from the oppression must come from the oppressed themselves (Freire, 1988).

CHAPTER III

3.1. Research Design

In this chapter I will justify the chosen paradigm, research approach and methods of data collection and analysis for this descriptive study and demonstrate how it fits with the particular research questions I am attempting to answer with my thesis. Furthermore, I will explain the selection of respondents, the rigour/trustworthiness of this study, and the associated ethical issues I anticipated while doing this research.

3.1.1. The Chosen Paradigm

In order to address the question of 'what is the theoretical framework that shapes nurse-patient interaction in one hospital unit?' I propose to use a qualitative research paradigm rather than a quantitative one, as I am searching to understand the situations and experiences of nurses in one particular hospital unit. Although the main purpose of both paradigms is to gain a realistic understanding, there is a difference between them in the way reality is viewed, the relationship between the researcher and the subject, and what is acceptable as a statement of truth (Haase and Myers, 1988). In order to justify why I have chosen the qualitative perspective I will now discuss three main differences between the two paradigms.

How (the) nature of reality is viewed in these two paradigms is very different. From the qualitative perspective reality is assumed to be multiple, interrelated and determined within context, subjective data are considered as much a reality as objective data, and the influence of context is part of the phenomena being studied (Haase and Myers, 1988). Variables are considered interdependent rather than dependent or independent (Haase and Myers, 1988, pp.131): 'The word qualitative implies an emphasis on processes and meanings that are not rigorously examined, or measured (if measured at all), in terms of quantity, amount, intensity, or frequency' (Denzin and Lincoln, 1998b, pp.8). From the quantitative perspective, on the other hand, 'reality is singularly focused, that is, it can be reduced to its simplest form by delineating the objective definitions of variables. Through knowledge of the parts,

which are objectively defined and quantified, knowledge of the whole will be accumulated. The objective perspective also requires rigours external validation that strives to minimise subjectivity` (Haase and Myers, 1988, pp.131). This means that the quantitative perspective emphasises measurement to test hypothesis and analysis of causal relationship between variables so that predictions can be made (Denzin and Lincoln, 1998, pp.8).

Another factor that is different between these two paradigms concerns the relationship between the researcher and the respondent. In research based on the qualitative perspective the researcher and respondent are interrelated and this interaction influences the entire process (Haase and Myers, 1988). `Qualitative investigators think they can get closer to the actor's perspective through detailed interviewing and observation` (Denzin and Lincoln, 1998b, pp.10), but this provides few safeguards for the inherent danger of unintentional researchers bias (Haase and Myers, 1988). From the quantitative perspective the researcher accepts that an objective distance between the researcher him/her self and the respondent can be maintained. The researcher views him/her self as outside the process, controlling and manipulating variables to obtain information (Haase and Myers, 1988), that is, `they have to relay on more remote, inferential empirical materials` (Denzin and Lincoln, 1998b, pp.10).

The third factor that separates these two paradigms is the nature of truth. In the qualitative perspective the world is assumed to be in a dynamic state of circulation and truth is found in changing patterns of differences as well as similarities; that is, understanding of patterns and uniqueness is highly valued (Haase and Myers, 1988). Qualitative researchers are more likely to confront the constraints of the everyday social life (Denzin and Lincoln, 1998b, pp.10).

In the quantitative perspective the world is accepted as stable and therefore predictable and truth rests in statements about common norms or scientific principles and generalizability is of major concern. The world is seldom studied directly. Individual difference are controlled or are considered representative of an unknown factor (Haase and Myers, 1988, pp.134; Denzin and Lincoln, 1998b, pp.10).

The purpose of this study is to gain understanding of nurses' situation in one hospital unit; to observe them in their `natural` setting and to search for constrains in their everyday social situation. The qualitative perspective emphasises the

importance of the influence of context as a part of the phenomena being studied and the relationship between the researcher and respondents as being part of the research process. This interrelated relationship is also important to gain the respondent's interpretation of his/her situation. That is why the qualitative perspective is the best chose according to the purpose of this study.

3.2. Research Methodology

Ethnography, phenomenology, ethnomethodology and grounded theory originate in the qualitative philosophy or paradigm (Denzin and Lincoln, 1998a). These approaches have therefore identical interpretation of the nature of reality, the relationship between the researcher and the subject and what is acceptable as a statement of truth (Haase and Myers, 1988; Denzin and Lincoln, 1998a). The research approach or methodology I have chosen for this study is ethnographic. I will now discuss why I have chosen the ethnographic approach instead of phenomenology or ethnomethodology.

3.2.1. Ethnography

The explicit aim of the ethnographic method is to gaining better understanding of the life from the perspective of people, who must live in, by the codes by, or within the confines of a particular culture or subculture (Spradley, 1979, 1980; Atkinson and Hammerslay, 1995; Leininger, 1985). Phenomena must be investigated and understood within the context of their meaningful environments. According to Atkinson and Hammerslay (1995, p.1), this means that 'the ethnographer participating, overtly or covertly, in people's daily lives for an extended period of time, watching what happens, listening to what is said, asking questions – in fact [collects] whatever data are available to throw light on the issue that are the focus of the research'. According to Leininger (1985, p. 35) ethnography is 'the systematic process of observing, detailing, describing, documenting, and analyzing the lifeways or particular patterns of a culture (or subculture) in order to grasp the lifeways or patterns of the people in their familiar environment'.

Leininger (1985, p. 34) also points out that ethnography is an appropriate research methodology in nursing because it enables the researcher to 'obtain facts,

feelings, world views, and other kinds of data that reveal the real world, truths, and lifeways of people'. She thus identifies two types of ethnography: mini ethnography and maxi ethnography. Mini ethnography is defined as 'small-scale ethnography focused on a specific or a narrow area of inquiry', whereas 'maxi ethnography is defined as a large and comprehensive study of general and particular features of designated culture' (p. 35). My study falls under the definition of 'mini ethnography' in that it focuses on definite and relatively narrow aspects of nursing. Also, the overall time I spent in data collection is short, or one month. Savage (1995) uses the term ethnographic approach rather than full ethnography because of relatively short period of data collection. This reassembles Leininger's (1985) definition of mini ethnography.

My research is also grounded in the critical paradigm and feminist approach that emphasises misrecognition, as 'false consciousness'. In order to expose the hidden power imbalance which inhibits the condition for open, unconstrained communication and the position of nurses, most of whom are female and subordinate in the hospital culture on the grounds of their gender and tradition (Roberts, 1983; Allen, 1985, pp.61).

I aim to analyse, based on my observations, the cultural constraints nurses in one hospital unit are 'coping' from the perspective of the critical paradigm and feminist point of view. According to Roberts (1983), it is part of the emancipation of the nursing profession from being an oppressed group in the hospital to recognise the nurses' certain oppression, to help them understand that they are not inherently inferior; but live in a culture which does not justly value their contributions. My work could count for a dialogue among future nurses and lead to a basic commitment to maintain the integrity of the profession and to a perception of the oppressive forces that undermine this goal (Freire, 1988). Critical science helps remove conscious and unconscious constraints in our working lives and helps us to understand when we are 'doing unto others as others have done unto us' (Allen, 1985, pp.63).

3.2.2. Phenomenology

Phenomenology is a qualitative research methodology I could have used in this research. The aim of that approach is to describe the total systematic structure of lived experience, including the meanings that this experience has for the individuals

who participate in them (Omery, 1983; Anderson, 1991; Holloway and Wheeler, 1996). This is not in accordance with the research questions, so phenomenology is not suitable approach for this research. However, phenomenology and ethnography are both concerned with the use of the language and its linguistic expressions. The data are reported in the natural language of the event or in the shared scientific language of the discipline, and the research is done in natural setting rather than in the laboratory (Spradley, 1979; Omery, 1983).

3.2.3. Ethnomethodology

Ethnomethodological observation is more structural and objective compared with ethnographic observation and entails a different role of the researcher, who interacts with the setting participant only through the operation of the recording equipment, while the preferred observational techniques are audio- and videotaping (Adler & Adler, 1998, pp.99). Contemporary ethnomethodologists are interested in one aspect of the culture: interaction and discourse in the study setting; that is, they are concerned with the micro situations and their own internal dynamics but not with the patterns of the whole cultural setting as is the main purpose of the ethnographic approach (Adler & Adler, 1998, pp.99). Ethnomethodological researchers, like researchers studying from other qualitative approaches, are concerned about the use of the language. They assume the language to be the fundamental basis of communication and the basis of social order and thus the nature of roles, relationships, and social norms in the setting (Adler & Adler, 1998, pp.99). If I had used the ethnomethodological approach I would have observed especially the conversation between the nurse and the physicians. Analysed the use of language, that is hesitations, restarts, pauses, gaze behaviour of participants, and thus I would have gained a better understanding of the nature of their roles and the relationship between these two professions.

3.3. Research Methods

I will in following sub-chapters discuss the difference between participant observation, unstructured observation and structural observation and the different role of the observer in the setting, as well as the difference between unstructured

interviews, in-depth interviews and semi-structured interviews. I will then justify why I have chosen participant observation and informal interviews and a mixture of semi-structured and in-depth interview as a data collection method in this study.

The research methods ethnographers often use in their studies are participant observation, interviewing, and document analysis. Although questionnaires, as another level of data gathering, can be used -- then to collect additional data to support observational and interview data -- while it will not be the main source of data collection method in the ethnographic enterprise (Spradley, 1979; 1980 Atkinson and Hammersley, 1995; Holloway and Wheeler, 1996). Data from questionnaires impart little about the context in which responses were formulated (Burns and Grove, 1993, pp.368). Document analysis is another level of data gathering but is not relevant in this study because that method is not in congruence with the research question I put forward for this study. Document analysis could possibly support observational and interview findings or give another perspective of nurse's situation in a hospital unit.

3.3.1. Observation

Observation is a research method used within all research perspectives but the ways the observational data are collected and analysed and the role of the observer vary within different approaches (Spradley, 1980; Burns and Grove, 1993; Atkinson and Hammersley, 1995; Adler & Adler, 1998). The research question is the factor that affects the choice of the observation method (Lobo, 1992, pp.320).

3.3.2. Unstructured Observation

According to Burns and Grove (1993) unstructured observation involves observing and recording what is seen, but there is a risk that the observer may not remember all the details of the observed event and it is preferred that notes are taken during the observation or soon afterwards.

3.3.3. Structured Observation

Structured observation involves systematic approach to the quantification of behaviour and uses checklists or careful coding to record the presence or absence of certain behaviour (Burns and Grove, 1993).

3.3.4. Participant Observation

Participant observation as the role of the researcher is the key to the ethnographic research methodology (Spradley, 1980; Atkinson and Hammerslay, 1995) 'as in other qualitative approaches, the researcher is the major research tool' (Holloway and Wheeler, 1996, pp.84). The observation occurs in natural settings among the actors who would naturally be participating in the interaction, and follows the natural stream of everyday life (Adler & Adler, 1998, pp.81). That is, the phenomena are observed and understood in the context of their meaningful environment. In note-taking the participant observer do include in their notes descriptions of both the context and those with whom they come in contact (Spradley, 1980).

3.3.5. The Role of the Researcher

The role of the researcher in the field can, according to Gold (1958, cited in Research Methodology Study Guide, MIM60U, pp.87) lie on a continuum from non-participant or the complete observer, through observer-as-participant and participant-as-observer, to complete participant.

Lofland and Lofland (1995, cited in Research Methods, MIM60U, pp.88) divide the role of the researcher as 'unknown and known investigator'. The unknown investigator can have three positions. In public and open settings where anyone has the right to be and has to rely on what they can see and hear because asking too many questions could lead to suspicion. In closed settings the observer is a member and can witness a wide variety of behaviour, but s/he may find it difficult to inquire about any of those behaviours because colleagues might become suspicious. The third position of the unknown observer is also in closed setting where the researcher takes on a non-researcher role in the setting and s/he is confronted with the same problem as other

unknown researchers in closed settings. These three types of research fall under covert research.

The known researcher can have two positions or roles according to Lofland and Lofland (1995). S/he can either be a participant researcher, occupied by people researching in their own setting or be an outsider, coming to the setting only to carry out their research. In the former role the observers must let their colleagues know about their intentions and gain their co-operation and they may have to get formal permission. In the latter role the researcher must also have formal permission and win the co-operation of participants. These two types of research fall under overt research.

Leininger (1991) has developed an Observation-Participation-Reflection Model (O-P-R). The O-P-R model consists of four phases: 1) primary observation & active listening (non active participant); 2) primary observation with limited participation; 3) primary observation with continued observations; 4) primary reflection & reconfirmation (Leininger 1991, pp. 83). The O-P-R model is developed in order to observe nursing phenomena and can be used in observing nurses' own working environment. In the O-P-R Model the researcher is expected to devote some time observing before participating in the field or being an active participant. This observation time is important for the researcher as it allows 'the nurse researcher to become fully cognizant of the situation or context before becoming a full participant or "doer"' (p. 93).

I choose the ethnographic research approach for my study and I therefore used participant observation as a data collection method. I believe that it serves the purpose of this study, which is to observe nurses in their natural setting and specially observe constraints in the hospital unit culture they have to face. I participated in the setting and so I could observe nurses in their real life situations in an unconstrained manner. From Gold (1958) typology I took the participant-as-observer stand in this study because I wanted to be involved in all the central activities of the group but also because I am a nurse and think that I could not have been a salient observer. I am very familiar with the hospital environment and it was not difficult for me to participate in all the activities that were performed in such setting, but I did not take on any formal responsibilities.

According to Lofland and Lofland (1995) I would be a known observer because the participants in the setting know my role as a researcher. I could also be both an insider and outsider. Insider because I am a nurse and I have worked in this particular hospital for many years (I quit working there three years ago); also, I know what nurse's responsibilities are in hospital units. I could be an outsider because I am not part of the occupational group at the unit where this observation took place. I gained formal permission from the nursing director at the hospital and the head nurse at the unit to carry out this study, and all the nurses at the unit received informed consent before I started my observation. In the informed consent was outlined superficially the purpose of the study and assurance of privacy, confidentiality and anonymity was confirmed (see Appendix I).

3.3.6. Field notes

Atkinson and Hammerslay (1995) emphasize that field notes can be written in many ways but it is important not to rely on memory. The participant's own words should be used and a distinction made between observer's own descriptive glosses and what the participants say. This distinction is very important in the analysis of the data. Spradley (1980, pp.78) suggests that using a checklist to guide the writing of field notes will help to preserve the sense of context. The checklist looks like this:

- '1 Space: the physical place or places.
- 2 Actor: the people involved.
- 3 Activity: a set of related acts people do.
- 4 Object: the physical things that are present
- 5 Act: single actions that people do.
- 6 Event: a set of related activities that people carry out.
- 7 Time: the sequencing that takes place over time.
- 8 Goal: the things people are trying to accomplish.
- 9 Feeling: the emotions felt and expressed'.

It was useful to me having this checklist to guide writing field notes because I had never written field notes before. The checklist helps to focus on the matter under investigation and furthermore, all other events will be observed and noted in the same way. It increases the internal validity of this method of data collection and therefore this study.

3.3.7. Interview

The interview is one mode of data collection in any research approach (Burns and Grove, 1993; Denzin and Lincoln, 1998a). It can be structured, semi-structured, unstructured or an in-depth interview. It depends from which paradigm the study is carried out which type of interview is used (Burns and Grove, 1993; Fontana and Frey, 1998). The main differences between these interview types are the relationship between the interviewer and respondents, the interview schedules and the type of questions used in the interview (Burns and Grove, 1993; Fontana and Frey, 1998). I will now briefly discuss the differences between these types of interviews and justify why I choose a mixture of semi-structured interview and unstructured or in-depth interview as the second level of data collection in this study.

3.3.8. Structured Interview

The interview schedule is very exact so the same information is collected from each and every respondent (Fontana and Frey, 1998, pp.52). The relationship between the interviewer and the respondents is kept formal in order to control against potential biases (May, 1991; Burns and Grove, 1993; Fontana and Frey, 1998).

3.3.9. Semi-structured Interview

In the semi-structured interview or focused interview the questions are contained in an interview guide with a focus on the issues to be covered (Holloway and Wheeler, 1996). According to Barriball and While, (1994, pp.330) 'they are well suited for exploration of the perceptions and opinions of respondents regarding complex and sometimes sensitive issues and enable probing for more information and clarification of answers'.

3.3.10. Unstructured or In-depth Interview

The aim in unstructured or in-depth interview is an attempt to understand the meanings individuals give to their experience in the way they wish to express them rather than as a response to the way the interviewer views the topic (Burns and Grove,

1993; Fontana and Frey, 1998). That is, the participants structure the account of the situation or event under discussion. The interviewer asks open-ended questions in any order or sequence depending on the answers and allows flexibility and makes possible for the researcher to answer questions from the respondent (Holloway and Wheeler, 1996).

3.3.11. Informal Interview

The interviewing style mainly used in ethnographic researches is informal interviewing because such interviews go along with participant observation in the field or setting without peoples awareness, merely like a friendly conversation while the researcher introduces a few ethnographic questions (Spradley, 1979; May, 1991; Atkinson and Hammersley, 1995). They are called informal because they are not formally scheduled or planned but otherwise have the same character as unstructured interviews (May, 1991). The aim of the ethnographic interviews is to help the researcher to learn as much about the culture or group as possible (Spradley, 1979; Atkinson and Hammersley, 1995; Holloway and Wheeler, 1996; Fontana and Frey, 1998).

In this study I used informal interviews while I participated in the field but as I mentioned in the introduction I also used a mixture of semi-structured or focused interview and an in-depth interview with one key informant to learn more about the culture. In the first interview I had a list of open questions I wanted to ask my key informant which I later changed into a list of issues. In the following interviews, when more trust had been built in our relationship, the interview became more in-depth and unstructured but I was still focusing on particular issues I wanted to discuss with my informant.

3.4. Data analysis

Qualitative and quantitative researches are analysed in different ways. Findings from quantitative studies are transferred into numerical data in order for statistical analyses (Burns and Grove, 1993). The purpose of the statistical analysis can be to summarise, explore the meaning of deviation in the data, compare or

contrast descriptively, test the proposed relationship in a theoretical model, infer that the findings from the sample are indicative of the entire population, examine causality, predict, or infer from the sample to a theoretical model (Burns and Grove, 1993, pp.451). Quantitative researchers express their findings in numbers, tables or scales and today computer statistical packages are available to carry out any calculation necessary (Burns and Grove, 1993).

Qualitative researchers are dealing with written field notes or narratives and/or transcribed interviews (Holloway and Wheeler, 1996; Denzin and Lincoln, 1998a). The qualitative researcher is trying to understand the structure and meaning of the lived experience in the participant's world (Thorne, 1991). According to Burns and Grove (1993) the data must not be analysed out of context and can be analysed by developing a context chart and structured according to the phenomena of interest, themes or patterns, making metaphors. Ethnonursing Data Analysing Model developed by Leininger (1991) is an example of method used in analysing data from an ethnographic study and which I used in this study and will be described in more detail in Chapter IV. Other examples of analysing qualitative research findings are methods described by Colaizzi, Giorgi and Van Kaam (Ommrey, 1983). Rose (1990) used Colaizzi's method of data analysis in the phenomenological study of women's inner strength and added procedures created by the researcher to ensure deep and full elaboration of the phenomena.

3.5. Rigour/trustworthiness in qualitative/quantitative researches

All researches are judged from the criteria of validity and reliability (Lincoln, and Guba, 1989; Burns and Grove, 1993). How these concepts are interpreted depends on from which perspective the researcher is studying. I will now discuss how these concepts are interpreted from qualitative and quantitative perspectives.

Quantitative researches originate in positivist paradigm where the aim is to find the objective truth (Burns and Grove, 1993; Haase and Myers, 1988). According to Sandelowski (1986) 'the truth value of quantitative research is typically evaluated by how well threats to internal validity have been managed and by the validity of tests and instruments as measures of the phenomena under investigation. A research design is internally valid when there is confidence that the findings of a study are

characteristic of the variables being studied and not of the investigative procedure itself. A research instrument is valid when there is confidence that it measures what it was intended to measure' (pp.29). External validity relates to the generalisability of the study findings beyond this study (Sandelowski, 1986). Reliability represents the consistency and replicability of the study and the measurements will always give the same results over time, space and between researchers (Sandelowski, 1986).

Thompson and Barrett (1997) claim that the very nature of qualitative research means that it does not stand up to the traditional measures of validity, reliability, and objectivity (pp.61). According to Lincoln and Guba (1989) assessing validity and reliability in qualitative research or trustworthiness in such researches, is judged through credibility, transferability, and dependability. Does the research produce credible and transferable findings and is the researcher dependable in the research process? Credibility resembles the internal validity in quantitative research and truth. Burns and Grove (1997) mention that Hawthorn effect in observations can alter or threaten the internal validity in research based on observation. Reflection is one way to increase internal validity of the findings, that is, you constantly reflect on your findings for verification and also as a bracketing process or to minimise the researcher's bias (Leininger, 1991; Thomas, 1993; Atkinson and Hammerslay, 1995; Savage, 1995). Transferability is equivalent to external validity in quantitative research (Lincoln and Guba, 1989). Sandelowski (1986) implies that there are fewer threats to external validity in qualitative researches because it emphasises the study of phenomena in their natural settings and with few controlling conditions (pp.31). However, I argue that using checklist to guide the observation of all events in the same way increases the external validity and internal validity in this research and thus increases its reliability. Dependability refers to whether the researcher follows the research process truthfully and whether it does fulfil the associated criterion of auditability and therefore its reliability (Lincoln and Guba, 1989).

In qualitative research validity and reliability is not a linear process as in quantitative research but a circular one. The researcher is constantly checking and verifying the data throughout the research process and thus increases internal validity of qualitative studies while reflection minimises bias (Rose, 1990; Leininger, 1991; Thomas, 1993; Atkinson and Hammerslay, 1995; Savage, 1995).

To increase internal validity or credibility I will constantly reflect on the data and write down my feelings regarding observation and the matter under study and also as a bracketing process to minimise research bias (Redmond, 1995).

3.6. Selecting the respondents

I will structure my discussion on respondent's selection on Burns and Grove (1993) definition of random or probability sample, where the aim is to generalise the findings according to quantitative researches. Furthermore, the definition of purposive and theoretical sample where the aim is to increase the researchers' understanding of the phenomena under study, as in qualitative researches, is structured on Burns and Grove (1993) definition but also the discussion in the Research Methodology Study Guide.

In random or probability sample each individual in the population has an equal opportunity to be selected for the sample and the purpose of random sample is to increase the extent to which the sample represents the target population. 'Random sample leaves the selection to chance and thus increases the validity of the study' (Burns and Grove, 1993, pp.239). It ensures representativeness and generalizability and therefore often used in quantitative researches (Sandelowski, 1986). 'Purposive sampling involves the conscious selection by the researcher of certain subjects or elements to include in the study. Efforts might be made to include 'typical' subjects or 'typical situations' (Burns and Grove, 1993, pp.246). Theoretical sampling can emerge out of this purposive sampling in order to increase theoretical understanding of some aspects of the phenomena being studied (Burns and Grove, 1993, pp.246; Research Methodology Study Guide, MIM61U, 1996, pp.51). Qualitative researchers are dealing with verbal data and therefore use small size sample. They therefore frequently use theoretical or purposive sampling (Sandelowski, 1986).

According to Atkinson and Hammersley (1995, pp.37) the selection of the setting is grounded on the nature of the research question. The purpose of this study is to observe nurse's position and situation in one hospital unit. Therefore and in accordance with Burns and Grove (1993) the purposive sampling is chosen for this study, that is one hospital unit. Nurse's experiences and situations are the phenomena under study, therefore they are the theoretical sample in this study.

3.7. Summary

In order to answer the research question the qualitative research paradigm suits this study because from that perspective reality is assumed to be multiple, interrelated and determined within context and subjective data is considered as much a reality as objective data and the influence of context is part of the phenomena being studied (Haase and Myers, 1988, pp131). The selection of research methods for data collection, that is participant observation, field notes and mixture of semi-structured and in-depth interview, is justified because, according to Barriball and While (1994), 'they are well suited for exploration of the perceptions and opinions of respondents regarding complex and sometimes sensitive issues and enable probing for more information and clarification of answers' (pp.330). The aim in unstructured or in-depth interviews is an attempt to understand the meanings individuals give to their experience in the way they wish to express them rather than as a response to the way the interviewer views the topic (Burns and Grove, 1993; Fontana and Frey, 1998).

The selection of hospital unit as the purposive sample and nurses as a theoretical sample is justified because according to Atkinson and Hammerslay (1995, pp.37) the selection of the setting is grounded on the nature of the research question. The nature of the research question is to observe nurse's situation in one hospital unit and therefore one hospital unit is the purposive sample. According to Burns and Grove (1993) nurses at this unit are the theoretical sample in this study because their experiences and situations are the phenomena under study.

Quantitative and qualitative research data are analysed in a different way (Burns and Grove, 1993). Findings from quantitative studies are transferred into numerical data in order for statistical analyses (Burns and Grove, 1993). Qualitative researchers are dealing with written field notes or narratives and/or transcribed interviews (Holloway and Wheeler, 1996; Denzin and Lincoln, 1998a). According to Burns and Grove (1993) the qualitative data must not be analysed out of context. The data can be analysed by developing a context chart and structured according to the phenomena of interest, analysed in to themes or patterns, or by making metaphors. Leininger's Ethnonursing Data Analysing Model (1991) is one mode of analysing qualitative data and specially developed to analyse data from ethnographic studies in nursing called ethnonursing Leininger, (1991). The main emphasis in this model is to create themes or patterns out of the data. Qualitative researches are validated

according to trustworthiness in such researches, through credibility, transferability, and dependability of the studies and these can be increased through reflection and guided observation. Ethical issues like privacy and anonymity are considered regarding participant observation and interviewing.

CHAPTER IV

4.1. Data collection

The data collection method used in this descriptive ethnographic study is participant observation, field notes and informal interviews during participation in the field. The researcher also used a mixture of semi-structured interview and an in-depth interview with one key informant in order to learn more about the culture in this setting. In this chapter is outlined how the data collection was performed and the problems the researcher faced in collecting the data and how they were solved.

4.1.1. Access to the Setting

Many scholars (Leininger, 1985; Field, 1991; Holloway and Wheeler, 1996) argue that it has both advantages and disadvantages doing fieldwork among or studying your own peer group. The main advantages are that you know the language and the relatively ease entry into the setting, allowing you to uncover knowledge of the reason why people act as they do. The main disadvantages are that important pieces of data could be overlooked and the bias of the insider researcher. Burns and Grove also mention Hawthorn effect, defined as 'a psychological response in which subjects change their behaviour simply because they are subjects in a study, not because of the research treatment' (pp.769). Furthermore, Hawthorne effect can alter or threat the internal validity of this research (Burns and Grove, 1993). Reflection is one way to increase internal validity of the findings, as you constantly reflect on your findings for verification and also as a bracketing process or to minimise the researcher's bias (Leininger, 1991; Thomas, 1993; Atkinson and Hammerslay, 1995; Savage, 1995;).

I had been a consultant at this particular medical unit in the autumn 1997 when I did my consultancy project concerning organising efficient admission care process in acute admissions, in the Consultancy Module which is one Module in this Distance Learning Program. I decided to do this ethnographic study at the same unit because the staff knew me and I had gained an entrance at the unit. I also gained formal permission from the nursing director at the hospital and the head nurse at the unit and also from The Data Protection Commission in Iceland (see Appendix VI).

4.1.2. Participant Observation

I choose the ethnographic research approach for this descriptive study and I therefore used participant observation as a data collection method. This data collection method serves the purpose of this study, which is to observe nurses in their natural setting.

As a member of the nursing profession for 15 years now and having worked in this environment for many years I wanted to critically observe nurses situation in hospital units so I can be better prepared to make people, that is nursing students (I am a nursing educator), aware of the constraints under which they may be consciously or unconsciously operating in the future. I participated in the setting so I could observe nurses in their real life situations in an unconstrained manner. Lawler, (1991) indicates that 'because nursing practice is heavily influenced by experience, the researcher must share the same professional experience in order to decide what questions to ask nurses, if indeed the researcher wishes to get at the very essence of nursing practice. This is a study which must be grounded in more than abstractions and observable reality because nurses may not deliberately think about their practice until someone like me asks them to explain why they do certain things - that is, to explain what they take for granted' (pp. 6). But it is important to have in mind as Field (1991) implies that 'problem will arise if the researcher enters the study believing that the culture is already familiar as important pieces of data will be overlooked' (pp.92). I also agree with Aamodt (1991) about the discussion of being an ethnographer before doing it professionally, because I believe I have been practising 'ethnography' in my private life for about 10 years. As a part of my reflection process on my life in general I have been considering the different culture in different families and how it affects our life and how people obey rules without considering them. According to Handy (1993) every member of a group brings hidden agenda into the group life that influences the culture of the whole group. That is probably why I am so interested in culture in hospitals and how nurses 'obey' rules that are not created by them and/or mainly hinder them in communicating with the patient and/or other professions and staff.

I stayed at the unit for four hours each day from 8-12 in the morning shift and from 15-19 in the two evening shifts I observed. Burns and Grove (1993) claim that 30 minutes observation is maximal time for one observer. When I came home after

four hours I felt very tired and without energy. The observation was spread over three weeks in April 1998.

In the beginning of this observation I felt insecure in my role as an observer and researcher. I found it difficult to explain my role to others at the unit. I put the identity 'student' on my identity card and that surprised many because they knew I was a nurse, but I explained that I was a student in a masters program doing some observation regarding hospital units. I did not explain my role in much detail to everyone at the unit and nurses were the only ones that I had sent informed consent before I started my observation. I found it difficult not to take responsibility as a nurse and I sometimes was captured in a moral dilemma regarding patient care and communication with patients because I observed some emotionally violent and humiliating actions from the staff. I found it important to have something to do because I was not ready myself to work with nurses and to have informal conversation with them, but I also found that they were not ready to accept me. They were the only ones who knew the purpose of my stay at the unit. In the beginning I spend more time with the nursing auxiliaries than with nurses and from the first day I gained much information from them regarding their experience as participants in the culture. During the first morning I went to breakfast with one nursing auxiliary. We talked about the unit and she said: 'After a hard time at the unit I feel restless and therefore it is difficult for me to sit down'. On the fifth day I still felt as an outsider and I got critical looks from some of the staff. On the seventh day one nurse asked me to help her looking after one patient, which I did and after that I felt much more accepted in the setting. After three weeks I had the feeling of being at home, but according to Atkinson and Hammerslay (1995) it is a dangerous sign and I also noticed that I did not gain much new information. I therefore decided to end this observation time at this point.

From graduation as a nurse I have felt insecure in communicating with physicians. My personal aim in this observation was to explore these feelings and I therefore wrote comments about them whenever I felt insecure, both to explore these feelings and also as a bracketing process. Lipson (1991) implies that fieldwork brings one face to face with one's own values and that was exactly what I experienced while I was doing this fieldwork. I also wrote down other feelings I had regarding other situations I observed at the unit whenever I felt them in the same purpose.

4.1.2. Field notes

Atkinson and Hammersley (1995) emphasize that field notes can be written in many ways but it is important not to rely on memory. The participant's own words should be used and a distinction made between observer's own descriptive glosses and what the participants say, which I did. I also wrote about other feelings I had regarding the observations as a process of bracketing and to minimise bias (see discussion in the above chapter) because this distinction is very important in analysing the data. Spradley (1980) suggests that using a checklist to guide writing field notes will help preserve the sense of context. The checklist or guide list looks like this:

- '1 Space: the physical place or places.
- 2 Actor: the people involved.
- 3 Activity: a set of related acts people do.
- 4 Object: the physical things that are present
- 5 Act: single actions that people do.
- 6 Event: a set of related activities that people carry out.
- 7 Time: the sequencing that takes place over time.
- 8 Goal: the things people are trying to accomplish.
- 9 Feeling: the emotions felt and expressed' (pp.78).

I found it useful to have this checklist to guide writing field notes because I had never written field notes before and it helped me to focus on the matter under investigation. Furthermore, all other events were observed and noted in the same way. This procedure also increases internal and external validity of this study because all events are observed and noted in the same way and studying these phenomena in other settings is made possible if you know how the phenomena are observed and noted. Still, according to Sandelowski (1986), in qualitative researches every research situation is ultimately about a particular researcher in interaction with a particular subject in a particular context.

In the beginning of this observation I had the permission from the head nurse to use her office to write down my notes, which I did for three days. I noticed that other staff found that suspicious so I decided to write notes after each day except when I conducted informal interviews, which I wrote down in the WC room.

In this Dissertation I do not mention the names of staff or patients, just their occupation and gender in order to insure their anonymity and privacy. I do not either

mention the particular disease held by the patient because of this small community that makes it possible to know the patient.

4.1.3. Selecting the Key Informant

According to Spradley (1979) an ethnographer seeks out ordinary people with ordinary knowledge and builds on their common experience (pp. 25). Spradley also implies that 'informants are engaged by the ethnographer to speak in their own language or dialect, provide a model for the ethnographer to imitate and are source of information; literally they become teachers for the ethnographer' (pp.25). The key informant in this descriptive ethnographic study is a female nurse who has worked at the unit for five years as a nurse, one summer as a third year student and as a nursing auxiliary before that for a few years. The informant therefore knows the culture very well. She also works as a nurse in home-care for terminally ill cancer patients. She, therefore, knows the difference between working in a clinical setting and non-clinical setting and also the difference of being a nursing auxiliary and a nurse in this culture. I learned much about the difference between clinical nursing or nursing in hospital units and nursing patients in their home while doing this study.

4.1.4. Interview

The interviewing style mainly used in ethnographic researches is informal interviewing because such interviews goes along with participant observation in the field or setting (Spradley, 1979). They are called informal because they are not formally prepared but otherwise have the same character as unstructured interviews or friendly conversations (Spradley, 1979). I used informal interviews with different informants in the setting while doing the fieldwork, whenever it was possible.

The aim of the ethnographic interviews is to help the researcher learn as much about the culture or group as possible (Spradley, 1979; Atkinson and Hammerslay, 1995). I choose to interview one key informant (KI) to gain deeper understanding of the culture. In addition, I myself can be looked at as an informant because I am a nurse and I know the hospital culture from my own experience. The three face to face interviews with the key informant (KI) took place in the informant's home. They were one hour in length each and were audiotaped with the permission of the

informant. They were then transcribed and listened to again, checking for any mistakes and making final corrections. The key informant verified the transcriptions and the major themes emerging from the data.

In the first interview I had a list of open-ended questions (see list below) I wanted to ask my KI but which I used in later interviews as a guide list of issues I wanted to discuss with my informant. In the following interviews, when more trust had been built in our relationship, the interview became more in-depth and unstructured while I was still focusing on particular issues I wanted to discuss with my informant.

List of four topics and related open-ended questions that guided the interview

1. Difference between education and clinics.

In your opinion what is the main difference between the educational program and the working community, that is the hospital unit?

2. What situations or circumstances create much stress.

What do you find most difficult in coping within the hospital environment?

3. Communication.

Describe the communication you have with your fellow staff members?

4. Difficulties in communication.

Have you experienced difficult communication? If so describe it?

4.2. Data Analysis

The data were analysed according to Ethnonursing Data Analysis Model developed by Leininger (1991). This model consists of four phases:

'The first phase: Collecting, Describing, and Documenting Raw Data (Use of Field Journal and Computer).

The second phase: Identification and Categorisation of Descriptors and Components.

The third phase: Pattern and Context Analysis.

The fourth phase: Major Themes, Research Findings, Theoretical Formulations, and Recommendations' (p.95).

After transcription of the raw data (field notes and written interviews: phase one) and they have been read over the next step is to look for patterns and themes that can be looked in terms of constraints for nurses in this culture. This process

corresponds to phase two and three in Leininger's Ethnonursing Data Analysis Model. These themes are viewed as the cultural constraints nurses are facing in this particular unit and they were compared with research findings regarding identical themes from other studies, but this corresponds to phase four in the model.

As I mentioned in chapter III, this study is also grounded on the issues in the critical paradigm and feminist approach. Emphasising misrecognition or 'false consciousness' and entails exposing hidden power imbalances that inhibit the condition for open unconstrained communication and the position of nurses. The nursing profession is mostly a female occupation and nurses are a subordinated group in the hospital culture on the grounds of their gender and occupation (Allen, 1985, pp.61; Roberts, 1983). This view is also underpinned by hermeneutics interpretation of knowledge, which indicates that knowledge is both socially and historically constructed within various groups or cultures (Research Method Study Guide, MIM60U, pp.120).

The data analysis process used in this study was that the researcher read over the raw data (field notes and transcribed interviews) to search for words, phrases and situations that persistently recurred. These words, phrases and situations were highlighted and looked for patterns within the data to yield domains. Domains were then organised and categorised according to attributes. Thus themes that pervaded all categories were derived. Excerpts from interviews and field notes, which I use to illustrate these themes are typical quotes from informants. My key informant read the transcribed interview and themes derived from the data for verification. The findings or themes that emerged out of the data and could be seen as constraints of this culture against the nurses' ability to be patient-oriented in their nursing – the central matter of this study - was time and communication.

As mentioned above I used Ethnonursing Data Analysis Model developed by Leininger (1991) to analyse this data. To give an example of how the researcher worked this out the theme 'time' will be used as an example.

As I read over the field notes and transcribed interviews I noticed that time was an important part of this culture. Everything had to happen on time. The staff, nurses and nursing auxiliary and the nurses and the physicians talked together at a special time. Nurses have to have the medicine ready at a particular time. Taking care of the patients happened at a particular time. In the interview the KI talked a lot about time

and how much time was occasionally spent in waiting for the physicians to arrive at the unit. She also implied that she lost contact with the patient after she became a nurse because she now has much lesser time to spend with him/her. Nurses appear to be in a dilemma regarding time because physicians arrive at the unit at 9.30. That is the time when the patients finish their breakfast and nurses should go and help them. Nursing auxiliaries are often waiting for the nurses at this same time to assist them with the patients. These are the defining attributes for the categorisation of time as an important factor or theme in this culture and could be looked at as a constraining or impeding factor in nurses' life at this unit in caring for the patient.

4.3. Summary

This descriptive ethnographic study was conducted in a medical unit using participant observation and field notes, informal interviews and a mixture of semi-structured interview and in-depth interview as a data collection method. Access to the setting was easy because the researcher had been a consultant a year before and the staff therefore knew her. Fieldwork took three weeks with four hours of observation per day, five days a week. The researcher used field notes and informal interviews while doing fieldwork as a data collection method and also interviewed one key informant to gain more or deeper understanding of the culture as an additional data collection method. The key informant was a female nurse who had worked at this unit for five years as a nurse, one year as a third year student and as a nursing auxiliary before that. She also works as a home-care nurse for terminally ill cancer patients. She therefore knows this culture from different perspectives and is therefore a very suitable informant. Data were analysed according to Leininger's Ethnonursing Data Analysis Model which consists of four steps: 'The first phase: Collecting, Describing, and Documenting Raw Data (Use of Field Journal and Computer); The second phase: Identification and Categorisation of Descriptors and Components; The third phase: Pattern and Context Analysis; The fourth phase: Major Themes, Research Findings, Theoretical Formulations, and Recommendations' (p.95). The findings or themes that emerged out of the data and could be seen as constraints of this culture against the nurses' ability to be patient-oriented in their nursing – the central matter of this study - was time and communication. These are further outlined in next chapter.

CHAPTER V

5.1. Presentation of Findings and Discussions

In order to answer the research question regarding the theoretical framework that shapes nurse's practice I decided to separate the presentation and discussion of the findings of my study into sub-chapters according to the different themes that emerged from the data. The findings or themes that emerged out of the data and could be seen as constraints of this culture against the nurses' ability to be patient-oriented in their nursing was time and communication. I will first discuss the setting and the culture that shapes the setting or the unit. Then follows a discussion about the division of nurse's time in the setting. The second main theme emerging from the data were communication, but I will separate the discussion about communication into three sub-chapters according to nurse's communication with other members of staff, that is with other nurses, nursing auxiliaries and physicians. Conclusion, limitation of the research and recommendation for future research are the last sub-chapters in this chapter.

5.2. The Setting

The environment I choose to study is a medical unit with 23 beds. The geographical outlook of the unit is like 'T' (see Appendix II) and each part of the 'T' represents one of the three sub-units that the unit is split into. Each sub-unit is identified as red, blue or green part. As mentioned above the unit has beds for 23 patients, split into seven rooms for two patients, five rooms for one patient, and one room for four patients. The nursing station is located where the three parts of the 'T' come together, that is in the middle (see Appendix II). Two rooms for one patient are located on each side of the nursing station and have a window into the station. Inside these rooms are equipment for intensive care and one of them also has W.C. inside the room. Three of the other four rooms for one patient also have W.C. inside the room and two of them are in the blue sub-unit and the third is in the red sub-unit at the end of the corridor (see Appendix II).

On each sub-unit work at least one nurse and one nursing auxiliary on morning and evening shifts. The same people are working on the same sub-unit for

several weeks in order to create atmosphere for better teamwork and to provide more holistic nursing. On the night shift two nurses and one nursing auxiliary are responsible for all the patients in the whole unit.

At the unit are one head nurse, one assistant head nurse and one chief physician who have specialised in rheumatic diseases. There are also three other physicians who are specialised in cardiac diseases, pulmonary diseases and digestive diseases. There are in addition three assistant physicians working at the unit.

Sixteen nurses work at this unit, corresponding to 11.4 full-time nurse's positions, but full-time positions are 13.2 at this unit. Nurses and nursing auxiliary work on an eight-hour shift but physicians work on 24 hour duty and have to be 'on call' in the evening and at night. Assistant physicians also work on 24 hour duty but they have to stay at the hospital so they can be reached when necessary.

Today, in the health care system in Iceland and therefore also in this hospital, there are two generations of nurses, that is nurses with diploma graduation and nurses with baccalaureate degree. At this unit there are four nurses with diploma graduation and twelve nurses with baccalaureate degree.

Patients at this medical unit are mostly heavily dependent patients requiring a great deal of nursing attention. Many patients are admitted as emergencies (in the year 1997 there were 1069 patient admitted to the unit, approximately 3 pr. 24 hours) with mostly heart and chest complaints. At the unit there are many patients undergoing chemotherapy for cancer and some admitted for investigation. For some patients there needs to be a wait-and-see approach carried out or differing drug regimens are tried and evaluated as with cancer patients. There is a high death rate at this unit because of the problems the patients are dealing with and also because they are mostly elderly people.

Each patient has a file where all information about him/her are kept, i.e. personal information, tests results and ordination for treatment. Papers regarding nursing, that is personal information, nursing diagnosis and interventions and evaluation, are located far back in this file.

From about nine thirty until one or two o'clock is the most active time at the unit and there are many people at the unit moving around and sometimes it is noisy. Patients are often having test or examinations regarding their diseases at this time. The telephone rings a lot but the unit secretary takes care of these phone calls.

At seven thirty in the morning the head nurse arrives and receives the report from the night shift nurse. At eight o'clock the morning shift staff arrives, 3-4 nurses and 3-4 nursing auxiliary, and the head nurse reports information about patients. After that the team that works on each sub-unit (at least two or more staff, one nurse and one nursing auxiliary) talks together but they are responsible for seven to eleven patients. I observed that the aim of this discussion was not always the patients' condition but rather scheduling the tasks which needed to be done. Then the nurse goes to prepare medication and the nursing auxiliary goes and measures patients' vital sign. At nine o'clock is breakfast time for patients and some of the staff can also go and have breakfast in the hospital dining room or in the kitchen at the unit. At the same time the nurse hands out medicine to the patients.

Usually at nine thirty do the physicians and assistant physician arrive, but according to my KI will nurses often have to wait for them to arrive. When they arrive they all sit down and talk about the patients. At these meetings the physicians make changes regarding treatment or decide whether patients can leave the unit. Nurses have chances to talk about or report information about patients if necessary at these meetings. Then the physicians, the nurse and assistant physician go the round at each sub-unit and talk to the patients. As my key informant said, this waiting, the meetings and the rounds take much, much to long time and some of the actions that take place at these meetings could be done else were or at another time. Assistant physicians are dictating about patient condition or the physicians are teaching the assistant physicians about some cases or diseases. Nurses sometimes complain about this but not often. Therefore much of the nurse's time is spent in waiting for physicians and in these meetings and rounds through the sub-unit, but this can take up to one hour. As my informant says 'you don't begin to bathe someone because now you are waiting for the round to start but you have to do that afterwards'. 'Nurses (female) wait, for the (male) doctors to arrive. It is, after all, the doctor who is the initiator of action (Mackay, 1993, pp.56).

In this culture I sensed that the roles of nursing auxiliaries and physicians were clearly defined. Nursing auxiliaries are educated in order to take care of patients' physical needs and to be able to assist patients with their daily activities, physicians are responsible for medical treatment of diseases, but I did not grasp the hold of nurses role. Are they physican's handmaiden or do they have another sort of clear

role in this culture? Do they have real opportunities and manage to discuss matters that concerns patients and nursing?

Much is written about nurses power and autonomy in hospitals (Kupchak,1984; Prescott, et.al., 1985; Hewison, 1995; Brush and Capezuti, 1997) and Mackay (1993) claims that physicians have a great deal of power in hospitals and in relation with the nursing staff. They decide on day to day terms how many patients are to be admitted, how long they are going to stay at the unit, what sort of tests patient will undergo and what observations are to be carried out by the nursing staff. However, I agree with Mackay and Kupchak that nurses do have certain power in relationships with the medical profession. 'The fact that one person possesses power does not mean that another person lacks it - that is a simple concept, but one that seems to elude nurses' (Kupchak, 1984, pp.7). At the meetings nurses could use their knowledge and therefore power in relationship with physicians. Furthermore, Kupchak implies that it is only nurses who have the experience and are confident enough to stand their own ground, who have assurance to assert themselves in the face of medical power and are able to use that power.

At the same time as when the meetings and rounds take place nursing auxiliaries starts to help the patients out of bed or whatever they need. They are often waiting for the nurses to help them, but frequently they ask another nursing auxiliary from another sub-unit to help them or, as my informant put it, 'they can always catch a hand to help'. One nursing auxiliary said to me 'you can't let wet urinated patient wait'. Still, nurses often miss the chance of care for patients they would like 'to do' because of this schedule overlap.

When the evening shift comes I sense some kind of change in the culture. It is often much more quiet and not as many people are moving around at the unit. I also sense some shift in nurse's role and it becomes clearer. Nurses have often more time to talk to patients and they do not go round with the physician when he (they are all male at this unit) arrives around 17.30. My KI said that they used this time to ask the physician about patients if they had any questions. I observed that nurses are now more involved in direct patient care. I observe more teamwork as well. I did not observe nurses at night shift but the informant said that there were two nurses and one nursing auxiliary on that shift. Late in the evening the assistant physician sometimes arrives at the unit and the nurse asks him/her about patients condition and/or treatment if s/he has to.

I also sensed some kind of cultural change at the unit when the patient's role changed, especially when a patient was dying. Then the nurse becomes the most important professional around the patient, and s/he spends a lot of time with the patient and with relatives. I argue that during these moments nursing becomes more patient-oriented and holistic in nature. As indicated by my key informant, during one particular evening shift she had to care for two dying women and she did not do anything else on that shift but take care of them. Because of this situation other staff had to reschedule their work. My KI had said to them: 'I am stuck in this room now, would you please prepare the medication for me'. And they did. This also happens when a patient's condition changes suddenly or when a patient arrives at the unit who is in a very severe condition, e.g. with a heart attack or infarct. Then the one or more nurses become very busy taking care of this patient and the other nursing staff must take care of the rest of the patients at the unit on their own.

5.3. Time

As can be seen from the above discussion time is a very important factor in the nurses' life in this culture. Holloway et. al (1998) implies that rituals of everyday life structure time and help provide coherence and stability. In hospitals structures exists, organising such activities as rounds, rituals of meal times and visiting hours. Everything has to happen on time. The staff, nurses and nursing auxiliaries and nurses and physicians, talk together at a special time. Nurses have to have the medicine ready at a particular time. Taking care of patients has to happen at a particular time. During one of the interviews my KI talked a lot about time and how occasionally much time is spent waiting for the physicians to arrive and in meetings and rounds. She also implies that she lost contact with the patient after she became a nurse (she was a nursing auxiliary before she became a nurse) because she now has much less time to spend being with the patient. She also complained about the expansion of nurse's work because of more paper work.

In their study of the time factor in a hospital Holloway et. al. (1998) claim that patients appear to be more tolerant concerning lack of nurses' time than the nurses themselves and that the patients tried even to assist them in saving time. The heavy work of nurses did impinge on patients by making it difficult for them to ask for help

because they did not want to 'be a bother to nurses' and a waste their time. This was one of the rules that existed in this culture (pp.463-464).

In the study by Hendrickson et al. (1990) of how nurses use their time, it was concluded that nurses spend an average of 31% of their time or two and half hours on direct clinical care during a typical eight hour shift, an average of 25 to 30 minutes per shift with each patient. The average number of patients was 4.8 patients on day shift and 6.9 patients in the evening shift. Nurses spend 45% of their time or about three hours and 40 minutes on indirect patient care of clinical nature, like charting (11%), preparing therapies (10%), participating in shift change activities (9%), interacting with other professionals (8%), checking physician's orders (3%) and other miscellaneous clinical activities (4%). Non-clinical activities account for 10% of the shift, including paperwork, phone communications, and looking for and obtaining supplies. Thirteen percent of a nurse's time during each eight-hour shift was spent on miscellaneous activities, such as meals, breaks and personal conversations. In this study nurses in Medicine spent the least percentage of time with patients, or 27% of their time or 17-18 minutes in one eight-hour shift and there were also the highest nurse/patient ratio or 6.1 on day shift and 9.0 on evening shift. The Hendrickson's et al. study took place in a large metropolitan hospital with six units where modified primary care nursing was practised.

At the medical unit where my study was carried out the nurse/patient ratio is seven to eleven patients per nurse, which is considerably higher than in the medical unit studied by Hendrickson et al., where the average number of patients per nurse was 6.1-9.0. Therefore, according to the findings from the Hendrickson's et.al. study, nurses at this particular medical unit spend even less than 18 minutes with each patient on a typical eight hour shift or less than two and half hours on direct clinical care on one eight hour shift.

According to my research findings nurses normally find themselves in a dilemma regarding time because physicians arrive at the unit at the time when patients finish their breakfast and get out of bed and when nursing auxiliary begin attending to them. Nursing auxiliaries, therefore, are often waiting for nurses at this time to assist them for helping patients; however, their occupation was in a sense developed in order to assist nurses in taking care of patients. But I need to ask, is it now the other way round? Who is responsible for nursing actions regarding direct patient care? Nurses are educated to be responsible for patient care but are they present enough in

direct patient care to be able to be responsible? McCormack (1992) predicates that one of the factors that prevent nurses from exercising autonomy is the bureaucratic management styles and demands made on their time.

5.4. Relationship and Communication

5.4.1. Nurses and Nursing Auxiliary

My key informant talked much to me about communication with nursing auxiliaries. I also observed some constraints in the relationship between these two groups, mostly because nurses were not available to help nursing auxiliaries in taking care of patients at the particular needed time. When doing my fieldwork I sometimes took the positions of nurses because they were busy with other procedures. According to my key informant the policy in the hospital is to increase the number of nurses in the units who would then also be replacing nursing auxiliaries. Naturally, this situation creates tension in communication between these two occupational groups. According to my KI this tension tends to increase when there has been a heavy workload at the unit or when there has been an emotionally difficult situation there. The nursing auxiliaries endeavour to emphasise their part in caring for patients and I sense that this situation inhibits nurse's using their unique knowledge in planning and controlling patient care because of this conflict and also because of the time overlap that exists in the unit schedule.

From 9:30 and until around 10.30 in the morning nurses have to be in two places at the same time, taking care of patients, and meeting with physicians, and doing the rounds at the unit. This situation could hinder these two groups (nurses and nursing auxiliaries) in working together as a team and therefore it is possible that the patient does not get as good care as he/she could. Schein (1992) emphasises that fundamental for cultural formation is group formation. Shared patterns of thoughts, feelings, values and beliefs that results from shared experience and common learning should characterise the culture of the group: Staff members at a hospital unit could form a group according to 'the artifacts,' i.e. 'the visible products of the group such as architecture of its physical environment, its language, its technology and products, its artistic creation, and its style as embodied in clothing, manners of address, emotional displays, myths and stories told about the organisation, published lists of values,

observable rituals and ceremonies, and so on` (Schein 1992, p. 17). Schein also insists that these thoughts, values and beliefs must be shared on a day-to-day basis if the group is to achieve its goals and to fulfil its mission as prescribed in the organisational chart for the unit (Appendix III).

According to the above description I question whether these two groups, nurses and nursing auxiliaries, share the same pattern of thoughts, feelings, values and beliefs? What is the mission or goal these two groups are committed to? Is it to provide good, quality care to patients -- or is it to increase their importance and advance their position within the hospital and its culture?

Nurses find themselves trapped and captured in between the nursing auxiliaries and the physicians because of the schedule overlap at the unit. After all, as my key informant said, there can be a sudden change of treatment, or a patient may be leaving the unit and needing advice before s/he goes home. In these cases nurses have to know what the physician said to the patient, in order to repeat it or assist the patient in any other way.

I would also argue that because of this problematic situation between nurses and nursing auxiliaries, because of the change in hospital policy, there exists conflict between them. Therefore these two groups don't talk together much about how they should attain the goals they feel they are supposed to achieve. This argument is based on my observation in the field, but I did not observe it to be a regular habit talking about how the two occupation groups should schedule their shift according to the situation at the unit. My KI also mention that the nursing auxiliary can always find another nursing auxiliary from another sub-unit to help if they need an assistant. Therefore the nurse and nursing auxiliary on each sub-unit don't work as a team at the unit on regular basis, but according to Jones et al. (1997) and Idvall and Rooke (1998), teamwork is one of the fundamental attributes in patient-oriented nursing and care.

This conflict can also be an expression of submissive aggression syndrome, or horizontal violence, which is according to Roberts (1983) one characteristic of an oppressed group: Nurses become oppressors or sub-oppressors themselves. Freire (1988) says, this is one of the main thwarts against the liberation from the oppressed position.

This situation described above calls for collegiality in the nursing team at the unit. McMahon (1990) claims that when collegiality is collaborative, confidence,

respect and trust exist among members of the group and is a unique condition among often formally organised, professional work group (Hansen, 1995). Hansen also points out that there is a correlation between the degree of collegiality within nursing and the degrees of collaboration nurses have with other professionals. The production of a health team is healthcare service for the patient or the client and this service will improve if all members of the team work together.

5.4.2. Nurses and Physicians

The nurses at the unit in the hospital work also in close relations with the physicians. According to Roberts (1983) what fundamentally characterises this relationship is the one between the oppressor and the oppressed. Nurses have for long been educated and trained in the hospital culture and most of them work in that culture (Johns, 1989; Gottlieb and Gottlieb, 1998). Therefore they have been specially socialised as physician's handmaiden and have taken for granted beliefs and worldviews of the dominant group i.e. physicians basic assumptions (Roberts, 1983; Freire, 1988).

According to the findings of my research, nurses choose to follow the decisions made by the dominant group, the physician: Primarily they took into consideration the physicians opinions instead of considering the needs of the patients as they perceived them, leaving aside as well the need to work with the nursing auxiliary in direct patient care. Nurses also participate in the action they do not like and which are time consuming for them, i.e. very long rounds. I believe this is probably because many nurses don't have the courage to enter into a dialogue with physicians as equal partners, but rather as their subordinates. As Freire says, 'without dialogue there is no communication (1988, pp.81). Freire also insists that in order to have a constructive dialogue with another human being you must love and respect yourself and what you stand for and have faith in the power you have. Adding to this, Roberts (1983) reminds us that low self-esteem and self-hatred is one of the characteristics of the oppressed person. Furthermore, persons are not able to participate in a constructive dialogue if they are afraid of being humiliated or displaced, but the fact is that nurses are often viewed as expendable and easily replaced performers of tasks (Pavlovich-Dains, 1998).

According to Freire (1988) another issue is important in dialogue, that is hope: 'Hope is rooted in men's incompleteness, from which they move out in constant search - a search which can be carried out only in communion with other men' (pp.80). I argue that many nurses have learned that they have limited influence in relationship with physicians regarding patient care and therefore do not on regular basis enter into a constructive dialogue with them. Kupchak (1984) predicates that the nurses have the experience and confidence to stand their own ground; that they may be the only ones with the sense of assurance to assert themselves in facing the dominant powers within the medical profession, hence able to have constructive dialogue with physicians.

According to Weiss (1984) a 'productive dialogue is essential; otherwise the nurse may find that important conversation occur under stressful, rushed or less than optimum conditions' (pp.13). The oppressed person must enter in relationship with the oppressor in a solidarity way. 'Solidarity requires that one enter into the situation of those with whom one is solidary; it is a radical posture and requires true communication (Freire, 1988, pp.34).

My KI said to me that nurses are not taken seriously and have to struggle for what they believe to be the right thing to do for the patient. 'It was not myself, but another nurse. It was regarding chronic wound and the physician prescribed a treatment, but the wound did not heal for a long time. A nurse talked about this to the physician and recommended a treatment, which had proved to be effective in healing similar wound. This treatment was tried for few days and then the physicians treatment was started again'.

According to Mackay (1993) it is a part of the doctor-nurse game that many nurses assume that the patient believes the physicians rather than themselves. As my KI once said, 'will you (the physician) tell him (i.e tell the patient to increase mobility or eat another food) because he (the patient) pays more attention to what you say to him than me (the nurse)'.

According to Schein (1992) it is helpful to bring the group together to have congruence between espoused values and basic assumptions. Internal debate must take place if members do not share the priorities among the different functions, forcing the group to confront what collectively it has assumed to be at the top of this hierarchy. Otherwise the group may splinter and even dissolve (Schein, 1992; McMahon, 1990). However, to be active in a group is one way to increase self

esteem, because we all define our selves in relationship with other people (Handy, 1993, pp. 153).

According to Mackay, (1993, pp.13) it is normal to have conflict and it is difficult to work with other people and not to express disagreement and difference of opinion with the people in the work place. There is therefore a substantial degree of conflict between nurses and physicians. But Mackay implies that surprisingly some physicians and nurses deny the presence of any conflict or even irritations and that this reflects the need of some in the hospital world to present a secure and harmonious environment to all its visitors. According to Roberts (1983) nurses possibly deal with this irritation elsewhere, i.e. in communication with other staff.

Therefore the inconsonance in belief system and espoused values are not questioned and discussed in the working group and variety in sensitivity, suspiciousness and aggressiveness impede productivity. This is the character of harmonious tem (Johns, 1992) where avoidance of conflict and of sharing feelings is a deeply ingrained social norm. This prevents nurses from being influential members of the health care team and takes away their ability to utilise organisational resources to maximise their governance potential (Weiss, 1984; Handy, 1993). The group does not split or dissolve because nurses are socialised to be an oppressed group in hospitals, and tend to take for granted the skills and methods of the dominant professions or group i.e. physicians (Roberts, 1983; Leininger, 1991). However, it increases productivity of the group if it is heterogeneous, i.e. when the people in the group do not uphold the same attitudes, beliefs or values (Handy, 1993).

‘Only by starting from this situation – which determines [nurses] perception of it - can they begin to move. To do this authentically [nurses] must perceive their state not as fated and unalterable, but merely as limiting-and therefore challenging (Freire, 1988, pp.73). According to Weiss (1984) ‘cultivation skills include both the ability to recognise institutional factors which inhibit us from being influential members of the health care team as well as the ability to utilize organizational resources to maximize our governance potential’ (pp.12).

I believe that it is very important for nurses to start to focus on the meaning of this behaviour i.e. the oppressed behaviour nurses do have with their fellow members in their working culture. According to Freire (1988) the liberation from the oppression must come from the oppressed themselves. They are the only ones who know the effects of the oppression and can understand the necessity of liberation.

Blumer (1969) implies that 'new situations are constantly arising in the scope of group life that are problematic and for which existing rules are inadequate' (p. 18). From that point it is possible to interpret each new situation from another view and to put another meaning and action into the situation.

Role transformation process (Weiss, 1984), which I believe is congruent with perspective transformation or personal transformation (Wade, 1998 and Mezirow, 1981), is one way to empower nurses to be more autonomous and assertive. To practice patient-oriented nursing, with emphasis on using a cognitive, knowledge-based communication style when interacting with other members of staff in the work environment. The outcome of this transformational process is new self-definition and more freedom, creativity and an increased ability to handle stress (Wade, 1998). Thus I argue that if nurses gain more respect from other professionals that will lead to more governance potential and power in caring for the patient. That process will also increase nurses self esteem and assertiveness in communicating with other professionals. It will also increase their level of professional autonomy in caring for the patient (Weiss, 1984; Schutzenhofer and Musser, 1994). It is a cyclic process that will hopefully emancipate the nursing profession from old belief systems and traditional stereotypic professional image as an oppressed group and physician's handmaiden.

Role transformation process can be anxiety provoking and will temporarily cause upheaval within health care relationships, requiring negotiation if new behaviours are to be permanently integrated into the existing structure, which threaten the coherence and stability of the environment (Weiss, 1984). Nurses must be empowered to have the courage to confront the existing situation and thus systematically increase nurses' power in health care.

One way of handling this upheaval in the environment is this threefold negotiation process, involving role empathy, role clarification and role assertion (Weiss, 1984).

Role empathy will increase awareness and interest in the perspectives and needs of others in the work environment and nurses are quite skilled in empathising with patients needs. Thus nurses can respond more intelligently and sensitively to any resistance or anger shown toward their changing behaviour.

Role clarification involves "a) the identification of grounded rules for allocation of responsibility on the health care team, b) specification of diverse

expertise on an individual basis, c) resolution of differences of opinion regarding responsibilities, and d) delineation of mutually acceptable roles in the health care relationship” (Weiss, 1984, pp.12).

Role assertion can allow nurses to expand the traditional parameters of their historical and present role and will make them more autonomous in their nursing practice. To be qualified in each of these communication behaviours is essential to effective negotiation with those in the work environment, for they decrease ambiguity in existing role expectations and further the resolution of any conflicts which may result from disparate expectations (Weiss, 1984).

From the above discussion I argue that it is vital for the nursing profession to facilitate role transformation and for nursing educators to model and facilitate perspective transformation, as Mezirow (1981) also points out. Role transformation increase responsibility, autonomy and nurses will be more assertive and thus enable them to maximally use their expertise and to feel actually as members of the nursing profession and health care team for improving the clients situation and the quality of service. However Gottlieb and Gottlieb (1998) imply that majority of nurses are inadequately prepared for these critical changes because of the difficulties inherent in change. Their energies may be directed toward preserving the old health care order and existing hierarchical structure. Another source of resistance according to Gottlieb and Gottlieb is from the outside the profession and particularly from physicians who tenaciously hold onto the old order because they have much to lose, both in terms of power and status.

I agree with many scholars who say that nurses must in an open discussion with other professionals and in public articulate the nursing professional skills since numerous spheres of professional overlap have emerged in health care (Weiss, 1984; Freire, 1988; Paviovich-Danis et. al. 1998).

5.4.3. Nurses and Nurses

According to the research findings, nurses in the hospital setting or clinical nurses seem to rely on or gain acceptance from other nurses or other professions such as physicians. They feel more secure and relaxed at work if they have someone to ask for advice and it seemed that it is recommended that they ask for permission to give medication even though it has already been order as PN medication. McCormack

(1992) implies that the relationships between nurses and physicians appear to be an added source of stress for nurses and that they generally gain support in dealing with difficult situations and relationships from each other. Kupchak (1984) claims that only the nurses who have experience and are confident enough to stand their own ground and who have the assurance to assert themselves in the face of medical power are able to use their power and thus, as I would further argue, can be autonomous in their practice in the clinical setting.

On the other hand while nursing a patient in other settings, like his/her home, nurses are able to be more autonomous. They feel more secure and autonomous in their nursing procedures and do what has to be done for the patient and don't ask as often for advice or permission from physicians as they do in hospitals. As my KI said 'it is good to feel that you are able to do it'. Furthermore they have more time to spend with the patient and there are not as many external disturbances like telephone calls, other patients and other miscellaneous clinical activities. Later, when all the home care nurses meet they discuss these procedures and ask each other for opinion, but at the critical moment they do what needs to be done for the patient.

According to my KI the home care nursing is mostly palliative care for terminally ill cancer patients. According to Payne et.al. (1998), palliative care nurses aim to provide holistic care focusing not only on patient's physical needs but with a great emphasis on their social, psychological and spiritual needs. This is in accordance with what my KI implied when she described what she emphasis in the home-care nursing.

These findings led me as the researcher to think about socialisation process in the nursing profession at the hospital and in the nursing educational program in the University. Are nursing students and neophyte nurses forced to be on stage one in the hospital according to Cohen's socialisation development process? To be dependent and rely on others than themselves and thus never have the courage to question unless the fear of reprisal, humiliation or called rebellious. Meissner (1986) implies that too many nurses seem to be waiting to smash the novices' rosy view of nursing and trample their sensitivity to patient concerns (pp.53). However, in the educational program the nursing students are taught to respect the patient's individual response to pain and illness and are anxious to give the best personal care.

Pavalovich-Danis (1998) implies that critical thinking was not encouraged in nurses but instead nurses often sought gratitude, praise and approval from physicians

which superseded the need to be competent professionals. Ashley (1976) implies that physicians have blamed themselves for having 'permitted' nurses to become educated and too independent, but they hold on tenaciously to the old order because they have much to lose both in terms of power and status (Gottlieb and Gottlieb, 1989). However Gottlieb and Gottlieb also say that majority of nurses are inadequately prepared for these critical changes because of the difficulties inherent in change, their energies may be directed toward preserving the old health care order and existing hierarchical structure.

Are nursing students inadequately prepared also because of the socialisation development process in the nursing educational program does not encourage them to move on through the stages needed to be an interdependent professional nurse? I believe that nursing educators should seriously consider their socialisation process in their nursing courses and in the curriculum as a whole. What messages are we sending out to our students?

5.5. Conclusions

There are several issues that I like to emphasise in particular regarding these findings and discussion. Do physicians know what kind of education nurses achieve today? There were a few incidents I observed that indicate that physicians don't know exactly what nurses are educated for. One of the incidents was regarding nasogastric feeding and nursing patients with nasogastric tube. A particular physician once wrote down information about caring for patients with nasogastric tubes for the nurse. The other case I observed was regarding inflammation in vein as a result of intravenous needle and nursing patients with venous needles. But there were also incidences regarding communication with relatives.

Do nurses give off information to other professionals that they don't know how to care for patients they already know? Is that the reason why physicians don't realise nurse's knowledge about patient care. Or is it because, as Mackay (1993) implies, that physicians do not recognize the knowledge nurses have in patients care and therefore their power because they do not ask or listen to what they have to say but that is one of nurses strongest complaints. According to Green (1997) the most prominent stressors in nursing are conflicts with other people, nursing colleagues, co-

workers in other disciplines and patients while problems in nurse-physicians relationship are reported the most intense and frequently cited stressor.

Do nursing auxiliaries know what nurses are educated for? Do nurses themselves know what role they have regarding patient care? Is the nursing profession so undefined a profession in hospital units today that nobody knows what they are responsible for, not even they themselves? All these questions are worth considering.

According to Uchida's (1997) definition of the third culture or sub-cultures, on the ground of the communication they have with their fellow members, there exist at least three sub-cultures or groups in the hospital unit. Physicians are the dominant group (Ashley, 1976; Johns, 1989; Mackay, 1993; Gottlieb and Gottlieb, 1998), but then there is nurses sub-culture and nursing auxiliary's sub-culture.

According to Fleegeer's (1993) attributes for consonant and dissonant culture I would value the culture at this unit as dissonant culture. There seems to be mismatch between espoused values and organisational goal, competitive spirit exist among nurses and nursing auxiliaries, double standard exist for behaviour - i.e. nurses can wait for physicians but not the other way round – and because there are no formal systems to address conflict, just an informal one. According to my KI the staff discusses conflicts and difficulties informally at work and when they meet each other outside work. However, few years ago there was established a formal system to address conflict or difficulties which did not work out because nobody used it. Few years ago, in 1992, there was also established a strategy to enhance primary nursing at the unit, including that the staff on each sub-unit should work on each sub-unit for several weeks and work as a team on each shift. This system does not work out probably because of the schedule overlap at the unit, a high nurse/patient ratio or too few nurses, competitive spirit between groups, double standard of behaviour and because nurses act as an oppressed group at the unit.

It is my opinion that there exist great knowledge in nursing about patient care and their behaviour and coping methods with different health problems and illness. However, I consider that nurses are not able to utilise all this knowledge in caring for the patients in the hospital units because of what position nurses have there. 'People's cultural knowledge is often unknown to them or taken for granted, and they do not get

the opportunity to stand back from the exigencies of everyday life to examine pertinent aspects' (Germain, 1993, pp.245).

I value, grounded on the research findings, that the nursing procedures are task oriented at this particular unit. The main emphasis is on what needs to be done for the patient rather than with the patient and getting through the work is more important than how the patient is really coping with his/her situation (Johns, 1993). Therefore I argue that the theoretical framework that shapes the nurse-patient relationship is task-oriented.

Furthermore, according to the research findings, nurses are more able to give holistic nursing care and be more patient-oriented in patient's home. Why do nurses adhere and accept a system in the hospital unit that apparently hinders teamwork and holistic care and thus patient-oriented nursing? I consider that it is because they are captured in a theoretical framework characterised by the physicians' dominance and the nurses' subordination in the culture. Can nurses be advocates for the patients, who are an oppressed group in the hospital, when they are themselves an oppressed group there?

It is my opinion that nurses must openly discuss their situation in hospital units to unveil their subordination and the great knowledge that exist in nursing and thus change their situation there because, as Freire (1988) implies, the liberation from the oppression must come from the oppressed themselves. They are the only ones who know the effects of the oppression and can understand the necessity of liberation (Freire, 1988). I agree with Harden (1996) that only 'when our oppression, both as women and nurses has been recognised, and critical consciousness achieved, can true humanistic care be given' (pp.32).

My opinion is that if there are to be changes in the nursing practice, for it to become more patient-oriented, students should be socialised in the educational program to reach the stage IV, according to Cohen (1981). Therefore be more able to ask questions regarding practice and also be more able to think critically about their practice. I also believe that nurses should openly discuss and be proud of the feminist attributes that caring constitutes and thus be more able to change the hospital culture, they mostly work in, to be more caring in nature. Roberts, (1990) implies that it is necessary to uncover the existing caring actions so that it can be recognised, rewarded and taught to students of nursing. It is also my belief that caring attributes could enhance healing and thus influence cure.

As mentioned earlier, the role transformation process, which emphasises education for autonomy and responsibility more than any other education, is one way to empower nurses to be more autonomous and assertive. To practice patient-oriented nursing with emphasis on using a cognitive, knowledge-based communication style when interacting with other staff in the work environment (Weiss, 1984). It is my opinion that neophyte nurses should be supported or mentored in the clinical setting to reinforce the socialisation they achieve in the educational program. The outcome of this transformational process is new self-definition and more freedom, creativity and an increased ability to handle stress (Wade, 1998). Thus I argue nurses need to gain more respect from other professionals, which would lead to more governance potential and power in caring for the patient and more patient-oriented practice, but that is our mission.

5.6. Limitations

The main limitation regarding this study is that my research it focused only on one unit in this hospital and the participant observation lasted only for three weeks. The researcher interviewed one key informant but did not gain information from other nurses in this culture. This study is carried out in Icelandic and transcribed in English but that creates difficulties in translating and conveying the informants' understandings and meaning regarding this culture

5.7. Recommendation for Future Researches

It is worth studying whether nurses working in home settings are generally more autonomous than clinical nurses. I believe it is also important for nurses to study nursing auxiliary's and physician's experience and to develop better understanding of teamwork, communication, and other aspects of the culture in the hospital units. I believe it is very important for enhancing teamwork and thus the service will improve and be more patient-oriented. I also find it important to explore the patients perception of the hospital culture and the service they get there so it can be improved for their benefit. I also find it important to explore what kind of socialisation the nursing students get in the nursing educational program and on what stage they are when they graduate so they can be appropriately supported in the

neophyte stage of their practice. As I mentioned in the introduction chapter I believe that good nursing care is in fact cost saving process and I suggest that nursing researchers should explore that field in more depth in the future.

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APPENDIX Ia - Informed Consent

Dear nurse.

Letter of introduction for a Masters research project in nursing.

My final project towards a Masters degree in nursing from the University of Manchester is a research project. I am very interested in carrying out this research project here at the District Hospital in Akureyri, in order to connect my studies to the environment in which I work and also so that it may be utilized for further development in the teaching of nursing at the University of Akureyri, where I work as a lecturer in the Faculty of Health Science. **The final report of the research does not include information about where the research is carried out nor are individuals mentioned by name, except for sex, profession and year of graduation.**

Research:

I am very interested in relations and not least relations in nursing. New issues are being emphasized in nursing which are, to a great extent, based on relations between nurses and patients. I am interested in examining these relations on a theoretical basis in my research project for further development in the teaching of nursing students. I am interested in examining and connecting the real world that nurses work in with the world in which they receive their education and how it is possible to better connect these worlds. I am also very interested in pointing at the stress in nursing that nurses work under and which possibly prevents them from connecting to their clients and give them the nursing that their education emphasizes.

I believe it is best to approach this subject matter through being on the scene and examining the world which nurses work in, with relations in mind. Whether nurses nurse according to the ideas that are emphasized in the education of nurses or what kind of reality really spreads out before them when they come out onto the real 'field'. In order to further deepen my understanding of the subject matter, I am interested in taking half standardized interviews with 3-4 nurses and discuss the subject matter of the research.

Execution:

The collection of data will be done in the following manner: I will 'work' on the scene for a certain period of time, one to two months (April and May 1998) and keep a diary. **It is important to point out that total anonymity will be kept and everything written will be read by the participants before it leaves me in the final report of the research.** I am also interested in taking half standardized interviews with 3-4 nurses where they will be asked open questions about the subject matter of the research project. It would be good if the interviews could be recorded on tapes which later will be destroyed at the end of the project or can be retained if the person who was interviewed so wishes. The execution of such interviews is always a matter of agreement between the interviewer and the person being interviewed. My position on the scene is that of a researcher and I will as such not be responsible for the execution of nursing nor be responsible for the nursing of single patients. I

will 'work' as an assistant at nursing and participate in those activities on the ward that do not require my direct responsibility as a nurse.

If parties do not wish to participate in the research it is of course permitted and also to withdraw at any time from the research project if they wish to do so.

Thank you in advance for your participation and cooperation.

Hólmfríður Kristjánsdóttir,
lecturer at the Faculty of Health Science at the University of Akureyri

APPENDIX Ib – Informed Consent (in Icelandic)

Ágæti hjúkrunarfræðingur.

Kynningabréf fyrir mastersrannsókn í hjúkrunarfræði.

Lokaverkefni mitt til Meistaragráðu í hjúkrunarfræði frá Háskólanum í Manchester er rannsóknarverkefni. Þetta rannsóknarverkefni hef ég mikinn áhuga á að vinna hér á Fjórðungssjúkrahúsinu á Akureyri, til að tengja nám mitt við það umhverfi sem ég starfa í og einnig til að það geti nýst til frekari þróunar í kennslu í hjúkrunarfræði við Háskólann á Akureyri, en þar starfa ég sem lektor í Heilbrigðisdeild. **Í loka skýrslu rannsóknarinnar kemur ekki fram hvar rannsókn er gerð né persónur nafngreindar fyrir utan kyn, starfsheiti og hvenær lauk hjúkrunarprófi.**

Rannsókn:

Ég hef mikinn áhuga á samskiptum og ekki síst samskiptum í hjúkrun. Nýjar áherslur eru í hjúkrun og byggja þær mikið á samskiptum milli hjúkrunarfræðinga og sjúklinga. Sem rannsóknarverkefni hef ég mikinn áhuga á að skoða þessi samskipti út frá fræðilegum grunni til frekari þróunar í kennslu hjúkrunarfræðinema. Ég hef mikinn áhuga á að skoða og tengja hinn raunveruleg heim sem hjúkrunarfræðingar starfa í og þann heim sem þeir fá menntun sína í og hvernig hægt sé að tengja þessa heima betur saman. Ég hef einnig mikinn áhuga á að benda á það álag í hjúkrun sem hjúkrunarfræðingar starfa við og sem hugsanlega kemur í veg fyrir að þeir geti tengst skjólstæðingum sínum og veitt þá hjúkrun sem menntun þeirra leggur áherslu á.

Til að nálgast þetta efni tel ég best að fara á vettvang og athuga þann heim sem hjúkrunarfræðingar starfa í með samskipti í huga. Hvort hjúkrunarfræðingar hjúkra samkvæmt þeim hugmyndum sem lögð er áhersla á í námi í hjúkrunarfræði eða hvaða raunveruleiki blasir við þeim þegar út á hinn raunverulega “akur” er komið. Til að dýpka enn frekar skilning minn á efninu hef ég áhuga á að taka hálf stöðluð viðtöl við 3-4 hjúkrunarfræðinga og ræða efni rannsóknarinnar.

Framkvæmd:

Gagnasöfnun verður þannig háttað að ég “starfa” á vettvangi í ákveðinn tíma, einn til tvo mánuði (apríllog maí 1998) og skrifa dagbók. **Mikilvægt er að taka fram að algjör nafnleynd verður tryggð og allt sem ég skrifa munu þáttakenndur lesa yfir áður en það fer frá mér í loka skýrslu rannsóknarinnar.** Ég hef einnig áhuga á að taka hálf stöðluð viðtöl við 3-4 hjúkrunarfræðinga þar sem lagðar verða fyrir þá opnar spurningar um efni rannsóknarinnar. Gott væri ef hægt væri að taka viðtölin upp á segulbandsspólur sem verða síðan eyðilagðar að rannsókn lokinni eða viðmælandi getur fengið þau til eignar ef hann óskar þess. Framkvæmd slíkra viðtala er ávallt samkomulagsatriði milli viðmælanda og rannsækenda.

Staða mín á vettvangi er staða rannsakanda og mun ég sem slíkur ekki taka ábyrgð á framkvæmd hjúkrunar né bera ábyrgð á hjúkrun einstakra sjúklinga. Ég mun “starfa” sem aðstoðarmanneskja við hjúkrun og taka þátt í þeim störfum deildarinnar sem ekki krefjast beinnar ábyrgðar minnar sem hjúkrunarfræðings.

Óski aðilar að taka ekki þátt í rannsókn er það að sjálfsögðu heimilt og einnig að draga sig út úr rannsókn hvenær sem þess er óskað.

Með fyrirfram þökk fyrir þátttökuna og ósk um gott samstarf.

Hólmfríður Kristjánsdóttir,
lektor Heilbrigðisdeild Háskólans á Akureyri

APPENDIX II - Geographical Picture of the Unit

APPENDIX III - The Aim of the Ward

Our aim on Medicine Ward is to give our clients the best possible treatment at each time in the field of medicine and nursing. To give the best mental, physical and social care and to strengthen the ability of our clients for self-preservation. Nursing should be aimed at the individual as much as possible and the right of the patient should be respected. Respect must be shown to the patient's family and full consideration taken to the family's views.

APPENDIX IVa – Application To the The Science Ethics Committee

Akureyri 31/3/1998

**To the The Science Ethics Committee of the
Ministry of Health and Social Insurance**

I, the undersigned, Hólmfríður Kristjánsdóttir, apply for permission from the Science Ethics Committee to carry out a research project which is a final project leading to a Masters-degree in nursing from the University of Manchester. I also enclose the application which was sent to the Data Protection Commission and their answer and also a written permission from the Head of the Nursing Department at the District Hospital (Fjórðungssjúkrahúsið) in Akureyri where the intended research will take place. The enclosed documents contain all information concerning the research.

Respectfully,

Hólmfríður Kristjánsdóttir, lecturer,
The Faculty of Health Science at the University of Akureyri

APPENDIX Ivb - Application To the The Science Ethics Committee (in Icelandic)

Akureyri 31.03.98.

Vísindasiðanefnd!

Ég undirrituð, Hólmfríður Kristjánsdóttir, sæki um leyfi til Vísindasiðanefndar til að gera rannsókn sem er lokaverkefni til meistaraþráðu í hjúkrunarfræði við Háskólann í Manchester. Meðfylgjandi er umsókn sem send var til tölvunefndar og svar frá henni og einnig skriflegt leyfi frá hjúkrunarforstjóra Fjórðungssjúkrahúsins á Akureyri, þar sem fyrirhuguð rannsókn á að fara fram. Í meðfylgjandi gögnum eru allar upplýsingar um rannsóknina.

Virðingafyllst,

Hólmfríður Kristjánsdóttir, lektor,
Heilbrigðisdeild Háskólans á Akureyri

APPENDIX Va – The Response from The Science Ethics Committee

The Science Ethics Committee of the Ministry of Health and Social Insurance

SG/bó

Mrs. Hólmfríður Kristjánsdóttir
The Faculty of Health Science at the University of Akureyri
Eyrarlandsvegur 20, Akureyri

Reykjavík, 5/5/1998

Concerning: Application for 'Theoretical Framework that Shapes the Nurse-Patient Communication'

According to the application the research will take place solely at the District Hospital (Fjórðungssjúkrahúsið) in Akureyri. It is therefore sufficient that the hospital's Ethics Committee deals with the application and there is therefore no need for the Science Ethics Committee to discuss the matter.

With best regards

Sigurður Guðmundsson,
Chairman of the Science Ethics Committee

**APPENDIX Vb - The Response from The Science Ethics Committee
(in Icelandic)**

APPENDIX VIa – Response from the Nursing Director

Akureyri 6/3/1998

Lecturer

Hólmfríður Kristjánsdóttir

The Faculty of Health Science at the University of Akureyri

Subject: Permission to carry out research in connection with a final project leading to a Masters-degree in nursing from the University of Manchester.

It is delightful that you should choose the Hospital in Akureyri as a scene in gathering information during the making of your final project towards a Masters-degree. The permission is granted and I hope that you will be able to gather the information and receive all other assistance if needed.

Good luck

Þóra Ákadóttir

Acting Nursing Director

APPENDIX Vb - Response from the Nursing Director (in Icelandic)

APPENDIX VIIa – Response from the Data Protection Commission

**APPENDIX VIIb – Response from the Data Protection Commission
(in Icelandic)**

APPENDIX II - Geographical Picture of the Unit

