

Reconstructing Nurses' Relationships with Older Patients



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RECONSTRUCTING NURSES' RELATIONSHIPS WITH OLDER PATIENTS

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Abstract

This book will attempt to deconstruct communication patterns between registered nurses and older patients and propose methods for re-constructing the manner in which nurses and older patients relate to one another. The number of Americans over the age of 65 grew from 3.1 million in 1900 (about 4% of the population) to 35.3 million (12.4%) in 2001 and the population is expected to double by 2030. As older people experience chronic health problems, many become the recipients of inpatient health care services and find themselves in the care of registered nurses. These people are often treated in a manner that can be described as disrespectful and even infantilizing. The majority of older people report that they have experienced what is referred to as over-accommodative communication that uses simple vocabulary, high pitch, slow speech, the use of imperatives, repetition, and terms of endearment. This type of communication can result in an older adult's feeling of increased dependence, lack of control and incompetence.

This project explores how nurses can communicate with older patients such that independence, a sense of increased control, and competency are promoted. Further, focus is on how independence, control, and competency improve health and well-being (both key functions of the nursing profession). Effective, person centered communication can lead to care delivery where people are assessed and treated appropriately and where people understand information that is presented to them and how that information impacts decisions. My hope is that nursing communication with older patients can be grounded in I-Thou relationships (Buber, 1958) where mutuality and honesty prevail rather than I-It where the person is used as an object in need. If older patients feel valued and honored, nurses can open the door to healing, inspiration, and self-determination. Using an appreciative approach, nurses and patients are interviewed and observed in order to understand the qualities and characteristics of their communication and the impact of that communication on participants. Findings from this project can influence ways of thinking in the nursing community so that the dominant discourse will become one of respect and dignity instead of paternalism and control.

Are you in right relation?
Where is your water?
Know your garden.
It is time to speak the truth
Create your community.
Be good to each other.
And do not look outside yourself for the leader.
This could be a good time!
There is a river flowing now very fast
It is so great and swift that there are those who will be afraid.
They will try to hold on to the shore.
They will feel they are being torn apart and they will suffer greatly.
Know the river has its destination.
The elders say we must let go of the shore, and push off into the river,
Keep our eyes open, and our heads above water.
See who is in there with you and celebrate.
At this time in history, we are to take nothing personally, least of all ourselves.
For the moment that we do,
our spiritual growth and journey comes to a halt.
The time of the lone wolf is over. Gather yourselves!
Banish the word "struggle" from our attitude and your vocabulary.
All that you do now must be done in a sacred manner and in celebration.
We are the ones we have been waiting for...

THE ELDERS, Hopi Nation, Oraibi, Arizona, 2000

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Reconstructing Nurses' Relationships with Older Patients

This project explores the relationship between registered nurses and older patients with the hope that those relationships can result in increased independence and a sense of control that result in competency and promotes well-being. Effective, person centered communication can lead to care delivery where people are assessed and treated appropriately and where people understand information that is presented to them and how that information impacts decisions. My hope is that nurses' relationships with older patients can be grounded in I-Thou relationships (Buber, 1958) where mutuality and honesty prevail rather than I-It where the person is used as an object in need. If older patients feel valued and honored, nurses can open the door to healing, inspiration, and self-determination. Using an appreciative approach, nurses and patients are interviewed and observed in order to understand the qualities and characteristics of their communication and the impact of that communication on participants. Findings from this project can influence ways of thinking in the nursing community so that the dominant discourse will become one of respect and dignity instead of paternalism and control.

Chapter One provides an overview of the reasons for the study from my personal and professional perspective. In this chapter I describe two of the most difficult experiences that I have personally faced as a family member

Chapter Two describes the impact of ageism in the health care system and the effects of ageist communication on the well-being of older patients within the healthcare system.

An overview of social construction is provided in Chapter Three. Social construction is concerned with the way we think about the world around us and that reality, knowledge and meaning are all constructed through human interaction. The five assumptions that are inherent in social construction are presented as the foundation for this work and they are:

- The way in which we understand the world is not required by "what there is"
- The ways in which we describe and explain the world are the outcomes of relationships
- Constructions gain their significance from their social utility

- As we describe and explain, so do we fashion our future
- Reflection on our taken-for-granted worlds is vital to our future well-being

An understanding of social construction provides the reader with an alternative way of thinking and talking that is both generative and useful and that is direct contrast to the scientific method that typically defines the nurse patient relationship.

In chapter four, there is an extensive overview of the societal, political, institutional, and financial influences on the practice of nursing. The chapter will attempt to show how these forces have constructed the profession to be more like assembly line workers focused on task achievement rather than relational professionals focused on caring and well-being.

The study methodology using discourse analysis is described in chapter five. Here the reader will find a description of the appreciative approach used and the basis for selecting appreciative inquiry as a guiding principle. In addition, there is a description of the study participants and the general approach to the project.

Chapter six includes the analysis of the discourse and the key findings from the author's perspective. In this chapter there are dozens of excerpts from the hundreds of pages of transcripts as well as the major themes uncovered from the analysis.

In chapter seven the author describes how the following collection of words, phrases and narratives can be brought forth into ongoing conversations about the nurse patient culture and to explore possible ways of going on together. This chapter is an invitation to the reader to further shape this relationship as he/she considers its meaning.

Finally in chapter eight, the author provides her reflections on the perceived importance of the work as well as the limitations that are inherent in the study.

Chapter One: The Heart of the Matter

I believe that we are at a crossroads in nursing and in healthcare all around the world. Many will choose or have chosen the concrete highway that is built on science, evidence, and hard data because it is highly traveled and very familiar but many more are seeking a new path that will lead to places of healing, wholeness, and compassion. There are thousands of nurses who have already begun to flatten the grasses of this path; nurses like Jean Watson who wrote *The Theory of Human Caring*, or Marie Manthey, author of *The Practice of Primary Nursing* and founder of the Center for Creative Healthcare Management, or Kathleen Galvin and Les Todres who wrote *Caring and Wellbeing: A Lifeworld Approach*, or the thousands of Healing Touch practitioners who bring intention and their very presence to millions of patients every day.

The path that I would like to offer is one that brings the simplicity of mindfulness and the beauty of yoga to the practice of modern day nursing. The term nurse comes from the Middle English words *nurice* and *norice*, derived from Latin *nutricia* which means “a person who nourishes” (Dickinson, 2012). For nursing to remain relevant and unique, we need to embrace our role as those who nourish others through our presence, our intellect, and our humanity. This work provides my understanding of how modern nursing has come to be constructed and proposes a new way of being in relationship with those for whom we care through mindfulness and physical and spiritual practices.

This first chapter provides the author’s personal experiences as a young woman entering the field of nursing and as an experienced nurse assuming the role of a family member of a critically and terminally ill patient. Here, I offer the personal and emotional basis for undertaking this work. It is not intended to be a critique or condemnation of the profession of nursing or of the nurses who practice the profession but rather a perspective from the lens of an experienced, proud, professional nurse who is attempting to understand how nurses come to be the way they are with their patients and their families. I provide these observations as an opportunity to reconnect with the ancient practices of healing and caring through the power of relationship.

Early Years

And this conversation with everything – yes through words, but more through presence and attention – becomes the partnership by which we keep everything joined.

(Mark Nepo, 2012, p. 121)

More than 30 years ago, I entered into the field of “nursing” as a patient care assistant in what was known at the time as a nursing home. I worked in a place where people of all ages went when they were no longer able to care for themselves, were too debilitated to be cared for in their own home, or who had no other place to go. The residents remained there until they died. I can still picture the people for whom I cared and the bright but dismal place where I spent most of my summer days.

Each workday it was my responsibility to feed patients, clean their rooms, make their beds, and tend to their very personal care needs such as toileting and bathing. I recall a dark haired, younger man who was blind and developmentally delayed who spent most of his time in the main sitting area listening to television; his name was Danny. I remember two women, confined to their beds, in what must have been either persistent vegetative states or end stage Alzheimer’s disease. Although their names have not stayed with me, I can still see them living out their lives, confined to their beds, day in and day out. I remember how sad I felt when I took care of them and how awestruck I was that life could turn out like that. There were several older gentlemen who were World War I veterans who spent their days roaming the facility in wheelchairs. A couple of them would pat me on the behind when I walked by. I can also recall the staff with whom I worked. There were a few who seemed to have compassion for the residents and there were many who viewed them as objects and impositions. I witnessed what I perceived to be cruel and humiliating treatment more often than I care to remember, particularly to the most vulnerable, but I did my best to bring dignity and kindness to those in my care.

The person who I remember most was a white haired octogenarian who was described to me as difficult and downright mean. No one wanted to take care of him. Mr. Murphy was a very tall gentleman who wore thick, black-rimmed glasses, and was a bit unsteady on his feet. He didn’t leave his room for meals or other types of social activities. He lived his days in his room in the back corner of the facility watching game shows and old movies. The very first time I introduced myself, he yelled for me to get out of his room. Apparently he was in no mood for whatever it was I had to offer. Without any training or

any knowledge of aging, I sensed that there was more than met my eye. I went back and tried to talk to him without much success over the course of two or three weeks. Soon he began asking for me and others gladly gave up their assignments so that I could have the pleasure of his company. What I discovered was that Mr. Murphy was severely hard of hearing and he yelled because he couldn't hear how loud he was. I wonder now why none of the professional staff shared this with the patient care assistants or if they even knew. Most days he kept his blinds closed and sat in the dark because the glare from sunlight bothered his eyes. He had outlived his lovely wife of 50 years and had never been "blessed with children." Other than holiday visits from distant relatives, he was very much alone. We developed a lovely friendship that I will remember always. When I left for college, I visited him during breaks until one day, I went back and he was gone. I went to see him at the hospital where he was being treated for pneumonia. It was so painful to see him as sick as he was, I didn't go back, I said goodbye, knowing that that would be the last time I would see him.

The lessons I learned and the relationships I formed with many of the residents during my summers at Meadowbrook Manor have shaped the nurse that I have become. I have never been satisfied with the simple answers many nurses formulate based on appearances, assumptions, myths, or personal biases. I was horrified by the way many of my coworkers treated the vulnerable human beings in their care. I did my best to make up for the apathy, fear, disrespect, lack of compassion, and in some cases, abuse the residents endured. I have never lost this desire to right what I perceived to be "the wrongs" brought about by caregivers who seem to be are anything but giving and caring.

Over thirty-five years ago, when I applied to nursing school, my personal essay spoke to the care of older people in the United States. In graduate school, I focused on the barriers that exist in the health system for older people. I have spent decades trying to improve care with some success. I have developed programs, provided education, and implemented protocols, policies and guidelines, all aimed at improving care. But what I missed in all of this was attention to relationships. I react strongly to nurses who describe a woman in pain as a "drug seeker" because she asks for pain medicine before it is due or the young adult wracked in pain from a sickle cell crisis as a malingerer, or the eighty-year-old retired nurse as a pleasantly confused, little, old lady. Each of these individuals has a story and personal experiences that can help nurses and other providers better care for them, if they are known and understood.

According to Gergen, “virtually all intelligible action is born, sustained, and/or extinguished within the ongoing process of relationship.” I came to realize that if I were to affect change, my focus needed to be developing an appreciation for the relationships of nurses and patients. This realization was further influenced by very personal experiences with nurses as a wife and a daughter and not as a colleague or a leader. What I saw, heard, and felt moved me to consider this project.

I will primarily focus on my past thirty years of nursing practice for the purposes of this dissertation. The lens, framework, and perspective from which I am conducting this exploration, is based on decades of experiences with nurses who have come to practice more as technicians with ever increasing reliance on data, regulations, policies, and rules rather than as professional, caring practitioners.

Guiding Principles

The goal of nursing, according to Sister Callista Roy, the nurse whose theory has guided my practice, is to promote adaptation in four different modes. The Four Adaptive Modes of Roy's Model are *physiologic needs*, *self-concept*, *role function*, and *interdependence*. In the physiologic mode, adaptation involves achieving equilibrium. Basic human needs, like oxygen, nutrition and water are associated with this mode. The function of the self-concept mode is to maintain integrity and this occurs through one's perceptions of her physical, emotional and spiritual self. When human beings adapt to various role changes that occur throughout the lifespan, they are adapting in the role-function mode. Interdependence involves achieving a balance between dependence and independence. Dependent behaviors include pursuing affection, requesting help and attention seeking. Independent behaviors include mastery of skills and taking initiative.

The nurse's role is to assess, understand, and promote adaptation for individuals and groups in these four modes, thus contributing to health, quality of life, and dying with dignity by assessing behaviors and factors that influence adaptive abilities and by intervening to enhance environmental interactions (<http://nursing-theory.org/theories-and-models/roy-adaptation-model.php>). If actions are leading to positive coping and adaptation, the nurse acts to support and strengthen these actions. If coping and adaptation are not health promoting, the nurse works with the person and her family to uncover interventions that will build upon past successes and lead to positive adaptation (William F. Con-

nell School of Nursing, 2013). This model served as my professional practice model until I discovered a different way of being with appreciative inquiry and social construction.

Today's nursing environment is a significant departure from the theories that influenced so many nurses of my generation and older and I believe that this is a significant source of "burnout" and dissatisfaction. My hope is that through this work, I can begin to deconstruct and reconstruct nurses' relationships with their older patients in order to contribute to quality of life for patients and enhance the practice of the nurses for whom I am responsible.

Theory of Adaptation	
Explicit Assumptions	<ul style="list-style-type: none"> • The person is a bio-psycho-social being. • The person is in constant interaction with a changing environment. • To cope with a changing world, person uses both innate and acquired mechanisms which are biological, psychological and social in origin. • Health and illness are inevitable dimensions of the person's life. • To respond positively to environmental changes, the person must adapt. • Nursing accepts the humanistic approach of valuing other persons' opinions, and viewpoints. • Interpersonal relations are an integral part of nursing. • There is a dynamic objective for existence with ultimate goal of achieving dignity and integrity.
Implicit assumptions	<ul style="list-style-type: none"> • Patient's values and opinions are to be considered and respected. • A state of adaptation frees an individual's energy to respond to other stimuli.
Person	<ul style="list-style-type: none"> • Bio-psycho-social being in constant interaction with a changing environment. • Uses innate and acquired mechanisms to adapt. • Functions as a unity for some purpose. • Includes people as individuals or in groups-families, organizations, communities, and society as a whole.

Health	<ul style="list-style-type: none"> • Inevitable dimension of person's life. • Represented by a health-illness continuum. • A state and a process of being and becoming integrated and whole.
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Table 1 Callista Roy's Theory of Adaptation

From Nurse to Family Member: A Personal Vignette

When my role changed from nursing colleague to a patient's family member, I experienced tremendous sadness, frustration, anger, and despair when I observed how my loved ones were treated by their nurses. When emotional support, compassion, and advocacy were needed most, they experienced apathy, condescension, and control. When they became *dis-eased*, I saw my husband and my mother as the same people they had always been and I expected others to see them that way. They were vital, strong, capable individuals who were fighting for their lives and relying on complete strangers to help them. I can't really say how the nurses regarded them but what seemed to be missing was an appreciation for them as fellow *human beings*. I witnessed nurses and others talking about them in front of them, speaking to them as if they were children, and, in some cases, ignoring them when they needed them most. They were ridiculed, chastised, and discounted. There were some who recognized their distress and worked to alleviate their suffering but these were few and far between. The utter disregard for my loved ones' *humanity* was overwhelming for them and our family.

To this day, my husband talks about how he was "tortured" by his nurse with tears in his eyes. He truly believes that one nurse "tried to kill him" because she would not listen to his cry for help. My husband recovered from his illness but my mother did not. It pains me beyond imagination to know that the day before my mother died, her cries for help were also disregarded. One of the last things she told me was how she was treated by the nursing staff at the rehabilitation facility and how utterly insensitive they were. It took me four months to call the administrator and describe the events that were recounted to me.

When human beings become vulnerable from illness, one might expect that those professionals responsible for their care would act in ways to keep them safe and protect them from harm (*Primum non nocere*). Sadly, this isn't always the case. I assumed that this would be the case in my own hospital on nursing units for which I have responsibility,

but it wasn't. According to the American Nurses Association, *"nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations"* (American Nurses Association, 2014). This was not our experience of nursing.

Jim's Wife's Journey

In 2010, my husband was diagnosed with an extremely rare autoimmune disease, dermatomyositis, where his own body viciously attacked his muscles and his skin. Within weeks he lost 50 pounds of muscle mass and was unable to eat, speak, or walk unassisted. Because of the muscle destruction, he was required to have a tracheostomy (a surgical opening in the neck that made breathing easier) and a feeding tube in his stomach. He went from a vital, successful, 49 year old man to a frail, "difficult" patient who was incapable, through no fault of his own, of communicating his wishes, needs or desires. Jim was about as vulnerable as a person can be and he was experiencing spiritual, mental, and physical anguish. He was treated as if he was a small child in need of strict disciplinary actions.

Except for those six months of his life, Jim has been viewed as a powerful, opinionated, intelligent, vibrant human being. When he became incapacitated, he became vulnerable and impotent. Those feelings have stayed with him and will likely frame his opinions of doctors and nurses into the foreseeable future.

The day that my husband was to have his tracheostomy and his feeding tube placed, Jim's nurse approached me in the waiting room. Not once in the conversation did he call my husband by his name as he described his condition and the life altering procedure he was about to endure. Not long after this incredibly impersonal interaction, I asked to speak with the nurse about his approach. I told him how I felt about the fact that he didn't know my husband's name and suggested that when he approached family members in distress that it could be very comforting to know that the nurse who was providing care actually knew something about the patient. Perhaps it was easier for this nurse to depersonalize his patients rather than identify with them as fellow human beings facing overwhelming suffering.

We spent four months in two different hospitals on at least seven different patient care units. We interacted with dozens of nurses and doctors, varied support staff, and a

few speech and physical therapists. Across multiple settings from the emergency room to the operating room and everywhere in between, we faced nursing staff who responded to Jim as if he were a small child. Many used a tone of voice that one might hear in a day care setting, many ignored him, and even more offered him nothing but clean sheets, tube feedings, and medications. Three years later, Jim and I often talk about our experiences and for him there is still a great deal of anger and a lack of closure. He has even consulted with several attorneys to see if there is anything that can be done to “make up for his suffering”. Because he didn’t die and he is alive and well, there is no recourse. I have encouraged him to contact the Dean of the School of Medicine and the Vice Presidents of Medical Affairs at the respective hospitals and offer to come and share his experience with students, faculty, and staff. Sharing his story with a wider audience, rather than a few lawyers and risk managers, will have more of an impact than a lawsuit. It is critical that care providers hear from the “victims” of their care.

He is not the only one to face this sort of treatment and fortunately for him, he had strong advocates (family and friends) who understood how to navigate the system and who tended his emotional, spiritual, and physical needs. The patients who don’t have advocates inside or outside of the healthcare system are at risk for harm and that harm can come in many forms. A recent government report found that in October 2008, 13.5 percent of Medicare beneficiaries — 134,000 patients — experienced “adverse events” during hospital stays. The report said the extra treatment required as a result of the injuries could cost Medicare several billion dollars a year. And in 1.5 percent of the patients — 15,000 in the month studied — medical mistakes contributed to their deaths. That report, issued this month by the inspector general of the Department of Health and Human Services, was based on a sample of Medicare records from patients discharged from hospitals (Grady, 2010). The Agency for Healthcare Research and Quality recognizes that patient safety is one of the nation's most pressing health care challenges and recommends the following:

- Ask questions if you have doubts or concerns.
- Keep and bring a list of ALL the medicines you take.
- Get the results of any test or procedure.
- Talk to your doctor about which hospital is best for your health needs.

- Make sure you understand what will happen if you need surgery.
- Make sure that someone, such as your primary care doctor, coordinates your care.
- Make sure that all your doctors have your important health information.
- Ask a family member or friend to go to appointments with you.
- Learn about your condition and treatments by asking your doctor and nurse and by using other reliable sources. (AHRQ, 2011)

Each of these recommendations requires the patient to have a voice (literally and figuratively). What happens when you are unable to speak for yourself? What happens when there is cognitive impairment? What happens when you are invisible to those providing your care?

There are categories of vulnerable patients who are at heightened risk for medical errors and harm including those with limited English proficiency, low health literacy, the mentally ill, elderly, children, racial or ethnic minorities, patients in isolation (for infectious diseases) and patients at the end of life. What these people all share is first, the lack of recognition and second, being granted a voice in their care.

According to the American Academy of Family Physicians, the single most important way that people can help to prevent errors is to be an active member of their health care team. This means taking part in every decision about your health care. According to research, patients who are more involved with their care tend to get better results. When they cannot due to illness or other factors, what then?

Nancy's Daughter's Observations

It's so curious: one can resist tears and 'behave' very well in the hardest hours of grief. But then someone makes you a friendly sign behind a window, or one notices that a flower that was in bud only yesterday has suddenly blossomed, or a letter slips from a drawer... and everything collapses. —

(Collette, 2010, p. 38)



Photo 1: Author and her Mother

After being “cancer free” for five years, at the age of 68, my mother (Photo 1) was told that she had recurrent colon cancer and was admitted to the hospital to have the tumor removed. Her hospitalization, which was traumatic in and of itself, was complicated by delirium and other mental status changes. When my mother developed iatrogenic delirium (healthcare acquired mental status changes), she *knew* she was confused *and* she was unable to communicate her most basic needs. She was not allowed to have access to the most basic things like food and drink, bathroom and hygiene activities, or regular communication with her family. For most of the hospitalization, she was confined to a Vail bed, which she later described as a cage. A Vail bed is a bed enclosure made with soft netting that zips up around the entire bed and is used to keep patients “safe”. In reality, it keeps patients in their bed (see photo 2).



Photo 2. Vail Bed

My mother later told me how humiliating it was to experience the effects of delirium and to be treated by health care professionals as if she was a toddler. It was the rare nurse that treated her like an adult and who allowed her to try and make her needs know and/or attempt to interpret her behaviors. Her husband and her other daughters attributed her behaviors to her illness (possible brain metastasis) and felt that she needed to be placed in a nursing home. No one really took the time to explain what was happening to her and what the likely outcome was. There was one person that I will never forget that took time to take care of my mother, a nursing assistant named Miriam who was from East Africa. At one of my visits, Miriam came and asked if she could wash Mom's feet (Photo 3). She told us she did this for all her patients. The effect that this humble act had on my mother and on me was incredibly calming and purely compassionate.



Photo 3. Sacred Act of Washing Feet

Once the medical issues were resolved (except for the delirium) I was determined to get Mom home and in a familiar environment. The night before she left the hospital, she was transferred to a rehabilitation unit. When she arrived on the unit, there was a breakdown in communication and no one came to see her for several hours. She became agitated (angry) and left the unit and went to the lobby to find a ride home. She realized she didn't have a coat so she went to the Gift Shop to buy a coat. The volunteer in the shop called security to come and get her because she thought she was confused. Mom was not pleased. It took three physicians to convince her go back upstairs. She was not confused; she was angry and figured if no one even noticed she was on the unit for sever-

al hours, no one would notice if she left the hospital. As happens all too often, the physicians and the well-intentioned volunteer attributed her disruptive (unexplained) behavior to the delirium and called her husband to try and convince her to stay in the hospital. They insisted that she needed to stay in rehab for a few more days.

I went to visit my mother the day after this incident, expecting confusion and incoherence. I didn't get what I expected, thankfully. It would have been easy to attribute some of her statements to confusion but I quickly determined that my mom was completely coherent (and back to her baseline). My mother's delirium had cleared and she was "fit to be tied" (her words). At that time, she was angry that the staff ignored her until she decided to leave. She was angry that the physicians wouldn't listen to her and she was hurt that her husband agreed with the staff and didn't support her decision to leave the hospital. She was back to normal and ready to go home and resume treatment for her cancer. She was discharged that day and never experienced delirium again.

She and I spent a great deal of time talking about her experience and the feelings of anger, humiliation, confusion, and frustration related to the delirium. I was amazed at how much she remembered. I had always thought that when a person has delirium, there is no memory of the time. She remembered not being able to tell people what she needed and that what she was doing didn't make any sense. She remembered being talked to like a child and having her personal belongings taken away, especially her phone. When I called to speak with her, someone had to go in her room and hand her the phone. Sometimes she made sense and sometimes she didn't. Even when she couldn't clearly communicate, her granddaughters and I still called. I believe it was comforting for her to hear our voices and she remembered talking to us.

This was not my mother's last painful experience with healthcare providers. She continued her treatments until her body could no longer withstand the assault of chemotherapy. Her last few weeks were spent in a rehabilitation facility where they hoped she could get stronger in order to receive a new study drug. She didn't get stronger and her cancer progressed until she had an intestinal blockage that could not be surgically removed. While we were in the emergency room waiting to see what the cause of her vomiting was, she told me how she was treated the previous evening. Her simple request to have a clean nightgown to wear to the hospital was denied. The attendant who was with her didn't clean her up or help her change. She was too sick to be angry but I knew

how much it affected her. Later that day, she was transferred to a palliative care unit where she and her loved ones received wonderful care in her last days.

There is a sacredness in tears. They are not the mark of weakness, but of power. They speak more eloquently than ten thousand tongues. They are the messengers of overwhelming grief, of deep contrition and unspeakable love.

(Washington Irving, 2008, p. 38)

Both of these experiences now shape my professional goals and aspirations. I have spent the past several months sharing my stories and trying to help nurses understand what is important to their patients, from my perspective as a nurse and a family member. Whether patients are unable to express themselves to their caregivers (for whatever reason) or they experience social isolation, or become dependent on complete strangers for their most basic of needs, they experience a threat to their physical, emotional and spiritual safety. They experience helplessness and anonymity. Nurses and others who are successful in eliciting the voice of vulnerable patients and validating the needs of their fellow human beings through compassionate, professional, and humane care allow the patient to experience healing and wholeness. This aspect of care is more important than any treatment, medication, or intervention the best hospital in the world has to offer.

This project came about not only as a result of personal and professional experiences and dozens of conversations with like-minded nurse leaders from across the United States but also with encouragement from hundreds of practicing nurses who desire something different from their practice. The nurses and nurse leaders with whom I have shared my work and my insight into relationships in nursing are in total agreement that it is time for something new, vibrant, and full of compassion. It is my hope that the reader now understands that this is not simply a dissertation project; this is an attempt to understand the existing relationships between nurses and their patients in order to transform what is technical, scripted, and methodical into something that is sacred, compassionate and healing.

Chapter Two: The Business of Health Care

This chapter situates the project presented in this dissertation and provides the demographics of aging as well as a perspective of how an older person might experience being older in a complex and often impersonal system of treating illness and disease.

The Project Setting

The present project was carried out in a 900-bed tertiary care facility in central North Carolina that serves a community of approximately 350,000 with a racial makeup of the county being 63% non-Hispanic whites, 26% African-American and 9.5% Latino. Twenty-four percent of the population is under the age of 18, 10% from 18 to 24, 31% from 25 to 44, 23% from 45 to 64, and 13% who were 65 years of age or older. The median age was 36 years. About 11% of the population was below the poverty line, including 10% of people age 65 and over.

The hospital where the project was conducted is part of an integrated health system that employs more than 5000 registered nurses. Sixty-five percent of the nurses at this facility have an Associate degree (technical three year degree) in Nursing and the average age of the nurse is 44 years old. One in three people employed in the county works in the health care sector.

Facts and Figures

Older adults constitute a majority of people who receive nursing care in the United States. By the year 2050, 19 percent of people will be over 65 and one in five of those will be over 85. According to the U.S. Census, the number of centenarians is expected to exceed one million. The health care needs of these older patients are diverse and highly complex and few healthcare professionals are adequately prepared to meet them. About 80 percent of older people have at least one chronic problem and 50 percent have at least two. The focus of healthcare for older people is the prevention of functional decline and minimization of the loss of independence because so many experience chronic problems. Less than 40 percent of older people have current immunization status and many do not get preventative services such as mammography or colorectal cancer screenings that can prevent or minimize decline. In spite of these challenges, however, people have a life expectancy of an additional 17-19 years once that reach their sixty-fifth birthday.

Healthcare leaders, policy makers, and advocacy groups have known for years that the population is changing and that the needs of the older population will present many challenges. Despite forty years of growing anticipation, we are nowhere near where we need to be to provide age appropriate, cost effective, quality care. Nationally, there are less than 7000 gerontological certified nurses, compared to 40,000 certified critical care nurses (Briggs, Brown, Kesten, & Heath, 2006). While leaders in nursing education and gerontology recognize the importance of specialty training, there are only 110 geriatric nurse practitioners enrolled every year and while one out of three patients cared for by a nurse is over 65, less than a third of these nurses have received geriatric specific training. One of the reasons we have not adequately trained students and providers of health services to meet the needs of the older population could be due to widespread ageism in healthcare and in our social systems. Without an understanding and appreciation of the needs of our older patients, as well as the needs of the nurses who are providing their care, it will be nearly impossible to improve their health care experiences.

Prior to detailing the study conducted for this dissertation, a description of the background that frames this study is offered. This includes a description of ageism and ageism in healthcare and the impact of ageism on the older person. The concept of Elderspeak is introduced and the consequences of this mode of communication are then described to round out the foundational concepts of this work.

Ageism

Age prejudice is one of the most socially conditioned and institutionalized forms of prejudice in western or developed countries. In 1969, Robert Butler coined the term "ageism" which he described as a stereotypical, dehumanizing, negative construction of the way in which we experience older people. He suggested that ageism is an ideology that is held by younger people in order to legitimize the way older people are treated. Ageism is typified by depersonalized views of the disempowered group (older people) that is sustained through societal structures (Phelan, 2010). There are three different domains within ageism including: cognitive (which manifests in beliefs), affective (related to our attitudes), and behavioral (which impacts both direct and indirect practices). The three major constructs of ageism are that 1) old age disabilities are universal, 2) old age disabilities are irreversible and 3) disabilities are determined by biological processes and therefore unavoidable (McMinn, 1996).

The qualities of youthfulness that are blatantly promoted in the western culture surreptitiously support the prevalent view of older people as frail, disabled and/or impaired. Professional ageism, or the belief amongst healthcare providers that aging is equivalent to deterioration influences the entire system's approach to older people and ultimately to the care that they receive (Phelan, 2010).

Ageism allows young people to see older people as different from themselves. In order to reduce the sense of fear and dread of aging and death many young people cease to identify with their elders as human beings which allows them to ignore the plight of some older people (McMinn, 1996). This is particularly concerning in nursing where the ethical responsibility of nurses is "in all professional relationships, practice with compassion and respect for the inherent worth and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems" (ANA Code of Ethics with Interpretive Statements, 2001).

A study conducted in the early seventies, when ageism became a topic of interest, attributed increased negative attitudes towards elderly as being related to increased and functional disability of the older person and the lack of clinicians' interaction with older people. A more positive attitude is related to the perceiver's level of education and prior positive experiences with older people (Haight, Christ, & Dias, 1994). An Australian study showed that the most widely quoted explanation for ageist attitudes is the fear of aging, which is reinforced by culture and the media (McMinn, 1996).

Old age hasn't always been an "ism"; in fact getting or being older was once seen as a quite beneficial. In the mid 1800's a long life was attributed to moral superiority. At that time, someone who lived more than 50 years was believed to be chosen by God. Some social scientists have even suggested that attitudes about older people can be linked to the invention of the printing press which affected the status of elders as the village historians and to the industrial revolution that created increased mobility, impacted the extended family's ability to stay together, and created jobs suited to younger workers (Nelson, 2005).

Political discourses that come in the form of political speeches, governmental priorities, and administrative imperatives become integrated into social policy and can influence how people think about older members of society. Major advances in health care and longer life expectancy came at the same time as the industrial revolution causing even more challenges such as costs of care, forced retirement, and increased dependency in

the oldest of old. Old age became associated with negative qualities and older people came to be regarded as burdens to society and social order because society was not prepared for the numbers of older people. Sadly, these negative qualities/attributes have persisted until today (Nelson, 2005).

We do not believe in ourselves until someone reveals that deep inside us something is valuable, worth listening to, worthy of our trust, sacred to our touch. Once we believe in ourselves we can risk curiosity, wonder, spontaneous delight or any experience that reveals the human spirit. (Cumings, 2004, p. 126)

Ageism in Healthcare



Figure 1. Independent Cartoon from August 1913

Imagine a five-year-old patient arriving in a state of the art pediatric emergency room, covered in bruises, dehydrated, and disheveled, striking out at the doctors and nurses and demonstrating uncontrollable behaviors. The response would likely be one of great care and concern for the child's safety and wellbeing. The entire team would come together to assure that the child got the care that she needed. Now imagine that the same patient is 85 years old. The plan of care may not be as compassionate or as thorough as the child's because the treatment of older patients in healthcare facilities does not typically match the treatment of other patient populations because the symptoms or problems that older patients present with are often minimized or overlooked (McMinn, 1996).

In addition to gaps, mismatches and imbalances, the effects of covert rationing cannot be overestimated. Data shows there are consistent decreases in the use of resources across a range of interventions that cannot be explained by severity of illness, functional ability or general preferences (Mick & Ackerman, 1997). Aging typically involves an increased utilization of healthcare services for older Americans due to the prevalence of chronic conditions with advancing age. However, there is a disturbing trend in the current state of elder healthcare. For example, based on the ILC's 2006 report on ageism in America,

- 35 percent of doctors mistakenly consider an increase in blood pressure to be a normal process of aging and often treat unnecessarily.
- 60 percent of adults over 65 do not receive recommended preventive services, and 40 percent do not receive basic vaccines for flu and pneumonia. •
- 90 percent of people aged 65 and over do not receive appropriate screening tests for bone density, colorectal and prostate cancer, and glaucoma regardless of the fact that the average age of colorectal cancer patients is 70, more than 70 percent of prostate cancer is diagnosed in men over 65, and people over 60 are six times more likely to suffer from glaucoma.
- Chemotherapy is underused in the treatment of breast cancer patients over 65.
- Older Americans are the biggest users of prescription drugs, yet 40 percent of clinical trials excluded people over 75 from participating.
- Older patients are significantly underrepresented in clinical treatment trials for all types of cancer.
- In 2005, Congress eliminated funding for geriatrics education and training in the 2006 Labor-Health and Human Services appropriations bill (International Longevity Center, 2006).

In 2003, E. Wesley Ely, MD, MPH, of Vanderbilt University School of Medicine, noted that people 65 or older account for more than half of all intensive care unit (ICU) days nationwide, and people 75 or older account for seven times more ICU days than those under 65. In addition, older adults represent 50% of hospital days, 60% of all ambulatory adult primary care visits, 70% of all home care visits, and 85% of residents in nursing homes (Thornlow, Latimer, Kingsborough, & Arietti, 2006).

Further research done by Ely uncovered obvious evidence of age bias in ICUs. He noted that while older ICU patients generally require more interventions and resources,

they actually receive less aggressive care than do younger patients; in fact, the use of mechanical ventilation in the ICU sharply decreases in patients 70 or older (Currey, 2008).

Additionally, there is compelling research that suggests that preventive care addresses many of the healthcare concerns that face older Americans. Aside from mitigating the impact of disease, lengthening life, and improving quality of life along the way, prevention saves money in personal and government budgets. Unfortunately, prevention doesn't generate revenue and it doesn't fill hospital beds (Currey, 2008).

Typically, an older person's perception of quality of life is associated with self-esteem, friendships, work/recreation and access to medical care. This view, however, is inconsistent with healthcare providers' perception of the patient's quality of life that is only related to the patient's medical prognosis (Mick & Ackerman, 1997).

Impact of Ageism

But there are many languages as there are callings, and we can learn from each of them. One is not superior to the other. The woodworker, the gardener, the horse trainer, the gravedigger – each has their own language to discover, an experience at a time.

(Mark Nepo, 2012, p. 128)

Ageism in nursing in particular is manifested in: stereotypes and myths, outright disdain or dislike, subtle avoidance, distant/cold manner, baby talk and elderspeak, and attending to completion of tasks without personalized conversation (McMinn, 1996). Ageist attitudes directly impact the care that older patients receive from the policy level all the way to the personal relationship with care providers. Based on utilitarian based attitudes of health care providers (exacerbated by health care reform), older patients who take more time, are labor intensive, and costly may not be perceived as deserving of care. In addition, ageism results in the gratuitous application of negative stereotypes and the continuation of discrimination and inequity in the care provided (McMinn, 1996). A poor prognosis, cognitive impairment, decreased quality of life and social worth and limited life expectancy are attributed to older people strictly because of their age in spite of strong evidence that most people remain at the ability level until very late in their life. Ageist attitudes influence discussions around limiting care and can result in recommendations to "die and get out of the way". When the belief is that it is beneficial to deny care, a care

provider can feel good knowing that he/she benefitted society and helped an elderly patient live without the pain and suffering of medical treatment (Mick & Ackerman, 1997, p. 598).

In the United States, it is widely accepted that age is defined by physical attributes and old age is marked by inevitable decline. When older people are treated as if they are in decline, older people begin to view themselves as being in decline and define themselves as old or “elderly”. Research from just thirty years ago suggests that, at that time, ageist assumptions were widespread. It was believed that older people couldn’t hear, remember, or think for themselves and that they were depressed, non-productive and infantile (Gordon, Ellis-Hill, & Ashburn, 2008). Ageist discourses legitimize attitudes, beliefs, and practices that lead to infantilization. With this, self-determination then gives way to patronization and negative self-images become self-fulfilling and reinforces ageist attitudes (Phelan, 2010).

The current view of old age has not changed and it is reinforced by what nurses and other care providers see in the hospital or health system, which reinforces their beliefs about aging and decline. Because of the prevailing decline discourse, older adults in the US tend to be marginalized, institutionalized, and stripped of responsibility, power and dignity.

The messages that healthcare professionals consistently receive regarding aging suggest that the risk for age related changes begins to double every 5-7 years after age 50. They are also told that as the population ages and falls prey to chronic diseases that cause disability and loss of daily function, the need for long-term care will grow in magnitude and costs will be unimaginable. This dominant discourse influences how healthcare providers approach the care delivery services for older patients (Guralnik, Alexih, Branch, & Wiener, 2006). We know that 72% of people over the age of 85 are women and 74% of older women are poor and these trends likely contribute to the discourse of older adults as frail, poor women. Women who are no longer productive (or fertile) become a societal problem, because of this, many older women lose what power they possessed and come to identify with stereotypes and internalize ageist attitudes (Letvak, 2002).

Issues related to fragility, disability and disengagement dominate the focus of current geriatric literature. A recent Alliance for Aging Research report revealed “the enormous economic and social costs which result from lost independence” and provided the following recommendations:

1. increase funding for research with an emphasis on diseases that cause disability,
2. reform Medicare to reimburse based on improvements in functional health,
3. fund research for improved outcomes for chronically ill and elderly to improve access and decrease unnecessary costs,
4. increase the focus on prevention to postpone illnesses that affect the loss of independence,
5. improve population and cost data on conditions that affect health and independence and provide better training for medical providers to assess risk for disability (Guralnik et al., 2006).

Amanda Phalen (2010) describes three primary discourses of old age; biomedical, theoretical, and political that mediate how older patients are perceived in society and its healthcare institutions and directly impact the delivery of nursing care. The biomedical approach that conceptualizes aging as a time of physical decline has dominated the study of gerontology since its inception. The biomedical construction of aging has influenced care of older people by focusing on a reductionist approach that privileges physiological and pathological perspectives over all else (Phalen, 2010). For decades, philosophers and scientists have been studying experimental evidence and using observations to develop theories explaining why and how we age. As late as 1990, researcher Zhores Medvedev attempted to categorize more than 300 physiological theories of aging. Recently, scientists have started to come to a consensus about why and how we age. They have even narrowed the specifics of what affects how we age down to several significant hypotheses (American Federation for Aging Research, 2011).

Like the biological theories of aging, many psychological theories have focused on decline associated with aging. The activity theory hypothesizes that self-identity is related to the roles one assumed throughout life. As aging occurs, roles change and alter self-identity and that negative aspects of aging can be counteracted by participation in social relationships, roles and activities. This theory suggests that those who maintain high levels of activity will be more successful in aging (Harwood, 2007). The disengagement theory suggests that older people naturally withdraw as they age. As aging progresses, the older person interacts less and less until death. This natural withdrawal prepares the older person and society for the problem of death. Older people are located in “marginalized subject positions as they disengage from employment” and are viewed not only in terms of their physical decline but also in terms of the economic burden they

impose on society. This discourse can be seen in the paternalistic approaches to care that are currently heard in nursing practice (Phalen, 2010, p. 899).

Social theories of old age that began in the late 1930's came about with concerns related to demographic changes and younger worker shortages. Theorists like Talcott Parsons argued that society expects or requires certain functions of its members to preserve social order. He believed that human beings make up a social system with individual "actors interacting with each other in a situation which has at least a physical or environmental aspect, actors who are motivated in terms of a tendency to the 'optimization of gratification' and whose relation to their situations, including each other, is defined and mediated in terms of a system of culturally structured and shared symbols" (Parsons, 1991, p. 3). As people interact over time with people who are similarly oriented and a pattern of interactions and corresponding positions, roles and norms are created. Positions, roles, and norms are then expected and have positive or negative sanctions attached to them. Being elderly or aged, therefore is defined and mediated by the social system (Parson, 1991).

The political discourse of aging as a social problem has been influencing our culture since World War II, when the creation of pensions fostered structured dependency. Legal systems around the world have functioned to isolate older people as vulnerable and dependent by providing "special" recognition (Phalen, 2010, p. 899). The political discourses that reinforce the concepts of vulnerability, dependency and disempowerment are commonplace, not only for nursing students but for most of the Western world (Phalen, 2010).

The theoretical discourses of old age described above directly influence nursing practice. Most nursing students are exposed to the biological theories that are found in medical-surgical texts. In Brunner and Suddarth's Textbook of Medical Surgical nursing, a popular reference for nursing students, there is brief summary of the causes of aging. This summary describes intrinsic and extrinsic theories of aging and provides the students with the perspective that "cellular and extracellular changes of old age cause a change in physical appearance and a decline in function" (Hinckle & Brunner, 2014 p. 188). Some have brief introductions into the social, developmental or psychological hypotheses. These perspectives of aging promote a deficit-and-decline-based understanding of aging and leaves nursing students with a negative view of older patients that persists after graduation with very few nurses who pursue careers in gerontological nursing and less

than 3% of all practicing nurses with gerontology specialty certification.

Elderspeak

Given the current view of aging and the impact that has had on healthcare and nursing, in particular, there is a need to understand how these discourses affect the relationship between nurses and their older patients. The impact of ageism on nurses' interactions with their older patients particularly related to elderspeak (overaccommodative speech, infantilization, and baby talk) is well documented in the literature. In a study conducted with older people who listened to audio recordings of nurses talking to older people categorized 22% of utterances as baby talk and 75% of the recordings of nurses talking to older patients were interpreted as being directed at nursery school children (Brown & Draper, 2002). Another study found that 59% of older adults have experienced over-accommodative speech, 36% say it happens often, 58% of older people believed that older adults are spoken to in over-accommodative manner, 15% felt inferior when spoken to in that manner, and 58% felt patronized because of it (Brown & Draper, 2002).

Communication approaches that utilize elderspeak are characterized by slower speaking rate, exaggerated intonation, high pitch, increased loudness, more frequent repetition, simpler vocabulary, patronizing talk, feigned deference, controlling talk, inappropriate use of pronouns, terms of endearment, and decreased grammatical complexity (Ryan, Meredith, MacLean, & Orange, 1995). The result of this type of communication is an imbalance of care and control in the nurse patient relationship. Overly directive or bossy tones reflect a high degree of control without recognizing the autonomy of the older person. Possible consequences of over-accommodation are fostered dependence, lowered self-esteem, avoidance of speech situations, and acceptance of impolite speech. When over-accommodative speech is accepted as normal, those in power (nurses, in this case) use language in a controlling way where their or their organization's agendas are given more value than the older person's needs (Brown & Draper, 2002).

In addition, overly nurturing or baby talk on the part of nurses reflects inappropriate intimacy. Some authors have suggested that this style of speech could be an attempt to soften directness and others have proposed that the Speech Accommodation theory where it is believed that nurses may modify aspects of their speech in response to their evaluation of their patients (Williams, Kemper, & Hummert, 2005; Brown & Draper, 2002). The message that is conveyed (in spite of good intentions or because of stereotypi-

cal evaluations) is that an older adult is incompetent and it reaffirms the older adult's feelings of lack of control and incompetence. Not only does elderspeak fail to enhance communication, it reinforces dependency and engenders isolation and depression and contributes to a spiral decline that occurs when the older person begins to avoid social interaction, resulting in a loss of self-esteem and increased dependency (Whitmer & Whitbourne, 1997). This approach to older patients may not be intentional and often times the communicator (nurse) is unaware of his/her use of elderspeak or overaccommodative speech. However, the results are quite incongruent with nursing's goals to maintain and promote well-being of all patients, regardless of age.

Not all nurses use this type of approach with older patients and my hope is to better understand how the nurse-patient relationship is impacted by and how it impacts elderspeak and overaccommodative speech. We are facing the perfect storm in nursing and in healthcare with the growth of the older population and the spiraling costs of care. If nurses are communicating in a way that promotes dependency and that is not heard or valued by the receiver, they cannot impact health and well-being. Our older patient population deserves the best possible care we have to offer. Understanding how nurses and older patients relate to one another in a positive way can help us do just that.

This chapter has provided an overview of the beliefs about, and attitudes towards, older people in the United States. The impact of those attitudes and beliefs are presented as a means of setting the context for the social conditions that support how older patients are treated. The next chapter will describe my understanding of social construction and the complexity of the construction of the nurse-patient relationship.

Chapter Three: Social Construction

In the first part of this chapter I present my personal journey from a traditional, scientific approach to one that embraces the intricacies and complexities of a social constructionist approach. In the second part of this chapter I present how meaning is made through collaborative activities. From this point of view, we are creating meaning through our relationships with one another. This context is used for better understanding nurses' and patients' relationships with one another. The final part of this chapter describes relational responsibility and the possibilities that exist for transformation with an understanding of the importance of dialogue and conversation within relationships. The concept of dominant discourse is described along with the influence of some of the dominant discourses that exist within nursing. In the last section of this chapter, I share my understanding of status degradation in nursing and in "patienthood".

My understanding of the relationship between nurses and patients is presented through interpretation and analysis of several conversations with nurses and older patients and a lengthy discussion of the cultural, political, and institutional influences on the practice and the resulting interactions. However, I understand that "meaning derives from interactive interpretation by multiple persons, not simply from the cognition of a single individual" (Miranda and Saunders, 2003, p. 88). I know that the reader too will impose his or her subjective meaning into the work and that his/her interpretation will be based on biographies, positions in the social setting and even the social setting (Miranda and Saunders, 2003, p. 88) and our interpretations may be very different. It is my hope that this work will lead to meaningful dialogue about what it means to be a nurse and what it means to be a patient and how those two roles can come together to bring about healing and a sense of wellbeing for both.

We are talking here of the grammar of the words "reason" and "cause": in what cases do we say we have given a reason for doing a certain thing, and in what cases, a cause? If one answers the question 'Why did you move your arm?' by giving a behaviouristic explanation, one has specified a cause. Causes may be discovered by experiments, but experiments do not produce reasons. The word 'reason' is not used in connection with experimentation. It is senseless to say a reason is found by experiment.

(Ludwig Wittgenstein, 2012, p. 114)

When I began this project, my belief was that I could explain ageism as the reason that nurses interacted with patients in a manner that I considered disrespectful. I plowed through the literature for the “mathematical argument” for my theory and found that there is no shortage of “evidence” (Haight et al, 1994; Guralink et al, 2006; Mick & Ackerman, 1997; McMinn, 1996; Traxler, 1980; Williams et al, 2005; Higgins et al, 2007; Williams, 2006;; Ragan & Bowen, 2001). The “evidence” shows that nurses communicate with older patients in an overaccommodative, condescending manner because they have ageist attitudes. Furthermore, the studies show that this relationship can be enhanced through education and sensitivity training. Then, after revisiting several texts on the topics of Social Construction, Appreciative Inquiry and Relational Responsibility, my approach and my project changed. I stopped looking for causes and started looking at relationships and what I saw through my relational lens was very different from where I first started. An understanding and appreciation for social construction helped me to understand the relationship between nurses and patients as being a fluid, dynamic, process that exists because of hundreds of other relations and that any representation of that relationship is relative and arbitrary and open to interpretation. The social constructionist brings “new-found attention to the ingenuity needed to transcend the shortcomings of prior human constructions” (Lock and Strong p. 353). These constructions assume an objective nature as “facts” in the social world until they are reconstructed. Appreciative Inquiry provides a mechanism for envisioning what the reconstructed relationship can look like. Appreciative Inquiry studies have helped me to see that there are numerous possibilities for the future of these relationships and through engaging in more useful (appreciative) questions (inquiry), the relationship itself can be transformed. An understanding of relational responsibility helped me to shape my recommendations for moving forward with a different way of being. With a broad understanding of these concepts, I chose a reflexive, narrative approach to this work that would seek to understand the complexities and nuances of these relationships that would not be possible with a quantitative study that asked certain privileged questions and not others. I didn’t believe a traditional survey could help me understand how to move forward in a transformative, generative way.

Elderspeak, ageism, and *overaccommodative* speech ceased to be my focus. Once I stopped looking for causes, I saw compassion and caring and humor and light-heartedness, in addition to objectification, coercion, and forcefulness. I had been labeling something I didn’t understand because I wasn’t looking for the relationships that created

this way of being; I heard words and tone of voice. My attachment with the words “sweetie” or “honey” or “dearie” was based on what I read in nursing and medical journals. According to the research, these “terms of endearment” indicated a lack of respect and paternalism and were directly related to ageist prejudices. I think I had a celebration of what Ken Gergen (2009) refers to as “critical reflexivity” (which he describes as a moment when one’s view of what is seen as the obvious is suspended) which allowed me to consider alternative framings of reality as well as recognition of the influence of nursing, medical and cultural traditions. These traditions act as structures that support healthcare providers in choosing certain acts over others out of necessity to be understood and/or to create meaning.

Social construction is concerned with the way we think about the world around us. Social constructions believe that reality, knowledge and meaning are all constructed in human interaction. In *An Invitation to Social Construction*, Ken Gergen (2009) describes the five assumptions that are inherent in social construction.

1. **The way in which we understand the world is not required by “what there is” (p. 5).** Other ways of being and talking are possible and our versions of what is “truth” are optional. This is significant for this work because I was looking for a way out of the current reality in nursing. This assumption allowed me to see the possibility of a more promising future instead of simply retooling, revising or redesigning the current way of being in relationship.
2. **The ways in which we describe and explain the world are the outcomes of relationships (p. 6).** Words and phrases acquire their meaning through “game-like” relationships. There are limited numbers of responses that can be made to what is said. For example, if I were to ask a patient what brings them to the hospital, there are responses that are reasonable and if I were to ask a stranger what brings them to the hospital while standing in line at the grocery store, they would be very concerned or confused. This is important because it provides us with an understanding that “objectivity and truth are not byproducts of individual minds but of community traditions” (Gergen, 2009, p. 6). How nurses and patients interact, therefore is not based on individual minds and their choices but rather is based on culture and history. This assumption is significant for this work because it provides context for nurse - patient relationships instead of looking for a single cause and a prescribed solution. Understanding that individual choices are not responsible for relationships can lead to a more

comprehensive, transformative approach that is based on relational responsibility rather than blame and shame.

3. **Constructions gain their significance from their social utility (p. 9).** As we relate to one another, we develop reliable patterns of coordination. These patterns follow conventions about what is acceptable and what is not. We relate together in patterns that have the character of rules of a game that prescribe what is acceptable and what is not and can be thought of as cultural traditions. For many years, in many locations, I have noted that nurses' communication with older patients in a manner similar to that of a parent and a small child is seen as acceptable in the nurse/patient culture. The treatment of older people as being dependent and childlike is not necessarily accurate or true but this manner of treatment has come to function as true within the hospital and nursing home culture. This "truth" helps both nurses and patients function in ways that are practical and helpful in their world/culture. Studies have shown that this aspect of the relationship is not necessarily beneficial outside of this world and perhaps in many circumstances it is oppressive and can undermine the older person's ability to function as an independent, thoughtful member of the healthcare team. The fundamental social construction assumption that it is through relationships that we create ways of going on together that include our words, action, objects, and environments, helped me understand that this tradition had some social utility or it would not be prevalent. An understanding of that utility would serve to help me reframe and rethink an approach to re-constructing that relationship to one that is more appreciative and conducive to healing and self-actualization for the older person (Gergen, 2009, p. 9).
4. **As we describe and explain, so do we fashion our future (p. 11).** Without shared languages of description and explanation, the institution of nursing would cease to exist in its current form. The world of nursing would be meaningless without words like "patients", "medication", "assessments", and "the nursing process". When I have asked nurses about the terms of endearment used for older patients (or patients with cognitive impairment), they become confused and somewhat defensive. I have been told that it is meant to be caring and in no way offensive. For these nurses, it is just a way of being "friendly" rather than disrespectful. If they were to abandon the overaccommodative language of elderspeak, the long standing traditions of kind, motherly, caregiver would come under threat and when traditions come under threat, there is fear, hopelessness and frustration (Gergen, 2009, p. 11). With an understanding of the assump-

tion that if we desire change, we will need to shake up our traditional, maternalistic way of constructing our world and generate new ways of making sense, not only for the nursing culture but for the well-being of today's older people who seek to maintain their voice for as long as possible in as many aspects of their lives as possible.

5. Reflection on our taken-for-granted worlds is vital to our future well-being (p. 12).

"Every tradition closes the doors to the new; every bold creation undermines a tradition." (Gergen, 2009, p. 12). Within the tradition of nursing, there are many good reasons, validated evidence, and honorable values that have constructed the relationships that exist between nurses and older patients. For these relationships to change, it is critical to suspend what may seem obvious to many, listen to alternative framings of reality, and consider the implications for changing reality from a variety of perspectives. It will be essential to honor and release what has been taken for granted for many years but this will not be possible without dialogue that will recognize the legitimacy of traditions but will also invite new possibilities.

I have taken these assumptions as the foundation for my work in understanding and transforming nurse and older patient relationships. You will see these tenets threaded throughout this work, along with the assumptions of Appreciative Inquiry and Relational Responsibility.

Meaning is created through collaborative activities. "Reality" is created through social interaction; whatever exists and whatever happens has no meaning in itself but its meaning can only be created through social interaction. The reason for this is that a word or utterance can have multiple meanings depending on the context in which it is spoken. Meaning depends on the response of the person to whom the act has been directed. If the speaker confirms the meaning implied by this reaction, a meaning has been constructed (Gergen, 2009, p. 12). Furthermore, meaning is established by an active negotiation towards agreement in the course of communication (Lock and Strong, 2010, p. 353). When a nurse addresses a patient as sweetie, the meaning depends on the reaction of the person to whom this has been directed. If this is received as offensive; meaning has been constructed. If this is received as comforting; meaning has been constructed. Terms of endearment are not inherently offensive or disrespectful but dependent upon the relationship established between the nurse and the patient.

Gergen suggests, "virtually all intelligible action is born, sustained, and/or extinguished within the ongoing process of relationship" (Gergen, 2009, p. xv). He calls this

process co-action. During an interaction, an observation may be elaborated on, which then lends further weight to the primary intention and extends its meaning. Furthermore, a person is never completely free in making the *first* utterance in an interaction. She is rather part of a tradition, established in countless similar situations before (by her society at large and by herself) that guides her in choosing among endless possible acts that fit the situation according to the tradition and are therefore likely to be understood. So when a nurse and a patient enter into a conversation, they are never alone in this conversation. This conversation has been crafted by millions of others before them and there are typically no alien arrivals into the conversations that make up the nurse patient relationship. A nurse would never offer a patient a tennis racquet and a patient is highly unlikely to talk to his/her nurse about the stock market (Gergen, 2009, p. 32).

The choice of response from patients, likewise, is guided by tradition. There is a socially constructed way to be a patient, which typically means being dependent and oppressed. Social constructionist writers refer often to Foucault's concept of "discourse" and to Wittgenstein's concept of "language games" to support this notion of a tradition that guides the interactions of people. In both concepts, language plays an essential role in constituting our social world. Professional, educational, cultural and organizational traditions influence the nurse's first utterances with patients and they influence the patient's receipt of the words. Thus, in acting within their tradition(s), actions serve as an expression of tradition or of their discourse. Every time people act according to their tradition they strengthen it further, confirming its guiding power for future interactions. Therefore, "dialogues both express and constitute social reality. In other words, our conversations both express and help to create our particular world in which we and others live" (Gergen, 2009, p. 8). When patients wait to be told what to do or reluctantly accept plans not of their choosing, they are participating in the construction of the reality of patienthood.

If meaning is produced locally in relationships and in traditions, then words are not unchangeably representative of a certain reality. Rather, whether or not their depiction or meaning is regarded as "true" will depend on the local context or tradition. Therefore, knowledge is not absolute but valid only within a system of rules and conventions which Wittgenstein called language games (Sampson, 2008, p.101). Gergen proposed, "as we relate together we come to develop reasonably reliable patterns of coordination" (Gergen, 2009, p. 9). These patterns are similar to the rules of a game that describe what is ac-

ceptable and what is not. Our relationships are similar to games in the way in which we agree to go on together (Gergen, 2009, p. 9).

Gergen (2009) takes a closer look at the situation of people in interactions and introduces the concept of confluence, or the sum of those things and happenings in a given situation that make up its meaning. Confluences, like traditions, influence the spectrum of possible actions. The most profound consequence of interactions is that, there is no meaning without the other and therefore I am not without the other. The central proposition of social construction posits that there is no self without the other and no reason or emotion as the sole possession of an individual mind; these exist only through relationships (Gergen 2009). Nurses and their patients exist through their relationships. Pain, discomfort, suffering and other “feelings” are particularly relevant to the nurse patient relationship. The ongoing discourse between the nurse and the patient as well as their cultural practices contribute to the expression of emotions and the expression of pain and suffering.

Some social constructionist writers speak more to the ethics of agency and the more practical question of how we can shift our interactions to a mode that is more aware of the mutual creation of meaning and therefore more open-ended and tolerant. They are concerned with how to shift the mutual, relational construction of reality in our private as well as in professional lives to a more constructive, less confrontational mode. If we do shape reality through language and actions in our immediate relationships and if these in turn shape further relationships in a theoretically vast network then we indeed have an immense responsibility and we have infinity possibilities (McNamee & Gergen, 1999, p. 22).

If we did not distinguish between success and failure, and place such value on being successful, for example, we would not suffer because of failure.

(Ken Gergen, 2009, p. 26)

I had determined that success, in terms of the nurse patient relationship, needed to fit in my definition. I had defined successful (e.g. respectful) communication as the way that I communicated with older patients. Failure was therefore, disrespectful communication. What I have come to realize is that communication between nurses and their older patients represents “the intersection of multiple relationships” instead of good or not good

(McNamee & Gergen, 1999, p.22). My hypothesis and predictable answer was far too simple and lacked the depth, breadth, history, and culture of nurses and patients, healthcare, the community, and the organization.

Intergenerational relationships thrive where there is an appreciative voice giving rise to conjoint valuing – where young and old see the best in one another's life experiences and histories, where there is sharing of dreams and ultimate concerns in mutually affirming ways. (McNamee and Gergen, 1999, p. 58).

The more people feel valued and in turn open up in relationship to one another in increasingly substantive ways, the more likely it is that a listener will become aware of the culturally conditioned approaches of their own “true” world through reflection. They come to realize that what they considered individual actions are not his/hers alone but have come to be because of so many others. Relationships are usefully described as processes within which many relational engagements blend together, become reconstructed and are subsequently transformed. What is valuable in any relationship owes its debt to the close network of connections past and present, actual and vicarious. As participants become relationally responsible and each interlocutor takes on different voices and entertains alternatives, so is their relationship transformed (McNamee & Gergen, 1999, p. 14).

*So I am searching for the threads-
Like the many textures and colors of a vast, Persian rug.
Similarities of wonder, and goodness and love,
Commonalities of wishes, and hopes and dreams-
Lines of light that weave us together
Lines of love that whisper of oneness.*

Patricia L. Jobling (In McNamee & Gergen, 1999, p. 28)

When there is no appreciation for the past and present, actual and vicarious connections, there is no relationship and both members are at risk for objectification. When this occurs, the conversation freezes and budding relationships wither on the vine. I see this so often in my work. As a leader, I watch how staff and managers interact around patient care. The conversations about patients frequently turn to numbers and diagnoses.

There is no mention of the present situations or past experiences and no acknowledgment of the voices of nurse and patient ancestors. When this happens, the conversations come to an abrupt end because there is nowhere to go when patients become mere objects and the work of caring for them becomes a series of measurable data points.

“What is valuable in any relationship owes its debt to the surrounding network of connection, past and present, actual or vicarious.”

(McNamee & Gergen, 1999, p. 24)

Relational responsibility is present when our conversations are experienced as relational dances; where we can find alternative, creative steps in the dance of dialogue and where we invite participants into conversations regarding their own actions and how those actions form interdependent sequences that contribute to the whole focus on construction of the situation. Conversations then find ways of coordinating without denying the existence of other ways of being or disparaging other ways of achieving coherence. As we broaden the range of relationships under consideration, we move toward sensitivity of the systemic whole. We come to appreciate the worlds produced by various connections and innovative, useful options become available in place of the tradition of individual blame.

I began my project with an assumption of individual blame. I believed that I could explain the treatment of older patients as ageism. Ageist nurses unknowingly or even willfully were responsible for disrespectful treatment of vulnerable, older patients. I have come to understand that nothing is that simple. I desperately wanted to assign blame and fix the problem; to feel accomplished. I bought into the ontology of *us* versus *them* and believed that my way of being with older patients was *superior* (Gergen, 2009, p. 46). I wanted a final product, to fix blame, correct bad behavior and solve the problem. I now understand that there are innumerable factors that influence nurses and patients and their relationships with one another and an explanation is neither simple nor even possible. I have subsequently settled into a continuous engagement with my inquiry into nurses and their older patients. There have been and will continue to be momentary conclusions and brief resolutions but these will be replaced by further immersion and the generation of meaning for me and hopefully for those with whom I interact. I am moving from placing value on stable identification of deficits and corrective actions to a life that sustains a relationship of coordination and co-creation of meaning. It is my hope to shift the dis-

course from one of assigning a reason to one that gives voice to other issues of relevance and importance to nurses and their patients, (particularly the vulnerable and voiceless) may serve as building blocks for future relational webs (Gergen, 2009).

If you live in a world in which there are divine powers, evil spirits, and holy men, and I live in a world composed of neurons, synapses, and endorphins, we may find it difficult to go on together. If you are a surgeon and you ask your assistant for a scalpel and he gives you a stick of gum, you might have a problem.

(Ken Gergen, 2009, p. 32)

If I call you sweetie and you understand that to mean old lady, we both may have a problem. But, as we coordinate our talk within various contexts, we often establish a right way to do things and because we have these accepted standards, we can then perceive disruptions and failures (Gergen, 2009).

I began to wonder if I could help to open up space for understanding if I didn't label how nurses communicate as ageist. The stories that people have heard many times but rarely consider are within and throughout our conversations. Our thoughts, feelings, values, and opinions begin with and function in service of relationships. The stories we tell are often used to define the societal norms as well as the assumptions and understandings we have about how things are in the world.

Conversations themselves create certain relational practices and patterns and shape how we relate and our ongoing narrative then reinforces how we relate. How we relate to one another plays an important role in defining power and the norms and culture that influence our lives. This circular process of reinforcing culture and norms through patterns can seal off other possibilities of being, particularly when some voices are privileged and others are left out entirely. But when we *disrupt discourses that may be problematic*, we can create new possibilities. This can be done by bringing in new and different voices and stories that can lead to new conversations, new meaning, and generative possibilities (Bodiford, 2012, p. 4).

Social construction challenges us to examine recurring practices that are often represented as truth or reality and that are formed by conventional knowledge, assumptions and stereotypes. Social construction allows us to explore alternative ways of talking or thinking that can be more useful or generative (Bodiford, 2012). The nurse's way of life

and her social and professional practices both form and are formed by shared historical and cultural conventions. Nursing “norms” or codes of conduct form as principles that guide and grant models for behavior. These codes are those practices to which most nurses generally conform and they are the specific way that the nursing profession, the healthcare environment, as well as the community translate and effect behavior. Alternative ways of being in response to norms can serve to challenge problematic aspects of a dominant discourse. Seeing patients, particularly vulnerable, older patients as partners is seen as an alternative way of being in the nurse-patient relationship and is definitely a challenge to the dominant discourse of the nurse as the expert and protector of all patients (Bodiford, 2012).

Instead of asking about how a particular way we think originates within ourselves, as social constructionists, we can ask how it serves or functions within our relationships. We can also ask ourselves how a particular way of thinking or talking emerges from our conversations. Social construction invites us to examine ideas of truth in our work and in our communities and explore the implications of our labor. Rather than thinking that ideas or truths come from within, we can see meanings as created in the process of conversation. Social construction invites us to create shifts in thinking and talking through the questions we ask and step out of known ways of thinking (Bodiford, 2012).

If I see a stone as merely an object in the way or as some weight I can use, I am drawn into a limited plane of living that is governed by problem solving; this piece fits here, this one does not, this piece will help me get over there, this one is in the way.

(Mark Nepo, 2012, p. 120)

Dominant Discourse

A dominant discourse is the way we speak about, represent and see a particular issue or group of people. Certain discourses endure longer than others, are taken up and accepted by more people and achieve varying measures of dominance over others (Chouliaraki & Fairclough, 2010). Often unexamined, this dominant narrative can lead us to make assumptions that influence the beliefs we hold, the stories we tell, and how often we tell them. These taken for granted assumptions can create stereotypes or lead us to conclusions that impact our relationships with each other. Stereotypes and assumptions

then prevent us from developing a deeper understanding of each other, our experiences, and the unique ways we carry on through life. We often neglect to see others in the context of their lived experiences and their unique identities. The hidden strengths and alternative approaches that we overlook within the discourse may keep us from seeing the unlimited possibilities and preclude us from building alternative futures (Bodiford, 2012).

One of the dominant discourses in nursing and healthcare is that terms such as *sweetie* and *honey* are disrespectful and simply unacceptable under any circumstances. In the past ten years, thousands of nurses have been programmed to believe that patients wish to be called by their surname and prefer not to be referred to by their diagnosis or room number and to never, ever be called *honey* or *sweetie*. We have been told that the first few moments when a health professional meets a patient for the first time are important in developing a good rapport and how patients prefer to be addressed *and* how they prefer staff to introduce themselves during this initial period of acquaintance is very important. Studies have suggested that health professionals greet patients in a way that they dislike and that is potentially damaging to the likelihood of developing good rapport. Some studies have proposed that patients' perceptions and impressions regarding the quality of medical care they are likely to receive are formed simply by how they are greeted by a healthcare provider and from their appearance (Rashid, Mirshekar, & Karunaratne, 2009).

By taking this discourse for granted, I established and acted upon stereotypes of nurses and failed to see the unique ways some nurses compassionately related to their patients in spite of the tone of their voice or the terms of endearment they used. Dialogues both express and constitute social reality. Our conversations both express and help to create the world in which we live. We are conversational creatures whose lives are created in and through conversations and sustained or transformed in and through conversations. How we know, how we solve problems are best grasped by examining the conversations in the social worlds we inhabit which we appropriate and use. We learn that the qualities we come to name as our personality and identity are likewise constituted conversationally and sustained through our dialogues with others.

Our talk with others is both an expression of social reality and the means whereby social reality is created and sustained. The celebration of the other lies at the heart of human life and in the center of the human experience. The other is a vital co-creator of

our mind, our self, and our society. Without the other, we are mindless, selfless, and society-less (Sampson, 1993).

Often organizational leaders (self included) overlook the importance of co-creation and *implement* (e.g. mandate) strategies that result in mindless compliance. For example, all members of our healthcare system receive a document that describes (prescribes) thirty-six Standards of Excellence. They receive a copy of the standards during their orientation and are expected to adhere to these standards in all interactions, whether it be with patients, guests, or colleagues. “Avoid labeling patients and guests so that care is not affected by our judgment” is one of the standards which is further explained (e.g. scripted) by the following *behaviors*:

- Using terms or expressions such as “frequent flyer,” “drug seeker” or “professional patient” is disrespectful and judgmental.
- Treat our patients as individuals, *not* medical conditions or diagnoses.
- Seek first to understand; assumptions can lead to judgment.
- Use a social title and the patient’s last name (Mr. Jones or Ms. Smith) unless the customer expresses a wish to be called by another name.
- During first introductions, always refer to the patient using proper social titles.
- Ask the patient what they would like to be called.
- When introducing yourself, let the patient or guest know how to address you. For example, “*Mrs. Wilkes, I am Jonathan Press, your nurse. Feel free to call me John.*”

Recently a local healthcare organization *adopted* new service standards that are greatly simplified so they are “easy to remember and implement.” There are four core standards and each has an action statement that defines the standard and each is supported by three best practices that bring the standard to life. The new standards are:

Know me: I will be fully present when I am with you.

Respect me: I will honor you as an individual.

Care about me: I will be there for you in the way that you need.

Satisfy me: I will go the extra mile for you.

There is nothing inherently wrong with a discourse that promotes showing respect for an individual by calling them by their preferred name, if the discourse is co-created and the voices of others are not silenced. Sending out a list of easy- to-remember-and-implement statements however does not typically result in dialogue or relationships. In a command and control organization, it becomes a rule imposed from above. It simply

doesn't go far enough into the relational aspects of care. It is a simple to read, hard to forget slogan. And it thus loses its relationality.

According to Ken Gergen, "the recipient of monologic discourses is denied a voice of his/her own" (Gergen, 2001, p. 11). The end point achieved by monologic discourse in the form of a policy, procedure, rule, script, or regulation is a nurse who can repeat or regurgitate what has been presented but whatever talents, insights or specialized knowledge the nurse possesses is denied. Eventually, repeated denial in the form of monologues from above results in the denial of voice and an "obliteration of identity and an invitation to lethargy" (Gergen, ND, p. 11). The same is true for patients who constantly endure the monologue of nurses and physicians; many patients succumb to the lethargy that results from constantly being told what to do. When nurses and patients are asked merely to implement the plans of others, they lose their capacity to reflect on issues that are meaningful to them and they become unable to develop their own solutions or appropriate the information into practice or their life experiences.

Both nurses and patients are subjected to a hierarchical structure where the authoritative discourse is considered sacrosanct, they receive choreographed and scripted information that discourages flexibility and strips away the likelihood of improvisation. In the hierarchical structure of many acute care hospitals, leaders extract bodies of discourses from a variety of disciplines including medicine, law, ethics, and nursing as well as from regulatory and political arenas. These extracted discourses are passed to those beneath them in the hierarchy in the form of a policy, rule, or requirement or in the form of mandatory education/instructions. The discourses lose their significance and staff and patients are often told that the information passed down will be useful and important but the pragmatic function is often lost. Many changes that have been passed down through the hierarchy to nurses have reduced the nurse to the status of a low level employee whose main function is to implement reforms decided primarily by non-nurse experts. The expectation seems to be that both nurses and patients take their place unthinkingly in a world that "operates beyond their control with no respect for their needs" (Gergen, 2001, p. 12). It is no surprise to me when an executive nurse asks of her leadership team why nurses cannot think critically or use appropriate clinical judgement.

For nurses and their older patients, understanding the hidden strengths and discovering alternative, mutually agreed upon approaches to care is essential instead of simply performing a rehearsed script. When nurses are able to understand the context of their

patients' lived experiences and can uncover unique strengths, they can truly help them approach their illnesses and their quality of life in a way that is beneficial for the individual (patient) and for the ongoing relationship. I also believe that an approach such as this would ultimately benefit the nursing profession as nurses would bring a unique perspective to the healthcare team; one that is built on a foundation of strength and possibilities versus illness and deficits.

Status Degradation

Organizational leaders are attempting to construct a *remarkable experience* through coordination of activities. They have described the patterns of behavior and established rituals such as sitting down when speaking to a patient or introducing yourself with your title. Before long, it is anticipated that these patterns will become the norm (standard), job descriptions will be changed to reflect the expectations for performance and teaching tools will be created for new employees. This is typically where the cycle ends; we stop short of the work it takes that allows this effort to be internalized and subsequently used to describe our values. We fall short of understanding and embracing the relational aspects of our work.

Organizational relational patterns create organizational realities. Patterns of behavior or practiced rituals become standards and those activities become what is expected. When behaviors become what is expected, then it comes to be seen as the truth. Activities, relationships, and expectations are then coordinated around this reality or truth (See figure 1).

If you look at the example of *Delight me: I will think ahead and go the extra mile for you*, it is likely that scripts and tools will be created to establish patterns of behavior. Nurses will be told how to create a warm hand-off and then the standard for all nurses will be written into policy and communicated in staff meetings, annual evaluations, and orientation. The words *delighting patients* will be used to describe reality and until someone creates a new pattern or ritual, through ongoing coordination of activities, it will be the only way we describe how we are with our patients. Without question, nurses will blindly perform the required behaviors and, until a new cycle begins, nurses will believe that how they are is the *only* way to be.

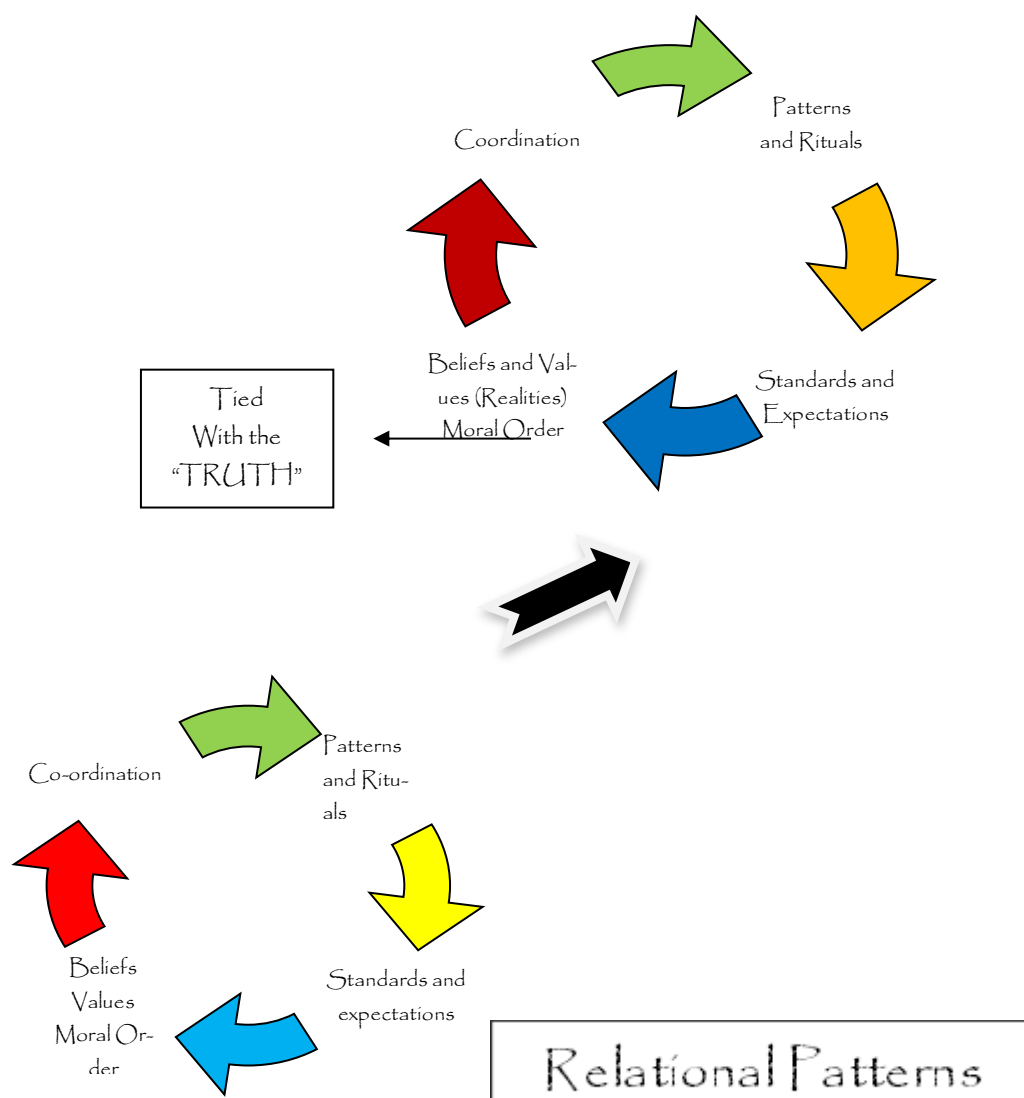


Figure 1. Relational Patterns (McNamee 2010)

In my readings, I came across an article by John Shotter (2003) that describes what he refers to as The Status Degradation Ceremony and Institutional Humiliation that I believe applies to the nurse patient relationship. It struck me that the Status Degradation Ceremony contributes to the social construction of both patients and nurses in today's healthcare machine. The status degradation ceremony suggests that:

- *The victim (patient or nurse) should be removed from the realm of their everyday character and be made to stand out as "out of the ordinary"*
- *What is unique and idiosyncratic about them should be ignored and they should be presented as an instance of a type (diagnosis or specialty).*
- *As a diagnosis or a patient, they should be presented as a dialectical counterpart to a preferred type caused to move by unknown influences (illness)*

- *Denunciation must be done by public persons (nurses or leaders), by those who can speak with the values of the community in mind and who have been licensed by the community so to speak*
- *The denouncers must distance themselves from those denounced*
- *What is unique and idiosyncratic about them should be ignored and they should be presented as an instance of a type (diagnosis or as an employee) (Shotter, 2003, p. 1).*

The quotes below describe the experiences of two nurses with whom I regularly interact with status degradation. The first nurse talks about her focus on her assigned tasks rather than on her patients' needs or desires. She describes her shift as "a nightmare", a situation that is truly out of the ordinary. The second nurse refers to her patients as "equal just like everyone else" who she treats the same, and no one is any different.

"I have my lists of everything to accomplish for each patient each shift and it's so easy to start seeing what's on that to-do list and what you have not done and know this nightmare's going to be, I didn't get this done whereas the patient might not care about what's on that list. You can put Vaseline gauze on the skin tear later. I'd rather tell you about my grandkids or my dog and so it's good when I get kind of into that situation where I'm worrying about one task and they sometimes throw me for a loop with something that I didn't plan on. But I needed that because that's not what it's all about. It's about what they need."

"In caring for others, we care for ourselves and that's kind of been my, I guess, mantra of sorts. I know when I do a good job taking care of someone, be it whatever role I'm doing, I mean, it's fulfilling; that might sound selfish but it's very rewarding to know. It can be difficult at times in terms of communication with them when there's the cognitive impairment. I find that that is more difficult for me than the patient. So even though I do have these negative feelings, they're good self-awareness things."

"And it's more the little things than it is anything that means the most to them. ... go in and sit and talk and listen to them, take time with them make them feel like you want to be there, you want to help take care of them and help get them better so they can go back home."

“Having respect, just respect for them I think is mainly one of the biggest things that go into my practice because they’re equal just like everyone else, try to treat everyone the same, no one any different.”

Nurses consistently react to their patients in a “scientific” way, as if they are merely numerical elements in a great process of manufacture and not unique individuals. I suggest that many nurses and other health care providers have wholly adopted methods of scientific management into their relationships with patients over the course of the past thirty years. No longer are patients someone in need of care, cure and compassion, they are a diagnosis, broken down into body systems, stripped of identity; a vessel into which we pour medications and treatments. Cause and effect thinking (e.g. the medical model) has led to the treatment of people as merely numbers or as physiological deficiencies. The growth of an “administered society”, particularly in health, can be found in distrustful relationships everywhere. The attempt to create this administered way of being to support our productive, materialistic lifestyle has generated a situation where we become dominated by our own techniques of domination and we find ourselves becoming increasingly objective and detached, even in relation to ourselves. We have always been required to program our actions before executing them and accordingly, we feel unable to act spontaneously or authentically.

Hospital nursing, in practice, is an extension of the practice of medicine. The state of North Carolina defines the practice of medicine as:

- Offering or undertaking to prescribe, order, give, or administer any drug or medicine for the use of any other individual.
- Offering or undertaking to prevent or diagnose, correct, prescribe for, administer to, or treat in any manner or by any means, methods, or devices any disease, illness, pain, wound, fracture, infirmity, defect, or abnormal physical or mental condition of any individual, including the management of pregnancy or parturition.
- Offering or undertaking to perform any surgical operation on any individual

Patients come to the hospital with an assumption of illness, which opens up the possibility all of the practices directed at a cure including invasive treatments, painful diagnostic tests, pharmacological treatments, and routine measurements of vital statistics. People come to healthcare providers with symptoms that accompany the report of a problem and activities are then set in motion to locate the causes of the problem and remove them.

According to the American Nurses' Association, "nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations" (American Nurses' Association, 2014). This definition, created by those who have been *licensed by the community to speak*, clearly distances the profession of nursing from the denounced in need of advocacy.

Chapter Four: Social Construction in Nursing

In this chapter, I will provide an extensive overview of the numerous social, financial, and institutional forces that influence the relationships between nurses and their older patients. The first section describes the general influences on the profession followed by the effects of the professional organizations, the impact of specialization, economic, institutional, regulatory and political influences. This chapter offers specific examples of the thousands of relationships that comprise a nurse's identity as well as the identities of their older patients. The next several paragraphs describe how many of the dominant discourses in healthcare leadership contribute to a paternalistic approach to care. Finally, there is a summary of the goals of this research rounding out this chapter.

It is perfectly clear that problem solving is solidly grounded in the nursing profession. Nurses are trained in the nursing process which undergirds our practice and consists of assessing, diagnosing, planning, developing interventions, and evaluating effectiveness of interventions (e.g. the scientific method). We look for what is wrong, name it, develop and implement a plan to fix it, carry out the plan, and then see if the plan worked.

In my experience, when the patient presents to the hospital, most nurses assume the role of the expert and set about to impart his/her expertise and knowledge on the patient. She collects subjective and objective data, determines the nursing diagnosis and intervenes with tasks such as monitoring intake and output, lab values, and vital signs or encouraging mobility. Student nurses are trained to develop *plans of care* before they are ever given a patient assignment. Planning care involves pouring through textbooks to uncover the most appropriate interventions based on the patient's *diagnosis*. For the practicing nurse, the plan of care is selected from hundreds of plans in a database that are categorized by the admitting *medical* diagnosis. According to the Joint Commission and Centers for Medicare and Medicaid, an "individualized" plan is required. This means that the computerized plan is adjusted based on the "unique" presentation of the patient. For example, a patient who cannot read would have the standard plan of care for diabetic education modified to include pictures or demonstrations of what the nurse hopes to teach him/her. Thinking back to my training, I recall spending a great deal of time thinking about where and how the patient's diagnosis fits into the plan of care and little if no time involving the patient in the development of the individualized plan of care. None of the curriculum outside of the psychiatric rotation, focused on *dialogue* with the patient.

As I observe nursing students and practicing nurses on the units today, the emphasis on the medical diagnosis continues to dominate and frame interactions between nurses and patients. In addition, relationships with the patients are formed based on deficits and weaknesses. For example, Table 1 lists the North American Nursing Diagnosis list for *problems associated with activity or rest*. Ideally, the practicing nurse uses this list or a similar list as a way of determining the plan of care for a patient who presents with activity related complications. For example, if a patient is admitted with heart failure, the patient would likely tire very easily and have difficulty taking care of himself. The nurse would “diagnose” the patient with activity intolerance related to congestive heart failure and list nursing interventions that would be implemented to address the problems. Some possible interventions for this diagnosis include; encouraging physical activity consistent with patient's energy resources, assisting the patient with planning activities for times when he or she has the most energy and/ or encouraging verbalization of feelings regarding limitations.

Rarely, if ever, are patients approached from a perspective of strength and health in a holistic way nor is it assumed that patients are capable of doing great or even simple things to take care of themselves. Instead of balanced, collaborative relationships built on mutual respect and recognition of the patient as the owner of his or her health, we rely on paternalistic, dis-ease oriented interactions.

Insomnia Sleep deprivation Readiness for enhanced sleep Disturbed sleep pattern Risk for disuse syndrome Impaired bed mobility Impaired physical mobility Impaired wheelchair mobility Impaired transfer ability Impaired walking Disturbed energy field Fatigue Wandering Activity intolerance Risk for activity intolerance	Impaired home maintenance Readiness for enhanced self-care Bathing self-care deficit Toileting self-care deficit Feeding self-care deficit Dressing self-care deficit Risk for ineffective renal perfusion Impaired spontaneous ventilation Ineffective peripheral tissue perfusion Risk for decreased cardiac tissue perfusion Risk for ineffective cerebral tissue perfusion Risk for ineffective peripheral tissue perfusion Risk for ineffective gastrointestinal perfusion Self-neglect Decreased cardiac output
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Table 1: NANDA 2012-2014 (Domain 4 Activity/Rest Nursing Diagnoses

Wittgenstein brings our attention to what we do spontaneously, in immediate, unthinking response to events in our surroundings and the importance of our actions. His view stands in contrast to other philosophical approaches that emphasize the very “private” act of thinking. “For it is only in these detailed circumstances that the meaning in terms of which we conduct our daily lives together are revealed” (Shotter, 2003, p. 3). If we were to look at the words nurses and patients use, separate from their actions (divorced from their surroundings), we would lose what it is about their words that makes them meaningful to one another (Shotter, 2003). For example, a nurse who uses terms of endearment (like sweetie or honey) and who is comforting, compassionate, and responsive in her caregiving is conveying an entirely different message than a nurse who derisively calls her patient sugar as she pulls off the linens, lifts their gown and roughly begins her treatment. In addition, nurses interact with patients in response to their work environment. When the environment emphasizes technology, errors, and audits, then the nurse interacts with their patients accordingly. The nurse, responding to this type of environment will relate to the patient as a task to be completed and the words she uses will reflect that frame of thinking. On the other hand, if an organization attends to the use of words, utterances and other expressions in relation to their surroundings, the nurse is able to retain and even expand the humanity of his/her work.

To qualify as a person, individuals must be able to answer for themselves and their conduct; they have to be able to indicate in a way that makes sense to them, be able to fulfill certain duties, and monitor and evaluate their experiences in terms they share with others in their community. One way that people can share their experiences with others is through first person narratives that help us see another person’s inner life, thoughts, feelings, attitudes and judgments; how their world is for them. Personhood is a status conferred upon one by others, and if others do not take one’s expression of self seriously and do not respond to your words, utterances and expressions, then you are being denied your opportunity to be a person – you are being degraded and humiliated (Shotter, 2003).

Nurses do not typically hear the first person narrative because of their focus on tasks and problems and hence engage primarily in monologue. Sampson (1993) describes monologue as a construction designed to meet one person’s needs and desires, that involve another who is serviceable to that person. Although you and I may converse and interact together, in most respects the you with whom I am interacting has been constructed with me in mind. Your sole function has been to serve and service me

(Sampson, 1993). Bakhtin (1981) describes one who engages in monologue as “a hermetic and self-sufficient whole, one whose elements constitute a closed system presuming nothing beyond themselves, no other utterances” (Bakhtin, 1981, p. 273). Dialogue “requires that there be two separable presences, each coming from its own standpoint, expressing and enacting its own particular specificity” (Sampson, 1993, p. 15). The coordination of “two separable presences” characterizes the relational arrangement that is necessary for dialogue to emerge. Based on these understandings of dialogue and monologue, it seems apparent that monologue serves as the *chief instrument* of our nursing practice. What is needed however, is dialogue that emphasizes: 1) an expanded domain of patient and family participation, 2) patients’ needs placed on par with the nurse’s plan, 3) the assumption that patients are knowledgeable of their own health as opposed to dictating what is to be done, 4) substitution of the belief that there is one truth (and one plan) with the belief of possible multiple realities (Sampson, 2008).

It often appears as if nurses have been constructed to act as if they are relating to their patients as marionettes who move according to external forces and are controlled as if by pulling strings or pressing buttons. Nurses treat themselves and others like this because they believe the systems, within which they think about and talk about themselves, only allow certain views. The processes that could make them and their relationships unique are unknown to the organization. The only ways of talking which nurses can justify within their systems are those determined to be *scientific*. They talk about themselves in a cause and effect way, in a way which does not allow them to describe the special, non-causal processes that make us human and the organization does not allow space for this way of talking.

As we have discussed previously, meaning is created through collaborative activities and reality is created through social interaction. Whatever exists and whatever happens *has no meaning* in itself but its meaning can only be created through social interaction. Interaction occurs not only at the personal level but also at the macro, social, or system level and there are political, regulatory, organizational, structural, and financial interactions that help construct the nurse patient relationship in addition to the individual interactions.

Professional Nursing's Influence (The American Nurses Association)

Use of a standardized nursing language for documentation of nursing care is vital both to the nursing profession and to the bedside/direct care nurse. ... Currently, the American Nurses Association has approved thirteen standardized languages that support nursing practice, only ten of which are considered languages specific to nursing care. ... These benefits include: better communication among nurses and other health care providers, increased visibility of nursing interventions, improved patient care, enhanced data collection to evaluate nursing care outcomes, greater adherence to standards of care, and facilitated assessment of nursing competency.

(Marjorie A. Rutherford, RN, MA, 2008, p. 1)

Headquartered in Washington, D.C, the American Nurses Association has established itself as the voice of all registered nurses in the United States and claims to represent over 3.1 million nurses yet actual membership sits at about 145,000. Over the course of 120 years, the ANA has 1) established a code of professional nursing; 2) developed and instituted the means for registered nurses to be credentialed in areas of specialization; 3) legislatively advanced the nursing profession; 4) functioned as a union for some of its members and 5) published volumes of material on nursing practice and the profession. As the professional organization for all registered nurses, the American Nurses Association (ANA) has assumed the responsibility for developing the scope and standards (as well as the language) that apply to the practice of all professional nurses and serve as a template for nursing specialty practice.

Someone needs to ask the deeper, more difficult questions. Despite unionization, why do nurses still not have a significant voice in Health Care? Why are we divided into 526 different organizations and still fighting among ourselves for a hundred years about the most basic issues like nursing entry level requirements.

(Ashok Selvam, 2012, p. 1)

The Scope of Nursing Practice describes the “who,” “what,” “where,” “when,” “why,” and “how” of nursing practice. Each of these questions must be answered to provide a complete picture of the dynamic and complex practice of nursing and its evolving boundaries and membership. The profession of nursing has one scope of practice that encom-

passes the full range of nursing practice, regardless of the type of practice (general or specialty). The depth and breadth in which individual registered nurses engage in the scope of nursing practice is dependent on their education, experience, role, and the population served and is defined by state boards of nursing as well as individual organizations.

The Standards of Professional Nursing Practice are “authoritative statements of the duties that all registered nurses, regardless of role, population, or specialty, are expected to perform competently. The standards serve as evidence of the standard of care, with the understanding that application of the standards depends on context. The standards are subject to change with the dynamics of the nursing profession, as new patterns of professional practice are developed and accepted by the nursing profession and the public. In addition, specific conditions and clinical circumstances may also affect the application of the standards at a given time, e.g., during a natural disaster. The standards are subject to formal, periodic review and revision”. The ANA has also defined competencies that accompany each standard that serve as evidence of compliance with the standard (American Nurses Association, 2014).

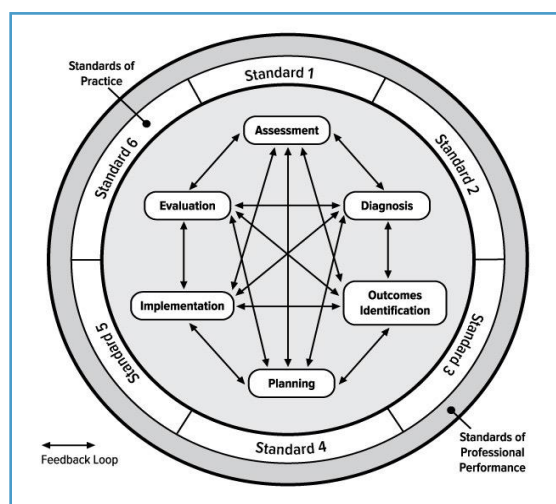


Figure 2: The Nursing Process and Standards of Professional Nursing Practice (Congress on Nursing Practice and Economics, 2010.)

The nursing process is often conceptualized as the integration of singular actions of assessment, diagnosis, and identification of outcomes, planning, implementation, and finally, evaluation. The nursing process in practice is not linear as often conceptualized, with a feedback loop from evaluation to assessment. Rather, it relies heavily on the bi-directional feedback loops from each component, as illustrated in Figure 2.

The Standards of Practice coincide with the steps of the nursing process to represent the directive nature of the standards as the professional nurse completes each component of the nursing process. Similarly, the Standards of Professional Performance relate to how the professional nurse adheres to the Standards of Practice, completes the nursing process, and addresses other nursing practice issues and concerns (ANA, 2010).

In October 2010, the Institute of Medicine (IOM) released a report entitled, *The Future of Nursing: Leading Change, Advancing Health*. The recommendations in the report focus on the critical intersection between the health care needs of diverse, changing patient populations across the lifespan and the actions of the nursing workforce. Their recommendations were designed to support efforts to improve the health of the U.S. population through nurses' contributions that enhance the delivery of care.

The report centered on four main issues:

- Nurses practicing to the full extent of their education and training.
- Nurses achieving higher levels of education and training through an improved education system that promotes seamless academic progression.
- Nurses acting as full partners, with physicians and other health professionals, in redesigning health care in the United States.
- Effective workforce planning and policy making that provides better data collection and information infrastructure (American Organization of Nurse Executives, 2014).

Recently, the phrase “practice at the top of license” began emerging in almost every healthcare and nursing institution. To most people, this is interpreted to mean that professional nurses should be able to care for patients at a level commensurate with their training and state law. Why is this the state of affairs for nurses? Why aren't nurses and nursing leaders reacting in shock and anger? Most nursing and healthcare organizations are now aligned with this approach to nursing's state of affairs. In fact, the American Organization of Nurse Executives (AONE), a branch of the American Hospital Association and the professional organization representing chief nurses across the country, has promoted this initiative. The assumption of all of these associations is that nurses are NOT practicing at an appropriate level.

It seems as if every year that goes by there is one attempt after another to re-humanize, or reorganize, or re-energize or somehow reinvent nursing care but the profes-

sion consistently continues to struggle with developing transformative changes and sustainable improvements. We have yet to successfully address bringing the patient back into the center of all we do. In the eighties we tried to implement primary nursing. In the nineties we were sold on the benefits of Relationship Based Care. In 2000, we tried to “get the nurses back to the bedside” with Transforming Care at the Bedside. And now we are back to the drawing board with patient centered or patient focused care and patient and nursing *engagement* initiatives.

All of the initiatives to revitalize the profession of nursing have had the same objectives with different names and the latest iteration will likely elicit the same outcomes as others before. Bringing the patient to the center of healthcare will require more than weak efforts at empowerment, the latest and greatest technology, or another initiative aimed at improving teamwork brought about by administrators, physicians, and politicians.

Specialization (Division of Labor)

If we cannot name it, we cannot control it, practice it, teach it, finance it, or put it into public policy.

(Normal Lang, Clark & Lang, 1992, p. 109)

In *The Web of Inclusion*, published in 1995, Sally Helgeson states that one of the first “industries” to divide the tasks of labor according to the factory model was health care. In the early 20th century, efficiency experts and scientists transformed hospitals into factories that dispensed treatments to sick customers. The work done by doctors and nurses has been broken down into standardized procedures that were overseen via a well-established chain of command. This breakdown began in the early 1900’s with the rise and growth of the medical specialty board movement. According to the American Board of Medical Specialties (ABMS), this movement has been associated directly with significant advancements in medical science that have resulted in improvements made in medical care delivery. Prior to the existence of specialty boards, there was “no system to protect the public from a physician claiming to be a specialist”. Until the development of the specialty board movement, each physician was the sole assessor of his or her own qualifications to practice a given specialty. The advent of specialty societies and medical education institutions brought a more *organized* approach and along with the organized approach, increased division of labor. Governing bodies such as the ABSM encouraged and assisted in the development of boards that defined specialty qualifications issued creden-

tials that would assure the public of the specialist's qualifications. Today the American Board of Medical Specialties recognizes 24 medical specialty boards that are used in the development and implementation of standards used for the ongoing evaluation and certification of specialty physicians (American Board of Medical Specialties, 2014).

According to Helgeson, the role of the front line workers (also known as nurses) was created along the lines of assembly line laborers in manufacturing operations. Orders were handed down from upon high and decisions were made far from the bedside. For some time, nursing care has been viewed (devalued) as an expertise of care and caring and nurses' functions were primarily limited to completing activities according to medical orders. Nurses' work has been defined in detail and under no circumstances can the nurse practice beyond what was defined for her. Decisions are made by the physician, in spite of the fact that the nurse is typically the only one at the bedside. Not only is there an imbalance of power within the organizational hierarchy, there is an even more extreme power differential at the bedside between doctors and nurses. Up until the 1970s, nursing students were taught how to address physicians, to rise when a physician entered a room, and even the appropriate way to pour coffee (Helgeson, 1995).

As greater numbers of patients were admitted to the hospital in the 70's, things started to change and the demand for nurses increased. Nursing salaries became more lucrative and nursing education moved from the hospital setting into colleges and universities. Nurses, armed with more education, became more dissatisfied with the organizational hierarchies and the power structures but little changed in the work that they did. "As technology made medicine more industrialized, patients were increasingly viewed as objects, whose disparate symptoms were treated in isolation from one another by a variety of specialists who rarely communicated among themselves. As the structure of hospitals adapted to serve the needs of the specialist, it became ever more difficult to treat patients as human beings with complex and interrelated illnesses" (Helgeson, 1995, p. 131).

During this time, the American Nurses Association (ANA) created the Federation of Nursing Specialty Organizations (1973) to bring together newly created certified nurses in Maternal Child Nursing, Emergency Department Nurses and Orthopedic Nurses. As the ANA's organizational structure evolved and specialty practice interests expanded, increasing numbers of specialty nursing organizations emerged to provide pertinent specialty focused continuing education and professional resources. The specialty nursing organizations also created specialty practice standards and guidelines to describe a distinct focus

of practice which in turn resulted in significant diversity in format and content. The rapidly changing healthcare environment's demands, including the call for certification of nurses for specialty practice, brought about a desire to control practice and with that came the need to develop consistent, standardized processes for recognizing specialty areas of nursing practice, approving specialty nursing scope of practice statements, and acknowledging specialty nursing standards of practice just as the medical specialties had done 40 years before. According to the Discover Nursing website, there are currently 104 areas to specialize in; 34 specialties let you work outside of the hospital, 68, are research-oriented, 37 are managerial, and 92 are *patient facing*. "Maybe you want to help people. Maybe someone inspired you. Maybe you want to learn something new every day. Whatever your reason for exploring nursing, there's a specialty that'll give you a fulfilling and rewarding career."

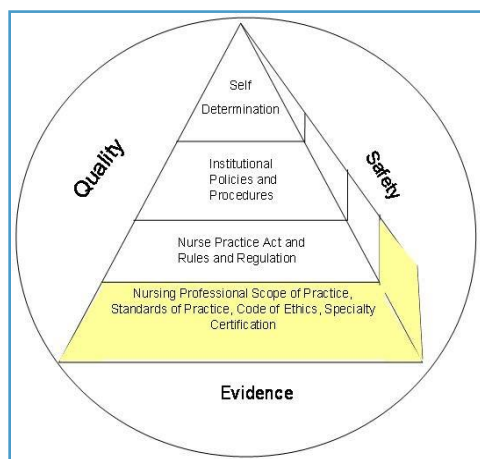


Figure 3: Specialty Nursing Standards of Practice (Styles, Bickford, & White, 2008)

During the late 1990's the ANA reconvened representatives from various specialty nursing groups to address the need for consistency in standards of practice and to identify a formal mechanism to confirm professional recognition of specialty practice. This resulted in the creation of the ANA Congress of Nursing Practice, now known as the Congress on Nursing Practice and Economics (CNPE), which is the reviewing body of specialty nursing standards of practice. Figure 3 depicts a model of the Specialty Nursing Standards of Practice and as you can see, evidence and the scientific model again serve as the foundation for practice. Specialization in the nursing profession has contributed to the status degradation of not only the professional nurse but also to the patients and their families

through massive specialization, standardization of practices and through the division of labor.

Economic Influences (Shortages, Staffing, and National Initiatives)

In the 1980 there were widespread reports of a severe nursing shortage in the United States. Hospitals had difficulty recruiting and retaining nurses. The increasing use of complex biomedical technology, the demand for hospitalization by a growing elderly population and changing patterns of medical care resulting in shorter but more acute hospital stays contributed to the need for more hospital nurses—and for more intense and skilled nursing care. Despite a nationwide supply of more than two million registered nurses and significant increases in patient assignments, hospitals across the country reported critical vacancies for budgeted nursing positions. Many hospitals were forced to delay admissions, or even close beds, because of an inadequate number of nurses on staff. At that time, two of the most frequently cited reasons for nurses leaving the field were 1) the high level of job dissatisfaction caused by nurses' lack of control over their work and 2) poor working relationships with physicians and nonclinical staff members. To respond to these concerns, the Secretary of Health and Human Services appointed a special Commission on Nursing to study the problem and make recommendations. In 1988, the Commission published sixteen specific recommendations and eighty-one strategies to relieve the nursing shortage in the United States.

Almost thirty years ago, the two themes agreed upon by the group were the need to project a positive image of nursing and the need for nurses assert more control over the practice environment and its resources. The first emphasized enhancing recruitment and the second was related to improving job satisfaction for nurses. In order to develop a positive image of nursing, the participants agreed that marketing strategies should communicate job satisfaction and a sense of vibrancy and joy in the profession. They all agreed on the need to enhance the image of nursing at all levels -- locally, statewide, and nationally. Their belief was that if they could convince the public that nursing was a vibrant and joyful profession, more young people would want to become nurses.

In the discussion related to lack of control, health system and nursing leaders proposed changes that led to lateral integration of nurses and downward substitution of nurses with unlicensed assistive personnel (UAP). The panel believed that increased

control by nurses through overseeing UAP's would lead to a work situation more attractive to new nurses.

Some examples of the panel's recommendations included:

- an exempt salary status that promotes a professional image by employing a nurse to do a job rather than to work hours;
- use of self-contained units with no floating or very limited floating of nurses to other units; ("floating" is taking a nurse from one unit to work on another)
- rewards for educational advancement and upgrading to professional practice;
- selective hiring practices that only bring in nurses who espouse the professional values the organization is promoting;
- a self-governance model at the staff nurse level
- a decompression of salaries so that clinical practice is rewarded through salary increases with a resulting wider salary range for nurses at the bedside.
- compromises in salary negotiations when there is risk of the elimination of full-time equivalencies (FTEs) associated with needed support services
- student experiences that stress that it is no longer a matter of delivering the best care ideally possible but rather a matter of deciding what is the best care possible under a given set of conditions with the available resources.
- projects that document nursing costs by nursing services or develop technological support systems, such as computerized nursing information systems to extend the effectiveness of the current workforce should be encouraged (US Department of Health and Human Services, 1988).

That same year, the Robert Wood Johnson Foundation and the Pew Charitable Trusts announced a jointly funded national initiative to provide better patient care through innovative, hospital-wide restructuring. From the outset, the foundations recognized the inherent connection between quality hospital patient care and strong hospital nursing services, and their program, Strengthening Hospital Nursing: A Program to Improve Patient Care, or SHN was developed. SHN projects were designed to restructure working environments in order to 1) optimally utilize nursing resources, 2) improve care in a cost-effective manner, and 3) provide services for the benefit of patients as well as nurses and other staff. Participating hospitals were given great flexibility in the means they chose to identify organizational and operational problems that impacted their current nursing services and in the measures they would take to remedy these problems and improve patient care. "The

Strengthening Hospital Nursing Program seeks to bring about a fundamental change in the U.S. hospital—from a discipline-driven, departmentalized institution to a patient-driven, unified one. It seeks an awakening by the hospital to the understanding that the patient is why it exists. It seeks a metamorphosis—a shedding of the old, tired image of the nursing profession and constructing a better-fitting image in keeping with what the profession actually contributes to patient care."

Clearly, this was an ambitious program based upon recommendations from an advisory board of nationally recognized leaders in nursing and medical care. The supporting foundations provided monetary resources as well as brand-name recognition to the effort. The challenges facing the grantee hospitals were to a significant extent understood by the program planners and the national governing staff, and these challenges were anticipated in many features of the program. At each site, a considerable investment was made in the education, training and empowerment of a team of people who could facilitate change. As one can imagine, the expectations for success were quite high.

The total financial commitment to the program of the Robert Wood Johnson Foundation and the Pew Charitable Trusts was \$26.8 million: \$4 million for one-year planning grants, \$20 million for the five-year implementation grants, and \$2.8 million for technical assistance, program administration and monitoring. In October 1990, the two foundations announced that twenty projects—twelve hospitals and eight consortiums of hospitals—had been selected to receive five-year SHN implementation grants of up to \$1 million each. The group of grantee hospitals was diverse, including rural and urban, large and small, academic and community hospitals.

The proposals of the grantee hospitals shared common themes, including the following:

- The use of planning and implementation processes that relied on collaboration and consensus building horizontally as well as vertically within the hospital.
- The use of organizational and management consultants to facilitate the hospital planning team's ability to envision new models of nursing and patient care.
- A focus on providers' relationships with patients rather than with one another.
- Cross-training of professional staff.
- Unbundling hotel services from patient care services.

- Self-governance for individual nursing units.
- New models of nursing care.

It is easy to see that there was consistency with the goals of the granting foundations and the report from the Department of Health and Human Services.

Teams from the grantee hospitals, consisting of the chief executive officer, the nurse executive, members of the board of trustees, a medical staff representative and the SHN project director, were required to attend an initial educational conference held in September 1989 in Orlando, Fla., and a follow-up two-day workshop. Visibly absent from these teams was the voice of the staff nurse as well as the patient. There was, however, a strong physician/administration presence. Russell L. Ackoff, emeritus professor of systems science at the Wharton School of the University of Pennsylvania, led the project teams through the principles and applications of systems thinking.

Interestingly, the outcomes of this grand plan were not as grand as the two foundations would have hoped for and what occurred instead was further industrialization of the nursing profession. All nine SHN study sites implemented process changes such as redesigning patient care pathways (defined plans of care or protocols) and creating new pathways for cardiovascular, cancer, maternity, pediatric, intensive care and emergency patients, among others. The changes in the patient care process were often accompanied by an increased use of nonprofessional patient care assistants, cross-training of professional staff people and the use of a case manager to coordinate care across the continuum of services.

Typically, changes in the patient care process were the most difficult ones for hospitals to adopt, because they were the ones most likely to be resisted by physicians and nurses, who often viewed them as threatening to their current job responsibilities and their autonomy. Moreover, changes in patient care processes often required changes in the activities of many ancillary and support personnel, which significantly complicated the process.

Six of nine SHN study sites supplemented their changes in the patient care process with the introduction of new services. These varied greatly, with each site creating new services uniquely tailored to its patients' needs and the existing services. Some new services added to the array of direct patient care services available at the hospital, such as special attention to the victims of domestic violence and sexual assault, hospice care,

outpatient chemical dependency treatment, cardiac rehabilitation and a program to give patients more control over their hospital care. Other new services were designed to expand the continuum of care to include pre-hospital and post-hospital services.

The changes in the SHN hospitals' patient care processes and services were often accompanied by changes in the administrative structures and processes of the hospital. In several sites, the organizational structure of the hospital was changed through the implementation of shared governance, the creation of new committees, the use of matrix organizational structures and the introduction of new administrative roles to support the clinical staff. The introduction of shared governance in hospitals was one of the most favored changes, because it decentralized decision-making, initially giving staff members *more* control over their work. However, this was a departure from the original charge of both the SHN initiative and the recommendations from DHHS, which was for self-governance.

One common administrative change was to strengthen the hospital's information systems. Some implemented systems to obtain more information and feedback from patients through the use of patient questionnaires. Others designed and adopted new computer-based information systems to support the care providers.

Many of the institutions reported that change in and of itself was threatening to staff at a personal level and the failure to readily adopt changes impacted the hospital's ability to achieve the desired outcomes. I often hear administrators proclaim that nurses are resistant to change or that nurses just don't like to do things differently but I have found just the opposite. When nurses understand change and can make meaning of it and have the opportunity to help define it, they typically incorporate the changes into their work. Nurses adapt to and embrace change when it makes sense. More often, however, changes are made at an administrative level and handed down to the bedside professionals. Nurses are no different than any other profession when it comes to embracing change but I rarely hear that physicians or therapists, for example, are resistant to change. Leaders tend to use these types of statements when change has been unsuccessfully managed as it takes the onus off of them. The lack of success at many of the institutions was wrongly attributed to the inability of the bedside nurse to adapt to changes, rather than the organization's inability to successfully integrate new processes.

During the first year of the grant, a work analysis team was formed to determine how best to support the nursing staff in caring for patients. The goal was to relieve the

nurses of chores that they didn't need to be doing so they could spend more time taking care of patients. Roles were created to support the nurse at the bedside. The support assistant role was responsible for housekeeping, nursing assistant activities such as bathing and feeding, and collecting specimens. This new role was also responsible for stocking supplies that the nurse needed to complete his/her work. By 1996, however, the role of support assistant fell by the wayside. A major obstacle to the hospital-wide adoption of the program was the cost. Full implementation was contingent on moving the program forward in a way that didn't cause budget increases, so nurses continued to do the work as before. To this day, there continues to be significant pressure on hospitals to use more nonprofessional assistants for mundane tasks, while maintaining a highly trained professional workforce to care for an increasingly acutely ill inpatient population. Few have learned from past initiatives that replacing nurses with "nonprofessional assistants" does not automatically result in substantive changes in practice. Work in today's health systems is being designed to facilitate practicing at the top of one's license, which translates into delegation of the more mundane tasks to UAP's. As we will see, however, nurses often perceive these mundane tasks as essential to their work.

In addition, the nursing shortage of the 1980s gave way to a more complicated picture in the mid-1990s. During the early nineties, new market forces, including the increasing use by payers of per diem and capitated hospital reimbursement (HMOs, PPOs, and managed care) and competition among hospitals for contracts with managed care plans, changed the demand for hospital nursing. As managed care techniques were adopted by health plans and providers, hospitals were required to cope with declining patient days, fewer admissions and lower payments. The use of the hospital for the observation of patients as part of the diagnostic regimen was greatly reduced. Similarly, hospitals were no longer being used for bed rest of patients, as more out-of-hospital exercise-oriented regimens for treatment and rehabilitation of both acute and chronic diseases were adopted. Although the patients who were admitted to hospitals were typically sicker and more complex than was true through most of the 1980s, pressure from payers of all sorts to reduce hospital costs caused hospitals to attempt to redesign hospital work to reduce lengths of stay while maintaining quality of care. Increasingly, hospitals sought to cut costs by reducing the number of full-time equivalent employees, cutting nursing hours per patient, and lowering overall wages by employing fewer high-cost registered nurses. Labor costs in health care have been and continue to be primary targets for cost-cutting.

Professional nurses, the group of healthcare providers who take up most of the hospital budget, are often targeted as an expendable budget item.

Some changes implemented by the Strengthening Hospital Nursing sites ran deep and wide and were brought to bear not only in hospitals but also in educational settings. Core patient care processes were redesigned, affecting the practice patterns and the working relationships among many different clinical care providers. In many cases, patient care practice was standardized for the first time. Those who attempted to stem the tide of standardization and remind those in charge of the need for individualized approaches to care were brought down as change resisters or nay-sayers.

As the program was unfolding and change was being realized across the country, the nursing shortage, which instigated the work in the first place, evaporated, which led to questions about the need for future funding. The spread of managed care and increasing financial pressures became more dominant forces in shaping nursing practice. Much of the progress made was undermined by financial imperatives that focused more on decreasing the direct cost of nursing care. The original work of the Strengthening Hospital Nursing program continues to this day with pressure from local and national initiatives that support “more time at the bedside” and “practicing at the top of one’s license” and if anything, these forces acting on hospitals to transform the patient care process have strengthened but sustained progress is rare. Over the past 40 years, there have been many attempts to empower nurses such as primary nursing, advanced practice licensing, and shared governance, to name a few. However, there have been far more counter activities that have impacted the nurse’s ability to define her practice.

Exacerbating the challenges to the work environment for nursing practice is the current nationwide shortage of nurses, physicians, and other allied health professionals. Evidence suggests that, if left unchecked, current shortages of nurses will escalate into a national health care crisis. Multiple factors of demand, supply, and the aging workforce have contributed to the problem of insufficient numbers of nurses available to care for the rising needs of the American public. Although the actual supply of nurses has continued to grow; it has not kept up with the significant increase in demand for nurses.

Demand for nurses has exceeded supply in certain types of patient care specialties, such as critical care, cardiac, neonatal, and perioperative nursing (ANA, 2000). Demand has intensified for more baccalaureate-prepared nurses with skills in critical thinking, case management, and health promotion skills across a variety of inpatient and outpatient

settings (Goode et al., 2001). Demand has increased for more culturally competent nurses with knowledge of gerontology and long-term care because of rapidly changing population demographics (President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, 1998). Additionally, the supply of nurses is affected by a highly competitive labor market that attracts the best candidates away from health professions careers (AHA, 2001).

The current nursing workforce is estimated to be nearly 2.7 million, with the average age of nurses at 45.2 years. Of these, only 82% or 2.2 million are employed either full- or part-time in nursing with an average age of 43.3 years. (U.S. Department of Health & Human Services, Bureau of Health Professions, Division of Nursing, 2001).

The largest cohort of currently practicing nurses will be in their 50s or 60s in the next decade, with many of these nurses retiring or decreasing their work time (Buerhaus, Staiger, & Auerbach, 2000, p. 279). The average age of nurses is increasing at more than twice the rate of all other occupations in the U.S. workforce, with the number of nurses under age 30 decreasing by 41 percent from 1983 to 1998 (Needleman, et al., 2001).

I think it's safe to say, with the average age of registered nurses being in the forties, the majority of nurses have seen the discourse of nursing evolve into an increasingly industrialized practice, mainly attributable to economic pressures and increased regulatory requirements.

Institutional Influences (Peer Pressure)

Beth Israel Hospital serves as one of the primary teaching hospitals for the Harvard School of Medicine and is nationally recognized as one of the nation's premier health care institutions. In addition to its reputation as a leader in the field of medicine, Beth Israel Hospital is recognized both nationally and internationally for its professional nursing practice model (primary nursing) and the quality of its nursing care. Under the leadership of Joyce Clifford, the hospital's nurse-in-chief, the nursing division at Beth Israel successfully developed and adopted primary nursing in 1974. Elements of the primary nursing model at Beth Israel included an individualized patient relationship, twenty-four hour accountability for nursing care by a primary and associate nurse, admission-to-discharge accountability for a patient by one nurse who cares for that patient when present, and case-based management of care through the use of nursing care plans as well as direct communication between caregivers.

This model of professional practice was widely adopted in hospitals throughout the United States for about ten years. For those ten years, Joyce Clifford is said to have strengthened the professionalism and scholarship of nursing to levels matching those of the medical specialties. She moved her staff from nursing station desks to the patient's bedside and she encouraged nurses to become true professional colleagues of their patients' doctors. Ms. Clifford was credited with being the first nursing leader in the country to promote the professionalism of bedside nursing where the nurse could remain working at the bedside providing hands-on care and know that she could advance in stature and salary. Administrative roles were no longer the only path for advancement. Nurses, like their medical colleagues, performed research, presented at national meetings and as they gained experience, served as specialty consultants to others on staff confronted with challenging issues of nursing and medical care.

Dr. Clifford's obituary, found on the Beth Israel website, credits her with eliminating the notion of "scut work". She believed that each and every interaction with patients gave nurses the opportunity to learn more of the patient's understanding of the illness and ability to cope, and to observe more often and more closely the patient's clinical status, look for potential problems or signs of trouble, and to make the patient more comfortable. She didn't see the work as a series of tasks to be completed but her vision was one where everything the nurse did would be incorporated into the nursing process to achieve the best outcomes for the patient. Joyce Clifford's contributions at Beth Israel have influenced nursing practice throughout Boston's hospitals and schools of nursing, across the entire United States, and beyond. This unique philosophy guided nursing practice for many years until the economy could no longer sustain it. It was a significant improvement over the traditional approach yet it was modeled after the very structures that it attempted to overcome (Berger, 2011).

Underlying the primary nursing model was the value the organization placed on the clinical practice of nursing at that time. The Strengthening Hospital Nursing Program facilitated the change from primary nursing to a new model referred to as integrated clinical practice. Two of the major internal forces stimulating the need for change at Beth Israel were the increasing severity of patients' illnesses and the decreasing length of stay, which resulted in greater demands on the nurses. Changes brought about by managed care resulted in increased complexity in patients' conditions - patients were staying for shorter periods of time and nurses were admitting and discharging more patients than ever

before. External factors also pressured Beth Israel to change. Increasing competition for managed care contracts required the hospital to reduce its costs. In 1994, the nursing division lost more than 120 positions, mainly from inpatient nursing while patients were sicker, beds were turning more frequently, and there were fewer nurses providing care. On top of that, many nurses experienced monetary losses with the move to 12 hour shifts. It was very difficult for nurses to see their patients being discharged sooner than they thought they should be, all in the name of cost savings. The average length of stay in 1990 for a patient with a hip fracture was about 13 days. Five years later, the length of stay was around 6.5 (see Figure 4). Few nurses at the time received any training on how to provide the same amount of care in half the time. This “sicker and quicker,” inpatient environment led to a significant increase in both the intensity of nursing care for each patient and the need for more nurses, requiring a higher ratio of nurses to patients. Between 1980 and 2004 the average number of registered nursing-care hours per patient day more than doubled from 4.7 hours per day to 10.7 hours (see Figure 5). With this type of increase in-patient care requirements, there was a concomitant increase in the costs of providing nursing care (American Nurses Association, 2014).

Clinical Practice and it stressed a multifaceted, interdisciplinary approach that they believed would ultimately enhance patient care at a lower cost. The guiding principles for Beth Israel were:

- Improve patient and family care through the development of processes that would span the system of care and the spectrum of illness
- Utilize advanced practitioners of nursing effectively in achieving a consistent quality and standard of care.
- Restructure the organizational framework of hospital nursing practice based concepts for novice through expert nursing practice.
- Refine and strengthen interdisciplinary collaboration through integrated systems for the planning and the management of patient care.
- Develop institutionally focused, patient-centered support systems for the delivery of care.

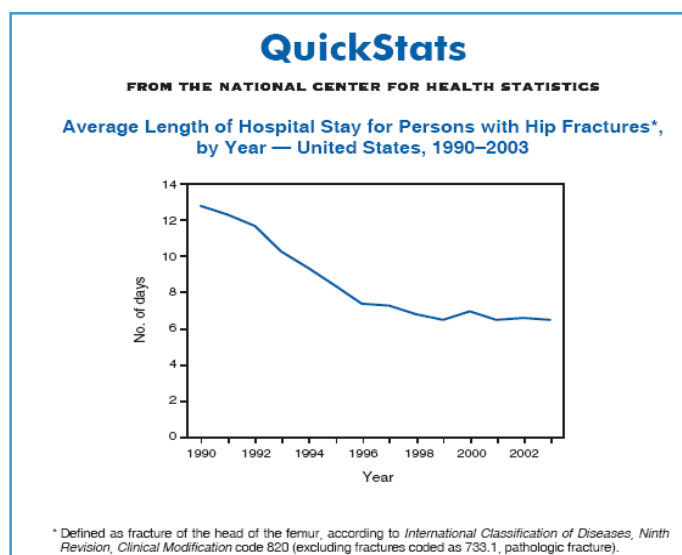


Figure 4: Average Length of Stay for Hip Fractures

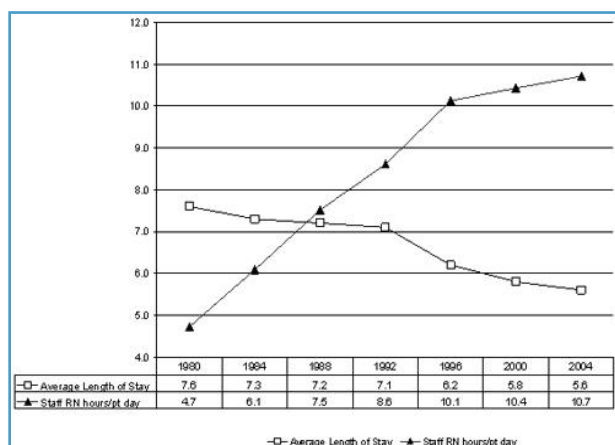


Figure 5: Length of Stay and HPPD (Welton, 2007)

Because of its status as a premiere nursing institution, Beth Israel's solutions become the model for nursing care around the country. The guiding principles were sound but the environment in which they were developed were not supportive of meaningful changes that would impact what the DHHS set out to address in the first place, which was to increase nurses' influence over their work and to enhance the image of nursing. The end result, in an environment of limited resources and increased need, ended up being greater division of labor and greater industrialization through the creation of additional roles that took more and more of the nursing work away from registered nurses.

The strategies proposed by the Strengthening Hospital Nursing initiative were revisited in 2003 with Transforming Care at the Bedside Initiatives, funded by the Institutes for Healthcare Improvement (IHI) and the Robert Wood Johnson Foundation (RWJF). The

Program Results Report from IHI stated that *Transforming Care at the Bedside* (TCAB) was a national initiative designed to improve hospital patient care and the hospital work environment by *empowering* front-line nurses to implement innovative new practices on their units. TCAB differed from the traditional hospital quality improvement program by emphasizing a “*bottom-up* approach to change”. The goal was not only to make the hospital experience safer and more pleasant for patients but also to free up nurses to spend more time in direct patient care, thereby increasing nurse job satisfaction and retention as well as quality of care.

The key finding from the pilot sights included:

- TCAB units in 10 hospitals tested 533 changes in work processes and adopted 377 (71%) of them. A total of 20 (39%) of the changes were spread to other units.
- Available data from the TCAB units showed a statistically significant reduction in harmful falls and readmissions within 30 days of discharge—two measures indicating improvements in safe and reliable care.
- Other TCAB outcome measures showed little movement.
- Questionnaire responses by hospital unit managers and chief nursing officers were supportive of TCAB.
- Staff engagement in TCAB increased—and resistance decreased—as the initiative progressed.

The TCAB program developed, tested and disseminated a structured process for empowering nurses and other front-line hospital staff to take the lead in improving the work environment and quality of patient care on medical-surgical units. Through TCAB, a movement has begun to transform the care delivered on medical-surgical units to better serve patients and to transform the work environment to support professional nursing practice and collaborative teamwork at the bedside.

Seven years later, the Institute of Medicine’s, *A Summary of the October 2009 Forum on the Future of Nursing: Acute Care* released in April 14, 2010 proposed the following “new” strategies:

- Redesign care to optimize nurses’ professional expertise and knowledge.
- Work together to ensure safe and reliable care in acute settings.
- Build systems and cultures that encourage, support, and spread vitality and teamwork in all areas of nursing.

- Put structures and processes into place that ensure patient individual values and choices, and ensures continuity of centered care.
- Create a national learning system to make all models and prototypes accessible to nurses at all levels everywhere in the country.

Each of these initiatives, Strengthening Hospital Nursing, TCAB, and the Forum on the Future of Nursing attempted to address empowerment, patient centered care, and teamwork. There has been little sustained improvement in any of these areas and with even greater economic pressure in 2014, nursing will continued to be faced with these challenges. Now, with sicker, older, and more complex patients, nurses will be expected to care for with fewer and fewer resources without the benefit of a united, patient centered, empowered workforce unless the approaches to change incorporate vast improvements in the power structure in health systems that keeps nurses and patients at the lowest rung of the hierarchy.

Influence of Regulatory Agencies (Empiricism)

The practice of nursing is greatly influenced by external agencies (governmental and private) who are in the business of regulating healthcare delivery. These entities have contributed to the current state of nursing practice through policy development, legal requirements, and defining (prescribing) quality of care. The Centers for Medicare and Medicaid Services have developed Conditions of Participation (CoPs) and Conditions for Coverage (CfCs) that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs (e.g. get paid). These health and safety standards are designed to serve as the foundation for improving quality and protecting the health and safety of beneficiaries (patients) and they impact every nurse in the United States. CMS also ensures that the standards of accrediting organizations like the Joint Commission meet or exceed the Medicare standards set forth in the CoPs/CfCs. The Joint Commission and the Centers for Medicare and Medicaid Services (CMS) have a long history of working together on health care quality and safety issues. The two entities share a common goal of helping health care organizations provide high-quality, safe care, treatment, and services for all patients and their families. CMS granted The Joint Commission deeming authority to evaluate whether hospitals (among other health care organizations) comply with the requirements set forth in federal regulations. By granting deeming authority, CMS has determined that The Joint Commission's accreditation requirements

meet or exceed the federal requirements for hospitals, called Conditions of Participation (CoPs).

In 1910, Ernest Codman, M.D., created the prevailing regulatory body in healthcare, the Joint Commission, formerly known as the Joint Commission on Accreditation of Healthcare Organizations. His proposed system of hospital standardization would allow hospitals to track every patient it treated long enough to determine whether the treatment was effective. If the treatment was not effective, the hospital would then attempt to determine why, so that similar cases could be treated successfully in the future. This classic cause and effect approach (scientific method) resulted in the construction of an empirical system of patient care. The power of the Joint Commission has grown since its inception through congressional support. In 1972, the Social Security Act was amended to require that the Secretary of the U.S. Department of Health and Human Services (DHHS) validate Joint Commission findings. The law also requires the Secretary to include an evaluation of the accreditation process in the annual DHHS report to Congress. Today, health systems are required to be accredited by the Joint Commission (or comparable agency) in order to receive Medicare and Medicaid funding (The Joint Commission, 2014).

The Joint Commission has accredited hospitals for more than 50 years and today it accredits (controls) approximately 4,250 general, children's, long term acute, psychiatric, rehabilitation and surgical specialty hospitals, and accredits 358 critical access hospitals maintaining a unique accreditation program for these organizations. Approximately 91 percent of the nation's hospitals are currently accredited by The Joint Commission. Joint Commission standards, of which there are hundreds, address the organization's level of performance in key functional areas, such as patient rights, patient treatment, medication safety and infection control. The standards focus on important patient care and organization functions that are essential to providing safe, high quality care. The Joint Commission believes that if an organization does the right things and does them well, there is a strong likelihood that its patients will experience good outcomes. The Joint Commission develops its standards with input from healthcare professionals, providers, subject matter experts, consumer organizations, government agencies (including the Centers for Medicare & Medicaid Services), and employers. The Joint Commission on-site survey process is *data-driven*, patient-centered and focused on evaluating actual care processes through observation. The objectives of the survey are not only to evaluate the organization, but to provide education and *good practice* guidance that will help staff continually improve the

organization's performance. Joint Commission surveys are designed to be organization-specific, consistent, and supportive of the organization's mission and goals. Additionally, Joint Commission accredited organizations can opt for certification in dozens of specialty areas (see Table 2).

<ul style="list-style-type: none"> • Acute coronary syndrome • Alzheimer's disease • Asthma • Cancer • Chronic kidney disease • Chronic obstructive pulmonary disease • Congestive heart failure • Coronary artery disease • Depression • Diabetes • Emphysema • Hemophilia 	<ul style="list-style-type: none"> • HIV/AIDS • Ischemic heart disease • Low back pain • Lung volume reduction surgery • Migraines • Multiple sclerosis • Obesity/bariatric surgery • Osteoporosis • Parkinson's disease • Primary stroke • Sickle cell disease • Ventricular assist device or VAD
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Table 2: Joint Commission Specialty Certifications

When I started my career in the late eighties, I was vaguely aware of the Joint Commission and its purpose. Today, its purpose and its presence is made known to each and every employee, provider and volunteer who works in a health system, hospital or clinic; noticeably, at least every two years with on-site surveys and fundamentally through their influence in all of the work that we do. The Joint Commission has purview over every process, practice, procedure, and plan related to the care of the patient.

In addition to the influence of Joint Commission, the American Nurses' Association has created what is known as the Magnet Recognition Program. This program was created to address nurse recruitment and retention concerns brought about by the 1990s nursing shortage. The American Academy of Nursing (part of the ANA) created a task force on Nursing Practice in Hospitals and conducted a study that identified work environ-

ments that attract and retain well-qualified nurses who promote quality patient, resident and client care. Forty-one of 163 institutions possessed qualities that enabled greater capacity to attract and retain nurses, and were therefore described as “magnet” hospitals. These characteristics that distinguished 25% of the organizations from others are known to this day as the "Forces of Magnetism." Today, there are five guiding principles that include Transformational Leadership, Structural Empowerment, Exemplary Professional Practice, New Knowledge, Innovations, & Improvements and Empirical Outcomes.

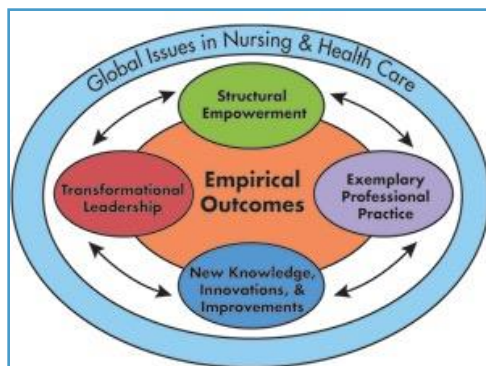


Figure 6 : Magnet Model (ANCC, 2008)

As you can see from Figure 6, the center (foundation) of the Magnet Recognition Program is Empirical Outcomes. The documents prepared for the Magnet Recognition Site Survey consist of thousands of pages filled with outcomes, lending credence to the belief that all that nursing does can and should be measured, especially if you want to attract and retain nurses.

Also playing a role in defining the profession of nursing are the Institute of Medicine, The Institute for Healthcare Improvement, The Leapfrog Group, The Agency for Healthcare Quality and Research (arm of DHHS), the American Nurses' Association, and the American Nurse Executive Organization, to name a few noteworthy organizations who exert significant influence on healthcare systems. In addition to external agencies' influences on the work of the nurse, there are volumes (thousands) of policies, procedures, protocols, rules, and regulations developed within an organization all that can be tied back to a regulatory agency, governmental body, or professional organization of one sort or another. Some organizations *allow* bedside nurses or patients to have the ability to exert influence into these processes through what is known as *shared* governance. Shared governance involves collaboration in such activities as staff education and development or

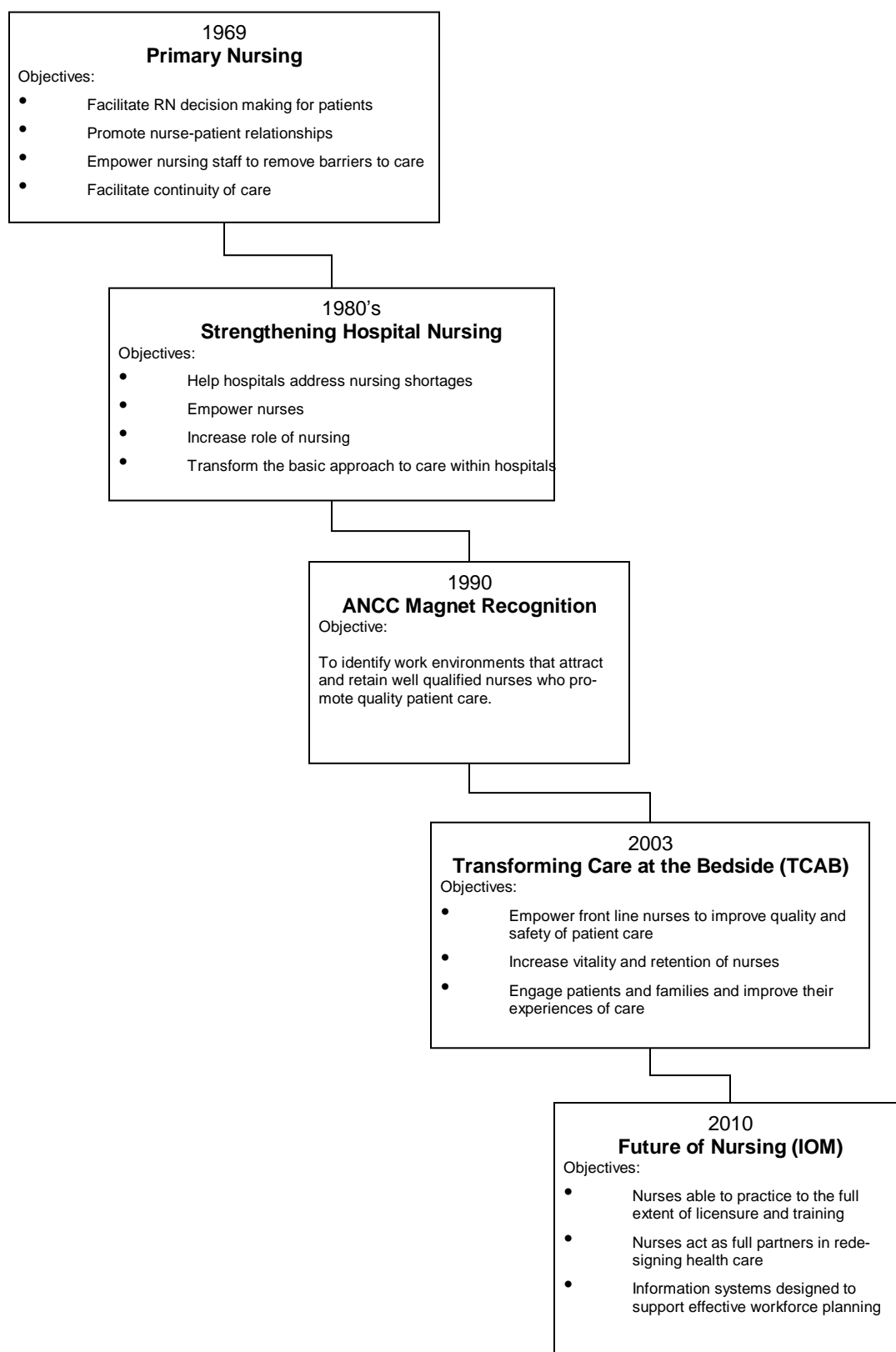


Figure 7: Forty Years of Practice Improvement Initiatives

implementing evidence-based practice. It involves teamwork, problem-solving, and accountability (themes that are pervasive within the practice of nursing and efforts to improve the practice of nursing). The goals of shared governance are improved staff satisfaction, productivity, and patient outcomes through representative participation. Similarly, many organizations are creating patient advisory councils or boards for the purpose of improving the patient experience (American Nurses Association, 2011).

For more than forty years, powerful groups have set out to transform the practice of nursing (see Figure 7). Some of these groups have come from within the practice, like the American Nurses Association, but most have been external. The Robert Wood Johnson Foundation, the United States Government and most recently, the Institute of Medicine have taken major roles in leading and providing financial support for these initiatives. All of the efforts have attempted to reconstruct the practice of nurses through empowerment and engagement, the elevation of practice, and the redistribution of work. Ultimately, the results have largely been influenced by economic forces, resulting in nursing services being diminished or modified and fewer nurses taking care of more and sicker patients.

Political Influence (Healthcare Reform)

In 2013, healthcare jobs in the U.S. declined for the first time in anticipation of reimbursement cuts and to prepare for medical treatment moving from the acute care setting to less expensive outpatient facilities, once again the job losses reflected an industry in flux as the 2010 Patient Protection and Affordable Care Act, also known as Obamacare, took effect. Reimbursements for Medicare, the U.S. health plan for the elderly, are being reduced to help cover the insurance expansion under Obamacare, and hospitals are contending with lower payment rates from insurers on the public exchanges. Acute care, provided at hospitals is shifting once again to outpatient settings, lowering patient volumes and creating a situation where patients in hospitals are sicker and their discharges occur quicker. The terms population health, patient centered medical homes, disease management have replaced the terms managed care, professional practice organizations, and care management but the desired outcomes are remarkably similar; one of providing care at the lowest cost and in the most efficient setting (Chen, 2014).

Prior to the Affordable Care Act, hospitals allocated all patient care expenses to specific categories or cost centers that were mapped to a Medical Cost Report (Centers for Medicare & Medicaid Services, 2005; Centers for Medicare & Medicaid Services,

2006). For example, medications would map to the pharmacy cost center, and a blood sample would map to the lab cost center. Currently direct nursing costs are allocated to one of only two accommodation cost centers: routine care where nurses have an assignment of 4-7 patients and intensive care where nurses care for 1-2 patients. Nursing costs are treated as a lump sum and then averaged and standardized per patient day and are treated no differently than housekeeping and food services. Since direct nursing care hours and costs are highly correlated, this accounting approach implies that all patients within either the routine or intensive cost centers receive the same level and standard of nursing care (Welton, 2007).

Hospitals receive the same payment for a given diagnosis, based on the Diagnosis Related Group (DRG) relative weight, regardless of age, acuity or co-morbidities. Standardized nursing costs per patient day are used to set these weights, rather than the individualized amount of care given a particular patient. This creates a distortion or bias in the DRG-based system in that nursing care is held at a constant cost per patient day so does not affect the relative weight used to calculate the actual hospital reimbursement despite the fact that nursing care makes up 41% of all hospital costs (Dalton, 2007).

Hospitals like Cleveland Clinic have begun offering thousands of buyouts in an effort to cut costs, citing financial pressures from health care reform as one of the reasons for their decision. Dozens of hospitals across the country are taking similar measures due to health care reform requirements and because of significant cuts to Medicare, hospital debt, and states' rejection of Medicaid expansions. This economic situation could be the new norm for healthcare. The Office of the Actuary for the Centers for Medicare & Medicaid Services predicted that decreases like these would occur, stating in a 2010 memo that by 2019 it expected hospitals, skilled nursing facilities and home health agencies would undergo a 15 percent reduction in nursing positions (Leonard, 2013).

For a sector that employs more than 5.5 million people, according to the American Hospital Association, the numbers are likely to get worse. The requirements that hospitals must meet in order to receive full Medicare reimbursements are having a large impact. Hospitals once were able to bill insurance companies and the federal government for services rendered, but now they have to demonstrate that those services help keep patients healthy. This approach increases the pressure for organizations to produce even more outcomes data and further standardize care.

The government has capped reimbursement rates for specific diagnoses and is requiring that hospitals pay to fix their own medical errors, including hospital-acquired infections. The plan is to lower inefficiencies caused by errors, thereby lowering costs. Medicare will not pay the treatment costs for these secondary diagnoses unless they were present on admission. The conditions that will no longer be covered by Medicare include surgical site infection after coronary artery bypass graft (CABG) surgery, pressure ulcers, falls, air embolism, leaving objects inside the patient during surgery, vascular catheter-associated infections and certain catheter-associated urinary tract infections. Many of these are also, coincidentally, nursing sensitive indicators (Leonard, 2013).

Many cost savings initiatives in health care have been realized at the expense of direct caregivers, including downsizing of the professional nursing workforce, restructuring of nursing services, changes in staffing mix, rapid movement of patients to alternative care settings, and decreased support services for patient care. Furthermore, poor collaboration among health care providers hampers efforts to provide quality care in today's health systems. Many nurses describe the current work environment as highly stressful and professionally unfulfilling (Josiah Macy Foundation, 2000).

Nurse leaders and academia have to continually *prove* the value of nursing and remind health system executives as well as government regulatory agencies that the cost of having more nurses offsets the high costs that are incurred as a result of the treating those patient complications that could have been prevented by having an adequate number of nurses, but which will occur when an adequate number of nurses per shift are not provided. Many have determined the cost of these preventable complications in order to demonstrate the economic value of the registered nurse (RN), who is prepared to prevent these complications.

The federal government now impacts nursing practice more than ever before with a pay-for-performance system that measures patient's perception of care as well as patient satisfaction. HCAHPS itself is a survey instrument that aims to measure patient satisfaction with the entire hospital experience. Recently discharged patients are asked to answer 27 questions, in seven key topic areas that include responsiveness of hospital staff, nursing communication skills, physician communication skills, pain management, quietness and cleanliness, explanations about medications, and discharge instructions.

The survey is designed to provide *objective* (measurable) and meaningful comparisons between hospitals, in areas that have been determined to be *important to consum-*

ers. The results of surveys will be used to determine reimbursement and hospitals can gain or lose up to two percent of their Medicare reimbursement fees, depending on how well they score. If a hospital or health system chooses not to participate in HCAHPS, two percent of their payments will be eliminated, which can make the difference between financial viability and certain failure. HCAHPS survey data is currently being collected and tallied, and the Centers for Medicare and Medicaid Services began implementing incentive payments for hospitals in 2013. There are over fifty government approved vendors for HCAHPS, including companies like Press Ganey and Gallup.

Nurse-patient interactions, as defined by CMS are being measured, studied and used for improvement purposes. For the first time in nursing history, patient satisfaction scores are being examined frequently through weekly reports by consultants, analysts, healthcare leaders and the staff who interact directly with patients because, for the first time in history, health systems are being paid by the government and insurance companies for positive patient satisfaction scores.

Nurses make up the largest group of health care workers, and they are the “face” of the daily care that patients receive and the HCAHPS survey section on nurses’ communication has been found to have the greatest impact on overall patient satisfaction and likelihood to recommend the hospital to family and friends. The survey asks questions like “how often do nurses communicate well or respond quickly to a patient request?”, and patients can respond with Always, Usually, Sometimes, or Never. Hospitals only receive credit for the *Always* responses and every nurse in the United States is being held accountable (punished or rewarded) for the HCAHPS score and two percent of billions of dollars. This further breaks down the interpersonal, compassionate aspect of the nurse patient relationship into measurable and reportable pieces of data.

Nurses repeatedly have to prove their economic value and do so by enumerating the costs of problems that occur without adequate numbers of nurses. However, (not surprisingly), there has been little evidence that specific nurse-to-patient staffing ratios improve safety or quality. For example, a study of California hospitals before and after the imposition of mandatory ratios demonstrated an increase in costs but no improvement in quality of care (Donaldson, Bolton, Aydin, Brown, Elashoff, & Sandhu, 2005). Legislatively mandated nurse-to-patient staffing ratios also create an unfunded mandate because the current payment system treats nursing care as a fixed cost that is the same for all patients regardless of the actual amount of nursing care delivered to an individual patient (Welton,

2007; Welton & Harris, 2007). The cost associated with hiring more RNs who are needed for the higher, mandated ratios is not offset by additional payment to hospitals. As we now know, with the adoption of the Affordable Care Act, payments to health systems are now actually lower than they have ever been.

Over the past several decades, health system leaders have broken down patient care/nursing into a hierarchy of thousands of activities so successfully that each activity could be performed by a machine, or at best a technician. This has been accomplished through the provision of tools, diagrams, algorithms, policies, procedures, best practices, rosters, and regulations. There are tools for determining suicide risk, fall risk, skin impairment risk, risk for infection, and even risk for elopement (escape). Each individual tool “prompts” the nurse to assess risk for failure of some sort or other. None of the tools prompt the nurse to assess success or allows the nurse to view the patient as a whole, complex individual. Today, when nurses “write” about patients, they are checking/clicking boxes in a menu of body system options. Years ago, there were more opportunities for sharing patient stories and experiencing the patient as a whole being. It is not surprising that nurses cannot tell stories about patients as subjects. Every day, I ask nurses “What was Mrs. Smith like before she got sick?” and the resounding answer frequently is “I don’t know”. You may be asking why nurses wouldn’t know the answer to this question and I believe it is because there isn’t a box to check that addresses this topic. It’s as if the patient didn’t exist before that nurse started to provide care.

Work has been broken down even further into new and different professional categories. Twenty-five years ago, there were few allied health professionals (i.e. therapists, dietitians, risk managers) in acute care facilities. In the early 1990’s after the adoption of PPS (prospective payment system), case managers, who are responsible for coordinating patient care across the continuum, starting being utilized in acute care facilities in place of or in addition to the primary nurse. Case management roles were developed in response to the bedside nurse’s inability to manage complex discharges and in response to the creation of DRG (Diagnosis Related Groups) payment categories that replaced fee for service payments. Case managers were able to influence length of stay, which positively impacted the bottom line with the new payment system. The number of respiratory therapists, (who treat people with breathing or cardiopulmonary problems), also saw dramatic growth (53%) in the acute care settings from 2000 to 2010. Allied health professionals are now performing functions once performed by nurses and these roles have experienced

tremendous growth; further eroding the role of the professional nurse. There are patient transporters, clinical documentation specialists, bed placement staff, patient representatives, discharge planners and others whose roles did not exist twenty years ago. These roles have all been designed to allow the nurse to provide care for more and more patients. We continue to take more and more off the plates of nurses because of the increased pressure to provide affordable care. This has resulted in the nurse being unable to appreciate the patient as a whole human being. The number of tasks performed by nurses is the primary focus of administrators and consultants and as a result the work of nursing is no longer seen as holistic and many practitioners are now experiencing what is perceived to be a scarcity of meaningful work.

An ordinary day for a medical/surgical, acute care nurse begins with receiving a report from the previous nurse that relays vital signs (blood pressure, pulse, temperature and respirations), diagnosis, intravenous fluids, upcoming procedures, and lab results, followed by gathering medications for the first medication delivery of the day. The next two hours is spent delivering medications and “documenting”, which means checking boxes in the EMR.

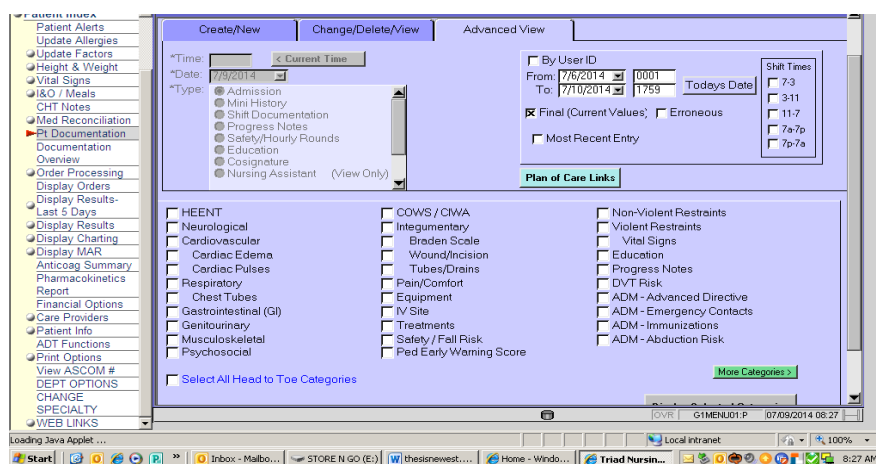


Figure 8: Example of Patient Documentation

The screenshot shows a medical documentation software window. On the left is a sidebar with a tree view containing categories like Patient Index, Patient Alerts, Update Allergies, Update Factors, Height & Weight, Vital Signs, I&O / Meals, CHT Notes, Med Reconciliation, Pt Documentation, Documentation Overview, Order Processing, Display Orders, Display Results (Last 5 Days, Display Results, Display Charting, Display MAR), Anticoag Summary, Pharmacokinetics Report, Financial Options, Care Providers, Patient Info, ADT Functions, Print Options, View ASCOM #, DEPT OPTIONS, CHANGE SPECIALTY, and WEB LINKS. The main window has a title bar 'WDL' and a large form area. The form is divided into sections for Eyes, Nose, Throat, Ears, Teeth, and Mouth. Each section has checkboxes for various symptoms. For example, the Eyes section has checkboxes for Redness, Edema, Blind, Blurred Vision, Double Vision, Cataract, and Discharge, each with sub-options for Right, Left, and Bilateral. The Nose section has checkboxes for Congestion, Bleeding, and Other. The Throat section has checkboxes for Redness, Hoarse, Sore, and Other, with an additional checkbox for Edema and Difficulty Swallowing. The Ears section has checkboxes for Discharge, HOH, Tinnitus, Earache, and Deaf, each with sub-options for Right, Left, and Bilateral. The Teeth section has a checkbox for Other. The Mouth section has checkboxes for Lesions and Other. At the bottom of the form is a 'Comment' field with a text area and a scroll bar. Below the form are buttons for 'Continue', 'Prev', 'Complete', and 'Cancel'. The status bar at the bottom shows 'OVR | G1CHEMT-P | 07/09/2014 08:32'.

Figure 9: Example of Specific System Documentation

Once documentation is complete, the nurse will review any new orders, admit and discharge patients, accompany patients to procedures, and review data as it is produced. Most communication with patients throughout the day is related to tasks and procedures.

The inextricable linkages between nurses and their focus on tasks and the standardization of work have become more noticeable, primarily because decreased reimbursement is tied to poor outcomes and people are now very interested. These outcome conditions include catheter-associated urinary tract infection, stage III or IV pressure ulcers, manifestations of poor glycemic control, deep vein thrombosis/pulmonary embolism, and falls. Because of this, tasks such as turning, ambulating, personal care, and blood sugar checks are emphasized over holistic care. Nurses are told repeatedly that when these care activities are missed, either delayed or omitted, the probability of costly outcomes increase. Nursing is typically held *responsible or accountable* for the negative outcomes. For example, if turning and/or ambulating is missed, the likelihood of developing a pressure ulcer increases as does the likelihood of developing a deep vein thrombosis, both of which reduce the quality of care and reimbursement. Nursing administrators and risk managers create audits upon audits, checklists, and score cards to assure compliance with activities to prevent costly outcomes.

Another manifestation that has further increased the standardization and break down of nursing activities is the increase in mandated public reporting of hospital perfor-

mance, which is now required by a number of states. Public reports of outcomes reflect nursing's negative contributions, according to health system leaders. Missed care, which might otherwise have remained unknown, is now public information. Because, according to the American Nurses' Association, registered nurses have public accountability for providing safe care, this accountability is becoming increasingly scrutinized at the "C-Suite" and board levels and the focus on tasks has consumed nurse leaders, nurses, and other interested parties (e.g. risk management). More than ever, the challenge for nurses in their daily practice is to view safety as a focus of all actions and not a byproduct of care.

However, overreliance on standards that results in routine interpretations and behaviors may jeopardize patient safety when nurses do not engage in the development of relationships with their patients. It is no surprise, based on the focus of health system leaders, government agencies, and consumer advocacy groups that nurses are focused primarily on task, numbers, and data elements versus the person who comes to them in need of healing and compassion (Anthony & Vidal, 2010).

Below is a portion of an abstract published in the *Journal of Nursing Administration* in 2009:

To improve the healthcare environment where nurses work and patients receive care, it is necessary to understand the elements that define the healthcare environment. Primary elements include (a) the occupants of the room and what knowledge, skills, and abilities they bring to the situation; (b) what tasks the occupants will be doing in the room; and (c) the characteristics of the built environment. To better understand these components, a task analysis from human factor research was conducted to study nurses as they cared for hospitalized patients (Battisto, Pak, & Vander Wood, 2009).

In the United States, the concept of health and health care has largely been governed by the medical model or more specifically the biomedical model. The medical model presumes the existence of illness or disease and emphasizes clinical diagnosis and medical intervention, (cause and effect) in the treatment of disease or its symptoms. Under the medical model, health is defined as the absence of illness or disease and death is considered the opposite of health. The implication is that optimum health exists when a person is free of symptoms and does not require medical treatment. Prevention of disease and health promotion are relegated to a secondary status (Shi & Singh, 2010).

A view of biomedical causality that is pushed down from the hierarchy in healthcare organizations stresses microanalysis of parts that virtually prohibits any perspective of the complexity of relationships between patients and providers, between patients and their world and between providers and their worlds. The oversimplification of nursing activities through policies and procedures, scripts, and checkboxes can reduce one's sense of embodiment for both patients and providers. An example of a dehumanizing interaction that is informed by a reductionist view of the body occurs when nurses are unable to see a unique, complex individual behind a diagnosis such as delirium or dementia that is expressed in elderspeak and undermining of autonomy and self-actualization (Freire, 1996).

"To be human means to live within the fragile limits of human embodiment." Our human body reveals tiredness, pain, hunger, vitality, and satiety. Our attention is often on the dehumanized, bodily messages that reflect disease or medical diagnoses rather than on the possibilities and potentials. A more humanizing perspective would view well-being as a quality that makes life worth living versus an absence of disease. Our current model of causality that is deterministic and linear is not only dehumanizing, it "underestimates human spirit, purpose and meaning" (Freire, 1996, p. 18).

Organizational or Structural Impact

The political, regulatory, and economic influences significantly impact every organization in the country. Because of these influences, tasks and patients have become compartmentalized. Nurses are assigned measurable tasks such as medication administration, IV care, dressing changes, physical assessments, admissions, discharges, and more recently added, bedside shift report, hourly rounding, medication reconciliation, quality checks, risk assessments, charting (documentation), and care team conferences. Nurses organize their shifts according to their tasks. Interestingly, as I write this, nurses on two of my units are collecting data with a PDA that is pre-loaded with a list of activities (tasks) that they are prompted to click at random times so that Organizational Improvement staff can quantify how much time is spent "at the bedside".

Patients are compartmentalized as well; there are specialty floors, with specialty nurses and scopes of care. There are cardiac, renal, oncology, pulmonary, behavioral health, and GI units. There are levels of care, critical, pre-operative, operative, post-operative, emergency, acute, and post-acute (rehabilitation). There are geriatric, pediatric, and women's specialty units. There is a cardiac intensive care, a cardiac surgery inten-

sive care, and “ordinary” intensive care. So, a patient could come to the emergency room, go to the operating room, the post anesthesia unit, intensive care, intermediate care, surgical care, and rehab, if all goes well.

The hierarchy within nursing further stratifies and breaks up the work. There are students, orientees (novice nurses), experienced nurses, nurse practitioners, clinical specialists, nurse anesthetists, clinical educators, preceptors, clinical unit leaders, senior nurses, managers, directors, senior directors, and chief nursing officers. There are nurses in roles outside of “floor nursing” that include case managers, utilization reviewers, clinical documentation specialists, risk managers, patient relations representatives, radiology staff nurses, clinical improvement advisors, and organizational improvement specialists.

Outside of the practice of nursing, there are others who contribute to the care of patients. Physical therapists guide and direct the plan of care for mobility. Respiratory therapists provide oxygen therapy. Chaplains provide spiritual direction and comfort. Case managers and social workers plan transitions in care. Nursing assistants provide personal care, obtain vital signs, and help with turning, positioning, and toileting. Transporters move patients from place to place. Housekeepers provide a clean environment. Etcetera, etcetera.

The work that I performed almost thirty years ago exists only in the minds of the very experienced (old) nurses. When I worked in a neonatal intensive care nursery, I provided all aspects of care to one or two babies and their families. No therapists or chaplains or other assorted helpers existed at the time; except in very rare circumstances. Because of my training and my experiences I was able to see the whole picture of the babies within their family unit. My colleagues and I were completely responsible for emotional and spiritual support as well as the physical well-being of our patients. We were with our patients from the time they came into the world until they left us and even after they left us. We provided support for those who lived on and for those who died in our care through memorials and reunions.

The work of nursing and of nurses has become progressively industrialized over the past two decades primarily due to regulatory, political and economic influences that have either forced stratification of work or required measurement upon measurement to scrutinize or validate the work. Many noted nurse researchers have suggested patient complications occur and patient care deteriorates to the point that hospitals fail economically if nursing staff is either under-educated or under-staffed. Most healthcare institutions

monitor dozens of measures in order to prove that nurses bring value to the organization (or at least don't add cost). In 1996 a team of nurse researchers coined the phrase "nursing-sensitive indicators" to reflect elements of patient care that are directly affected by nursing practice – and it's become a buzzword in health care today. These indicators are said to reflect structure, process, and outcomes that are impacted by the nursing process (American Sentinel University, 2001). Structural nurse sensitive indicators include such things as the supply of nursing staff, the skill level of nursing staff, and the education and certification levels of nursing staff. Process indicators measure methods of patient assessment and the specific nursing interventions performed. Nursing job satisfaction is also considered a process indicator. Outcome indicators reflect patient outcomes that are determined to be nursing-sensitive because they depend on the quantity or quality of nursing care. These include things like pressure ulcers and falls. Other types of patient outcomes are related to other elements of medical care and are not considered to be nursing-sensitive and these include things like hospital readmission rates and length of stay.

In the facility in which I practice, patient outcomes are the predominant source of data and include adverse consequences as pressure ulcers, falls, infections, and intravenous infiltrations. Monthly scorecards that look at pressure ulcer (bedsores) rates, patient falls, patient satisfaction, hours per patient day, and staff satisfaction are used to measure success and failure in the provision of nursing care (American Nurses Association, 2014).

All Inpatient Units CAUTI Prevalence Study							
Documentation	Baseline Aug-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10
Percent of Census with Foley Catheters Goal: 20%	30%	26%	25%	27%	24%	25%	25%
Patient Meets Criteria Today Goal: 95%	96%	88%	89%	90%	90%	89%	95%
Criteria to Continue Met Documented Goal: 95%	0%	17%	40%	56%	44%	47%	56%
Assessment Complete Documented Goal: 95%	0%	20%	35%	56%	47%	48%	55%
Direct Patient Observation of Care Practice		Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10
Catheter Secured	33%	72%	81%	88%	88%	87%	88%
Tamper Evident Seal Intact	69%	81%	86%	88%	90%	92%	84%
Drain Tubing Positioned Properly	10%	82%	89%	90%	70%	79%	99%
Drainage Bag NOT Touching Floor	79%	89%	98%	98%	96%	97%	100%
Total Care Practices Met Goal: 95%	47%	81%	89%	91%	86%	89%	93%

4	Goal	Average	2007-2008	JAN	FEB	MAR
5						
6	Staffing					
7	10.0	4.0	Nursing Total Turnover Rate	4.0	3.0	5.0
8	5.0	4.0	Voluntary Turnover Rate	4.0		
9	5.0	3.0	Magnet Controllable Turnover rate	3.0		
10	60.0	59.0	RN Nursing Hours (%)	59.0		
11	30.0	30.0	LPN/LVN Nursing Hours (%)	30.0		
12	5.0	5.0	UAP Nursing Hours (%)	5.0		
13	5.0	59.0	Agency Nursing Hours (%)	59.0		
14	9.0	90.0	Nursing Hours/Patient Day	90.0		
15	6.0	60.0	RN Hours/Patient Day	60.0		
16	Clinical Quality					
17	3.0	10.0	Patient Falls per 1,000 Patient Days	10.0		
18	0.0	10.0	Injury Falls Per 1,000 Patient Days	10.0		
19	90.0	90.0	Pain Assessment	90.0		
20	5.0	3.0	Pressure Ulcer Prevalence	3.0		
21	0.0	2.0	Peripheral Intravenous Infiltrations	2.0		
22	0.0	0.0	Catheter Acquired UTI	0.0		
23	0.0	1.0	Blood Stream Infections	1.0		

Figure 10: Examples of Nursing Scorecards (QI Macros)

When the work is broken down into so many measurable pieces, it is very difficult for nurses (and others) to experience patients as anything but a number or a percentile ranking. Success in nursing is defined as the absence of a negative outcome rather than a positive impact on the patient's wellbeing, health or piece of mind. For the past four decades, academicians, politicians, physicians, executives and powerful, wealthy, philanthropic organizations have sought to re-fashion nursing practice to meet their needs. Their initiatives have been strikingly similar and it would seem since they have been oft repeated, disappointing in their impact. The voice of the powerful has been heard. The voices of the powerless; the nurses and the patients have been silent.

The Bearing of Constructions on the Practice of Nursing and Patient-hood

In *Celebrating the Other*, E. E. Sampson (1993) describes the effect of constructions as that which robs the other of genuine standing in the world by permitting the dominant groups to operate more freely to achieve validation and to ensure privilege and power. In healthcare, the dominant groups (i.e. administrators, physicians, and nurses) use others (such as nurses and patients) to be of service to the dominant group. Anyone who enters a hospital experiences the impact of the dominant groups on the *others* immediately. As soon as the patient-other enters a healthcare institution, he/she begins to perform as a submissive being, there for the benefit of the organization or the provider. Every patient receives a unique *identifier*, is placed in a room or cubicle, undergoes painful procedures, answers depersonalized (but deeply personal) questions, eats what he/she is

told to eat and when he/she can eat it, wears the uniform of the institution, and conforms to the fancies of the dominant.

I sat there in awe as the old monk answered our questions. Though I'm usually shy, I felt so comfortable in his presence that I found myself raising my hand, "Father, could you tell us something about yourself?" He leaned back. "Myself?" he mused. There was a long pause. "My name...Used to be... Me. But now... it's you.

(Theophane the Monk, 1981, p. 65)

Nurses, in response to their orientation and assimilation into the organization, are mandated into controlling their responses to people to such an extent that, instead of reacting to them in a responsive way, they react to them mechanically, according to body system parts, or checklist, or other protocols, scripts or devices imposed on them by others. Through the required application of scientific methods, all *naturally occurring* knowledge can be quarried, excavated, and fashioned into a marketable product, also known as the Electronic Medical Record.

Day One	Day Two
<ul style="list-style-type: none"> Welcome Mission, Vision, and Values Past, Present and Future Employment Handbook Healthcare Regulatory Compliance Continuous Improvement Getting Paid IT Employee Services Service Excellence 	<ul style="list-style-type: none"> First, Do No Harm Emergency Codes Fire Safety, Hazard Communication Safety Culture, Chest Pain and Public Safety Patient Bill of Rights and Responsibilities Ergonomics Infection Prevention Logistics Benefits

Figure 11. New Employee Orientation Schedule

A similar situation exists for the nurse-other. When a nurse joins the organization s/he spends the first two days in organizational orientation (See Figure 11). The nurse other is presented with a list of tasks and procedures that define and describe what her work will be. Obviously missing from the printed schedule are the words *patient* or *health*

or *caring*. Even the topic of *service* excellence touches on patient relationships from a service industry perspective rather than a relational, therapeutic perspective.

Table 3 provides a partial example of an orientation pathway for a nurse starting a job in critical care. This tool is used for nurses with at least one year of hospital practice. Inexperienced nurses required a more in depth orientation that lasts three to six months. Clearly, the focus for an experienced nurse is on completing tasks and understanding data. Nowhere in this document (that continues up to week six) will you find the words relationship, communication family, or support. According to Sampson, we become what we take ourselves to be and that the processes within which we generally make sense of ourselves to ourselves are produced and reproduced in our daily social activities (Sampson, 1993).

Nurses begin their careers making sense of themselves as taskmasters. It follows that what we are to ourselves reflects the character of that activity – and if that activity is scientifically managed, then our very being will become fragmented, separated into hierarchically ordered elements, and amenable to external control. And so, we have broken down the work of nurses into pieces and parts. We give medications, do assessments, take vital signs, complete a discharge, etc. and we measure as much of this as administrators and regulatory departments deems necessary. This is then how we make sense of ourselves and how we see the work we do.

I understand that it is essential for all critical care nurses to understand how to use emergency equipment and what the signs and symptoms of a stroke are but I also believe that it is equally important for nurses to understand coping skills, or the signs of grieving, or how to undergird family support; all of which are absent from any orientation pathway in use in our system. It is clear to the new nurse that learning to perform tasks takes precedence over establishing relationships and communicating compassionately during the *on-boarding* process.

Successful work, in today's nursing world, is viewed as getting tasks completed in the order determined by policies or procedures or the routine established by the institution.

	Week 1	Week 2
FOCUS	Familiar with environment Introduce frequently used equipment Define assess/data collection skills	Introduce atrial dysrhythmias Become familiar with emergency equipment Medication administration Care for one stable patient with back up Observe diagnostic stress testing Location of PO/IV meds/Narcotic box
ASSESS- MENT DATA COL- LECTION	Basic assessment IV therapy assessment Practice starts Rhythm recognition PIR charting Patient Education Micromedex	Lab data (normal/abnormal) Admission/discharge/transfers Heart/Lung sounds Ribs/Murmur/S3, S4 Rales/wheezes/rubs Signs and symptoms of angina
EQUIPMENT	Call system Beepers Glucometer Suction Pulse Ox Monitoring sys IV pumps Telephone Thermometer Oxygen	NIBP Drains Code Cart Pacers Arterial Line Fax machine Kardex Pressure line Telemetry
POLICY & PROCEDURE	Schedule I & O Shift routines Report Guidelines Medex Patient record Pathways Codes Assignments Kardex	Chart order Medication administration Order sets Routine orders Heparin protocol DNR
INDEPENDENT STUDY	Review Policies and Procedures Manuals Scavenger Hunt Complete learning packets from list	Review infection control manual View cardiac cath video/Angioplasty Learning packets from list
OUTCOMES	Perform basic assessment/data collection Measure PR/QRS/Rate Obtain rhythm strips Answer telephone and call bell Apply oxygen via wall supply	Provide safe and appropriate care for one patient Perform cardiac and pulmonary assessment Recognize signs and symptoms of angina and verbalize treatment Interpret sinus and atrial rhythms Perform IV access Perform Venipuncture

Table 3. Registered Nurse Orientation Pathway

With the recent addition of the Electronic Medical Record (EMR), the order of completion of one's work is now regulated by the computer system's logic. In conversations from nurses from around the country, this is not limited to the region in which I practice and seems to be the way that most nurses practice.

Many nurses believe that they alone are responsible for whom they are as professionals and for the problems inherent in their role and many have stopped believing that they can change their lot. They no longer dream of overcoming the problems they face because the problems are entrenched or embedded 'in the system' and cannot be located and solved by individuals, certainly not by individual nurses. They feel powerless. This perception encourages a survival mentality and often leads to burnout. Because the caring work and the patient nurse relationship seems to count for less than the recorded, formulated indicators of them, most nurses have come to believe that impression management or data manipulation is more important than their professional practice of caring and health promotion and significantly more important than an authentic, spontaneous relationship.

Professional Behavior Expectations

Research has implied that women and men who enter into the field of nursing are known to have issues with dependency and self-worth. A 1994 study by Holder, Farnsworth, and Wells found that 70% of the randomly selected nursing students surveyed came from families with histories of sexual molestation, chemical dependence or physical violence. A 2004 study of 35 southeastern and southwestern nursing programs conducted by Parker, Faulk and LoBello also found relationships between family pathology and codependency traits with students who experience difficulties with interpersonal relationships (Gessler & Ferron, 2012).

The National Council of State Boards of Nursing has issued statements that suggest that some nurses may not be capable of entering into a spontaneous relationship without becoming unprofessional and describes the possible impact of an abuse of power.

Professional boundaries are the spaces between the nurse's power and the patient's vulnerability. The power of the nurse comes from the professional position, the access to private knowledge about the patient and the patient's need for care.

Establishing boundaries allows the nurse to control this power differential and allows for a safe interaction to best meet the patient's needs.

Boundary crossings are brief excursions across professional lines of behavior that may be inadvertent, thoughtless or even purposeful, while attempting to meet a special therapeutic need of the patient. Boundary crossings can result in a return to established boundaries, but should be evaluated by the nurse for potential patient consequences and implications. Repeated boundary crossings should be avoided. Boundary violations can result when there is confusion between the needs of the nurse and those of the patient. Such violations are characterized by excessive personal disclosure by the nurse, secrecy or even a reversal of roles. Boundary violations can cause distress for the patient, which may not be recognized or felt by the patient until harmful consequences occur.

The National Council of State Boards of Nursing 2011

The State Boards of Nursing that regulate the practice of nursing across the United States have provided regulations which further restrict the responsiveness of nurses to enter in relationships with patients. They have provided a framework for professional behavior that precludes responding in an “excessive personal” manner. They stop short of defining what crossing that professional boundary looks like.

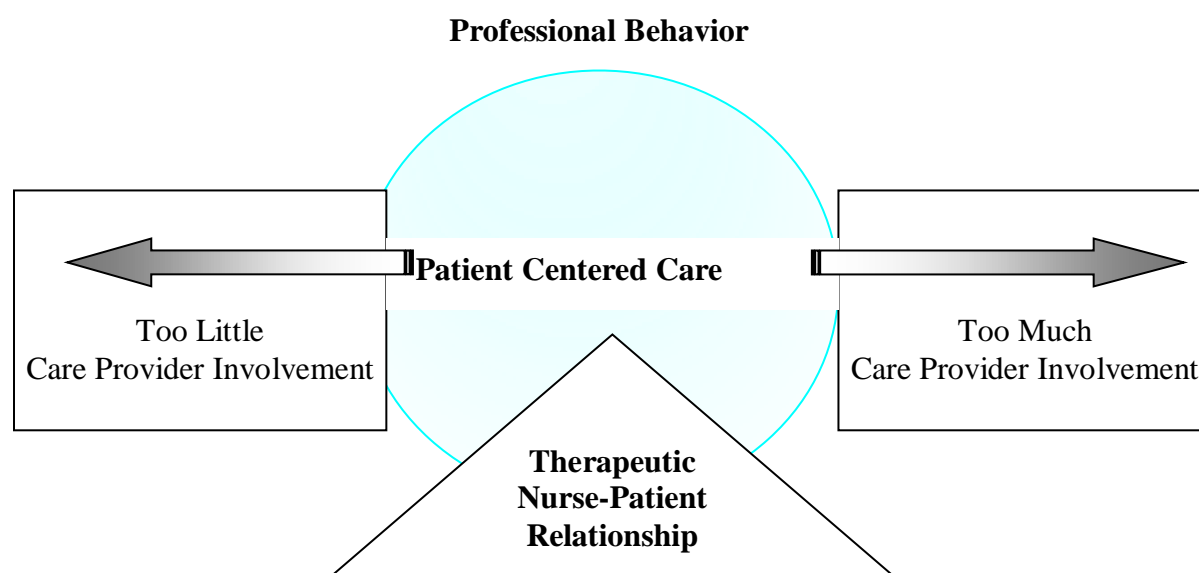


Figure 12. Continuum of Professional Behavior: National Council of State Boards of Nursing

Much like the industrialists, who, having seized the worker's knowledge; administrators, regulators and professional organizations have broken down the production of nursing into its component parts and nurses have come to view their work as piece work or factory work. Keeping the knowledge of the process as a whole to themselves, professional nursing organizations as well as health system administrators have assigned to each worker a specific function as well as a status within the system of passive dependency. Providing the knowledge required to practice has become a burgeoning industry with hundreds of specialty certifications, advanced training, and required continuing education hours.

The individual nurse's claim to the adequacy of her own unique (individually acquired) knowledge is being deprived of its legitimacy. At one time, nurses were required to know the whole person and they didn't worry about crossing boundaries or limiting control or balancing power. Nurses are no longer required to get to know who a patient is; the nurse needs to know what the patient prefers to be called and what is entailed in a *safe interaction* (i.e. professional relationship). Nurses are required to think as the other wants them to and there are thousands of policies, procedures, and checklists as evidence of this state of affairs. There are tens of thousands of consultants, business planners, and regulatory bodies who define how nursing care will be provided and this is how we find ourselves relegated to doing the "little things".

Impact of Status Degradation

In the health system of today, nurses and patients cannot be permitted to have a voice, a position, a being of their own, and must remain mute or speak only in the ways permitted by the dominant discourse of the hierarchy. They cannot be permitted to have a voice because their voices could undermine the hierarchies that exist and hierarchies can work only when a) everyone in it has a stable social identity, b) there is an intelligible place in the group's scheme of things and c) there is a communally shared reality.

Superiors with more power create the dominant discourse and may even act with aggression and hostility towards subordinates. Superiors can be administrators and physicians, but they are also nurses. They use threats, bribes, rewards, and punishment to continue the discourse. Inferiors do what they can to avoid them and comply with the expected behaviors. Inferiors can be patients, nursing assistants and other entry-level staff members, but they are also nurses.

We shall have succeeded in transforming all of our social institutions into self-producing status degradation ceremonies – except that within them there will be no denouncers and denounced. All will be denounced as unintended consequence of the system because it, of course, will come first. For it will have become institutionalized into our everyday relations with each other.

(John Shotter, 2003, p. 13)

According to Shotter, if someone like a patient or a nurse occupies a degraded position in a hierarchy, there is no simple way in which that can be changed without transgressing the social order. Unfortunately, those most in need of improved circumstances and who most need to break the rules are least likely to avail themselves of that opportunity. “For the fact is that, whether one has been down-graded in a full blown status degradation ceremony or simply informally by a passing insult, there is no simple way of ‘answering back’ except by transgressing the social order and by being rude oneself, etc. and running the risk of incurring negative sanctions” (Shotter, 2003, p. 13). Even those who are victimized by a hierarchical system often act to reproduce it rather than attempt to break down the structure so that they may avoid the loss of self. When those wronged are unwilling or unable to break down the victimizing structure, stability is maintained at the cost of “mutually responsive, spontaneous bodily reactions to each other”. This leads to not only the elimination of those expressive-responsive (authentic) reactions in which we make our selves known to each other and to the exclusion of creative potentials that are exist between us in our dialogical relationships (Shotter, 2003).

Shotter suggests that in order to “reproduce social order in their reactions, in their spontaneous, bodily reaction to each other, people must be able to relate what they do to their place, position or status within it”. Actors and speakers, nurses and patients have a moral right to expect others around them to value them and to treat them in ways appropriate to who they are and that is appropriate to their identity and others around them also have a moral duty to treat them as the first persons they are. Nurses, therefore, have a moral obligation to treat patients (people) as the whole persons they are and patients have the moral right to expect that others will value them and treat them appropriately (Shotter, 2003).

Not to be taken seriously as a valued human being, not to be accorded the right to express one's self, is to be *humiliated* and *degraded*. When people are not given the respect they deserve, they are likely to express anger and resentment and try to remedy in some way what seems to them to be immoral, unfair or inconsistent. However, those subjected to humiliation and degradation are deprived of spontaneous responses to the conditions to which they are exposed due to fear of repercussions, lack of a sense of self-worth, and/or initiative. When there is anger and resentment, it may not necessarily be directed at those responsible for creating the system in which they exist and in the case of nurses, may directed at patients and families and when there is an attempt to remedy what is unfair, it often falls on deaf ears.

Scientific Management

Scientific management continues to structure the social processes of nursing and healthcare into manufacturing processes and produces people who exist as passive and dependent in their very being (Shotter, 2003). The central aim of scientific management of processes was to separate the brain work from the muscle work and to place the muscle work in the hands of the lower orders and put the control of the brain work at the top of the hierarchy. Frederick Taylor developed the principles of scientific management in order to improve productivity. He attributed low productivity to three things:

1. The universally held belief among workers that if they are too productive, jobs will be eliminated.
2. Non-incentive wages encourage low productivity when employees get paid regardless of the work performed. Employees willfully work at a pace that is not too fast so that employers don't expect too much.
3. Workers waste time on rule-of-thumb and instinct versus processes that can be better determined by scientific study (evidence based practice) (Internet Center for Management and Business Administration, 2010).

These three tenets, also known as *soldiering*, are pervasive within administrative and nursing leadership circles as evidenced by the widespread attention to nurse/patient ratios, productivity systems, minimum nurse staffing laws, and acuity tools. All of these exist because nurses cannot be entrusted to provide the appropriate amount of care for their patients without administrative oversight.

One state in the nation, California, has been *successful* in mandating nurse to patient ratios. Several others, along with some nursing unions, are trying to mandate lower nurse patient ratios. The American Nurses Association, however, opposes mandated staffing ratios and their director of state government affairs doesn't expect any other state legislation will pass before 2015. According to the ANA, understaffing is a significant problem in most healthcare organizations, but it doesn't believe that nurse-to-patient ratio mandates are the right way to solve the problem. The association instead favors laws that require hospitals to set up committees made up of nurses and administrators that work together to create staffing plans. "We're respectful of all approaches as long as nurses have input," she said.

The concept of nurse-patient ratios is a recent nursing construction. Thirty years ago, no one had heard of nurse to patient ratios as a staffing model. When a nurse arrived to work, she took her assignment that was based on how many nurses were available and how many patients were on the unit. At that time, there were set schedules or tracks and set staffing assignments. If someone didn't come to work, the other nurses on the shift picked up the workload. With mandated staffing ratios, there must be nurses available for new admissions as well as for sick calls, and breaks (Schultz, 2013).

For many nurses, the work of the nursing process, clinical judgment, and critical thinking (the brain work) have been put in control of administrators, risk managers, and regulatory agencies and is *scientifically managed*. For many, the relationships with their patients have come to resemble processes that exist in manufacturing; particularly those open to measurement, numerical assessment, and rank ordering in terms of efficiency and/or effectiveness. Both nurses and patients have become entries on the organization's balance sheet. To turn the tide, we will have to move from logical or rational systems as conceived by an elite group of theorists/policy makers/leaders to a new dialogically-structured practice where patients and nurses become the researcher/theorists/policy makers. Without this, we all run the risk of becoming members of the "same democracy of misery in a continuing round of humiliating attempts to solve problems through the application of scientific methods" (Shotter, 2003, p. 1).

More than forty years ago, nurse and author, Felicity Stockwell, suggested that nurses prefer caring for patients who are able to communicate readily with the nurses, who know the nurses' names, are able to laugh and joke with the nurses, cooperate in being helped to get well, express appreciation for the nurses and are determined to get well. In

other words, nurses prefer patients whose voices are formed by the dominant discourse. The patients whom the nurses did not enjoy taking care of were those who were not happy to be in the hospital, who complained, grumbled or otherwise demanded attention, and those whom the nurses felt did not need to be in the hospital. These *unpopular* patients are those who resist the power and oppression that is of being a patient (Stockwell, 1972). This continues to be the case, at least in the facilities where I have practiced and in hundreds of observations made over the course of my career. It will be critical that nurses play a role in assuring that all patients have a voice in the reconstruction of the nurse patient relationship, not just the patients for whom they have a preference.

Until nurses and patients have a voice in creating the practice of health care in the true sense of health and care, the system will continue to be dominated by cause and effect thinking and scientific measurement. When nurses and patients try to gain their own voice, others cannot/will/do not hear it without the transformation in the relationships of power and privilege. It is essential that the voices we use are not what we are accustomed to hearing, nor voices that are formed in terms governed by the dominant group's vision of a dialogue (i.e. focus groups, market studies, or patient satisfaction scores). Merely having a voice is not sufficient if that voice must speak in a register that is alien to itself, and in doing so loses its own desires and interests. While having a voice is preferable to being held silent, if that voice does not reflect the interests, desires, or experiences, of the group, then that voice only furthers the dominant group's agenda. Genuine dialogue and healing relationships cannot occur unless and until the other (nurses and patients) gains his/her own voice. Unfortunately, having a voice and making your voice heard is no easy task.

Those at the top, defining the work of nurses, create the serviceable others whose creation gives both the self and the other the very qualities that define their nature. Administrators, physicians, and supervisors prefer nurses who are *engaged*, cooperative, and malleable. Nurses prefer patients who are cooperative, compliant and pleasant. Nurses who are creative, innovative, or who challenge the status quo are viewed with suspicion, particularly if what they are proposing is inconsistent with the dominant discourse. A dependent, physically weak patient who cooperates with his/her nurse will get his/her needs addressed. An aggressive, independent person (patient) is likely to be avoided and viewed as not in need (or deserving) of time and attention and patients who

want to control or determine the best course of action for their life and their health are labeled as difficult or disruptive and viewed with contempt.

The Function of Dominance

There are very real benefits for the balance of power in the relationships between patients and nurses and nurses and their institutions. The power that nurses possess is sometimes necessary to keep patients safe or to help keep patients from further decline in critical or rapidly evolving clinical situations. The nurse often has knowledge that the patient and family does not and can use this knowledge to positively impact clinical situations when used appropriately. Having power over patients also makes the nurses' work more efficient. It is much quicker to tell a patient to stay in bed than it is to explain all of the reasons why a patient could fall or to work with the patient to help him build strength or improve balance.

For the organization, power is essential in the current delivery system. Facilities are faced with regulations that reward them for avoiding mistakes. Often command and control leadership is viewed as the most efficient approach to change, further exerting power over nurses and other care providers. It is much quicker to enforce rules and distribute scripts or talking points than it is to develop relationships and influence behavior.

Power exerted from external sources influences care as much as internal sources. About five years ago, the Centers for Medicare and Medicaid announced that hospitals would no longer be paid for providing care related to falls that occur during a hospital stay and in 2014, the Joint Commission jumped on the Fall Prevention bandwagon and deemed Fall Prevention as a National Patient Safety Goal. Because injuries from falls occur frequently and are incredibly costly, health systems, regulatory agencies, and government payers have established care delivery requirements that specifically address how the patient's risk for falls are to be evaluated and which actions are to be taken to reduce the risk of falling. While I applaud the goals established for fall prevention, I am greatly concerned about the implications for how these goals are being addressed by a culture that values scientific management over patient autonomy. There is absolutely no *evidence* that bed alarms (or any other intervention for that matter) decrease falls or injuries from falls, yet in hospitals around the country there has been a dramatic increase in the use of bed alarms. Because bed alarms are easy to implement, use and monitor, the dominant (risk managers, health care executives, and regulatory agencies) have

mandated their use as a nursing intervention for any patient who is determined to be high risk for falls. Those most likely to be impacted by these rules, policies, and procedures are those who are the most vulnerable; the frail elderly. Ironically, this mandate has led to 1) more patients confined to bed for longer periods of time, 2) situations where patients are afraid to ask for help or 3) situations where patients are forced to take the risk of falling rather than enduring the embarrassment of wetting or soiling their beds. Patient autonomy and the fundamental goal of increased mobility are secondary to goals related to fall prevention.

Looking back on this recent change, it is easy to see how something becomes a rule/law and why. Twenty years ago, many nurses fought to have physical restraints eliminated, only to have the restraints replaced with alarms that keep the patient in the bed to prevent mobility without assistance. While the standards and expectations changed for application of physical restraints, the paternalistic beliefs and perceived moral duty remained the same. Coordinated activities through CMS, the Joint Commission and safety and regulatory bodies changed the agenda from preventing harm from restraints to harm from falls. The ritual changed from applying restraints to applying an alarm and/or having someone in the room telling the patient to stay in bed (see Figure 13).

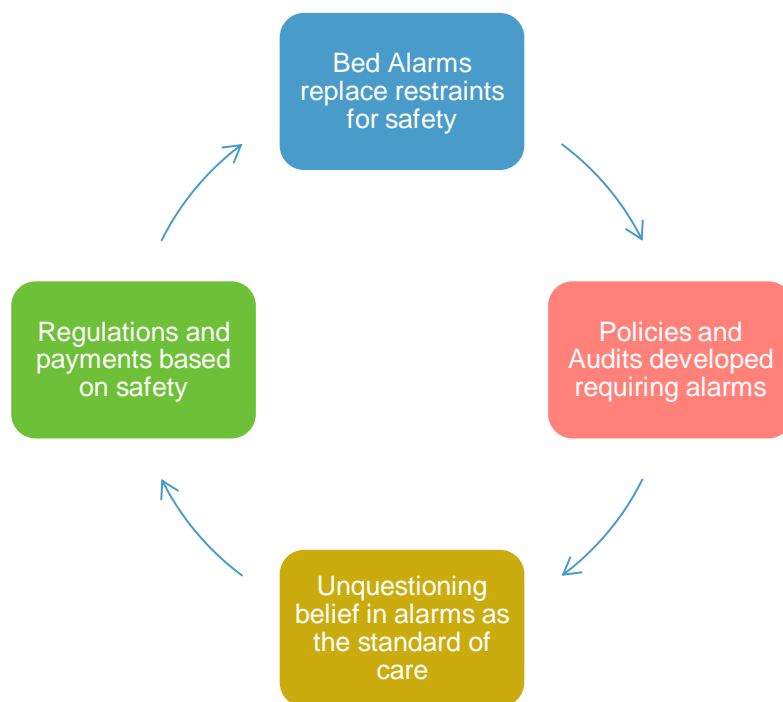


Figure 13: Dominant Discourse Regarding Fall Prevention

The current situation is unlikely to change as long as patients and health care organizations believe that patients are dependent on nurses and other health providers for

their well-being and/or that institutions are solely responsible for assuring patient safety. The replacement of restraints with alarms shows that disrupting standards alone will not ultimately change the held beliefs and moral order. Furthermore, the existing power imbalance prevents nurses from changing the standards and patients from exercising self-determination.

Physical Dependence

There are institutional imbalances that lead to forced dependency and there are very real medical conditions that contribute to physical dependency that play into the social construction of “patient safety”. When patients arrive in the emergency room, they are placed on a stretcher where they are examined and treated and confined to one place. If they are over the age of 65, they will likely get a catheter inserted in the bladder so that they do not have to get up and go to the bathroom and risk falling. The side rails are put up for safety and a call bell is placed at the bedside to call for assistance. Once admitted to the hospital, the patient is transferred to the bed in the patient room where the bed alarm is turned on so that the patient does not get up on his/her own. An older person who is ill and physically weaker may be less inclined to ask for assistance to get out of bed unless it is absolutely unavoidable. This leads to an inevitable downward spiral if the patient doesn’t get out of bed because it takes less than three days of confinement to bed to experience a 15% functional decline. If the patient is already in decline due to chronic disease or age related changes, this can mean the difference between independence and dependence. Predictably, this sequence of events frequently results in increased dependence and for many, the hospitalization can and does lead to institutionalization and further dependence.

When a patient is physically dependent, he/she can’t always say what he/she wants. According to Pablo Freire, before someone discovers his dependence, he suffers and this physical and/or emotional dependence can lead the oppressed to what is referred to as necrophilic behavior; the destruction of life – their own or that of their oppressed fellows (Freire, 1993). Many older people who come to hospitals for care and healing instead find conditions that contribute to further deterioration and decline and destruction of life because of the very systems designed to “protect” them.

From the current health system’s perspective, there is no other way to be a patient than to be passive and oppressed, (although the system would likely refer to the patient’s

situation as being safe and cared for). Increased autonomy and true self-determination would disrupt the entire healthcare universe. If patients had choices, power, and freedom to act as capable individuals instead of patients and relationships were promoted over rules and regulations, surely mayhem would ensue. Who knows what would happen if there was freedom for those with dis-ease and those who can ease dis-ease to spontaneously enter into healing relationships? Or if patients were truly given the opportunity for informed choices instead of the only choices deemed suitable in the opinion of the institution or its providers?

The term "institution" is commonly applied to customs and behavior patterns important to a society, as well as to particular formal organizations of government and public services. Healthcare institutions, like all other institutions, are structures and mechanisms of social order. The healthcare institution governs and maintains the behavior of its patients, staff members, and even its visitors. Its purpose is to bring sick people (or people who have been determined to be in need of medical treatment but not necessarily sick) into one location for the convenience (and cost effectiveness) of the system. The desires and needs of this institution transcend the needs of "sick people" as well as the desires and needs of the professional nursing staff.

To become partners in our relationships with our patients instead of controllers of behavior and activities, the work of nursing will need to change dramatically. Changes will require a reinvention ourselves, our sensibilities, and the 'background' practices we have embodied that make us the kind of professionals we are within our institutions. In Bakhtin's terms, our professional way of being is a one-sided, or one-way, monological stance: a stance in which we are physically unresponsive to the activities of the others around us. While we may 'observe' their 'movements' (vital signs, lab values, symptoms), we ignore any 'responses' that they, as other living, embodied beings, spontaneously 'call out' from us (or we from them): e.g., pity at their suffering or joy at their successes. "With a monologic approach, another person remains wholly and merely an object of consciousness, and not another consciousness. No response is expected from it and could change anything in the world of the nurse's consciousness. Monologue is closed off and deaf to the other's response; it does not expect a response and it does not acknowledge its existence. Monologue manages without the other. In other words, from with this stance, we are uninterested in interacting with the people themselves, and unconcerned with their concrete circumstances; we are only interested in collecting what they say about them-

selves, their self-talk as data” (Shotter, 2003. p. 4). When dialogue never has the chance to begin there is no possibility of uncovering the other’s unique perspectives or circumstances or of exploring the different meanings of similar acts performed in various settings by different people. This is the way of being for patients and their nurses.

To explore departures from the existing institution that have potential for valuing, sustaining and creating forms of relationship where common meaning can grow and develop and where critical consciousness guides our interactions it will be necessary to disrupt the forces of power that exist. Drs. Kumagai and Lypson from the University of Michigan Medical School recommend a reflective awareness of the differences in power and privilege and the inequities that exist in social relationships to create new relationships. This practice of critical consciousness fosters the development of what Paolo Freire calls “conscientization”, a process that is both cognitive and emotional that leads to engaged discourse, collaborative problem solving and the “rehumanization” of interpersonal relationships (Kumagai & Lypson, 2009, p. 783).

Nursing students are taught that they must possess *critical thinking skills* that are analytical, evaluative and logical. They are trained to seek reasons and evidence and use that evidence to make diagnoses. The ability to critically think alone may lead to technical proficiency but without the ability to self-reflect and engage in discourse through critical consciousness, nurses will not have the ability to truly impact health care in a meaningful way. We have (mostly) ignored *our embodied embeddedness in the routine flow of spontaneous, living, responsive activity*. We have let this consciousness linger unnoticed in the background of everything that we do and we have also ignored its importance as a sustaining and resourceful manifestation that is always present in our attempts to make sense of and in our lives. We have failed to notice its occurrence in those special but in fact everyday events, those departures from the routine, which enable us to gain access to the “inner worlds” of the people known as our patients and their families as they live in their complex relations to their circumstances, utterly unfamiliar to us, until we become one of them (Shotter, 1997, p. 2).

Shotter suggests that what is needed is the creation of indeterminacy instead of determinate meanings, facts, and statistics and that we should be open to possibilities and new discoveries. Instead of helping us find or discover something already existing, but supposedly hidden behind appearances, we can experience something new; something we haven’t seen before because we have been closed off from freedom. The problems

facing us are solved not by giving new information but by rearranging what we have always known. In arranging what we have already known in novel ways, we find innumerable possibilities for relating as well as for possibilities for new social practices (Shotter, 2003).

But we must see power – and leadership – as not things but as relationships.

(James MacGregor Burns, 2010, p. 5)

The Impact of *Leadership*

I have spent many years dedicated to the study and practice of leadership. In 2002, I completed studies in Health System Administration where I was introduced to McClelland, Vroom, Yetton, McGregor, Yukl, Douglas, Carlyle, and many others who have proposed a variety of theories and models of leaders and leadership. In 2006, I enrolled in a servant leadership certification program at Gonzaga University where I learned about Robert Greenleaf, Parker Palmer, and Larry Spears and where I began my personal leadership transformation. I was exposed to the ten principles of Servant Leadership, (listening, empathy, healing, awareness, persuasion, conceptualization, foresight, stewardship, commitment to the growth of people and building community) which were to become the foundation for my work as a leader. I pursued coursework in forgiveness, community, and ethics and I was also exposed to Appreciative Inquiry. One of the most memorable aspects of the curriculum was the week I spent at a Benedictine monastery with my professor and several classmates. During this week, we participated completely in the life of the monastery, including compline (the period of silence following night prayer), daily chores, and mass. We studied the teachings of Saint Benedict and discussed their relevance in our leadership practices. St. Benedict's rules for his followers resonated with me in my desire to serve as a leader rather than exert authority. The rules teach the following:

1. Follow the basic rules of courtesy and model good behavior.
2. Be mindful of the possibilities of pride and arrogance.
3. Follow and obey those placed over them in positions of authority.
4. Work towards peace and harmony.
5. Be honest and transparent about one's own limitations and weaknesses.
6. Practice contentment.

7. Practice the discipline of internal reflection.
8. Obey the common rule.
9. Use plain and clear avenues of communication.
10. Cultivate humility and seek to understand.
11. Speak simply, gently, and with kindness to everyone.
12. Act humbly in appearance.

I became a different leader and a different person through my continued studies, practices, and relationships. As a lifelong learner, when I completed my coursework in Organizational Leadership, I began studying Appreciative Inquiry and social construction to further my development as a relational leader.

Mine has not been an easy journey since most of the leaders to whom I am exposed have adopted the more traditional approaches to leadership practices; in particular Frederick Taylor (scientific management) and Thomas Carlyle (great man theory). Most of the men and women to whom I have reported have utilized reward and punishment as the primary tools in their leadership toolbox. Most of the nurses that I have worked with have had superiors who rely on the power of their position or the power of coercion to get things done. It is my belief that nurses' relationships with leaders who exert influence through command and control results in nurses who expect to be told what to do, when to do it and who expect to be rewarded when they perform as expected and punished when performance targets are not met. In addition, most nursing leaders practice cause and effect thinking and problem identification. The relationship that exists between nurses and their leaders impacts the relationship that exists between nurses and their patients and results in rewards and punishments and problems and solutions.

If I pressure you hard will you manage to keep going?

Will you keep your emotions under control?

Will the way you proceed demonstrate thought?

or merely a frantic search for a workable next step that imitates action,

less concerned if that option has shape? (Caroline Ramsey, 2006, p. 32)

The leader thinks about what *they* (employees) should rather than what *we* should do. In this type of relationship, each individual in the hierarchy has certain functions to perform and communication centers around these functions and only these functions. If

an employee is conditioned to take orders from above and his/her work serves to improve the status of those above, there is little incentive for engagement, collaboration or innovation “It is much less threatening to perform as required” (Hersted & Gergen, 2013, location 369). The command-and-control relationship between nurses and those higher up in the organization (as well as physicians) results in nurses perceiving themselves as objects of manipulation. When this occurs, orders from above nurses are often interpreted negatively resulting in anxiety and fear (Hersted and Gergen, 2013, location 1342). Practicing in a command and control organization comes with serious costs in health care. Top down (“controlled” change) is often disruptive, neglects dialogue, and results in gaps in practice due to the fact that those at the top are not familiar with the work at the bedside.

Hopes and Aspirations

Initially, what I really wanted was to change how nurses communicated with and related to their patients. I wanted to influence how nurses show respect to their patients and promote the patient’s experience of dignity and respect. Truth be told, I want to influence the work of nurses in a way that truly elevates the practice and I want to improve the well-being of older patients and those patients who cannot speak for themselves. While this may seem like an incredibly impractical or even ostentatious goal, I know that I can begin a conversation that can ultimately lead to the creation of new possibilities. I believe that I can contribute to the nurse-patient narrative with every conversation that I have with every nurse, patient, and leader if I continuously experiment and tinker with new possibilities “without knowing where (my) queries will lead or how action will unfold” (Barrett, 1998, p. 606). As a nurse, a leader and a future patient, I hope to:

1. understand and interrupt habit patterns of nurses and patients
2. embrace errors as a source of learning for myself and for those who I lead
3. engage in continual negotiation and dialogue that leads to synchronization horizontally and vertically within my organization
4. design simple structures that allow for maximum flexibility to promote authentic relationships
5. take turns soloing and supporting
6. participate in a community of practice
7. rely on retrospective sense-making (Barrett, 1998, p. 606).

This may seem incredibly ambitious for a project that ostensibly consisted of twelve participants but this exploration consisted of hundreds of participants and thousands of conversations that have occurred over the course of thirty years of practice. I will continue this work for many years to come. The next chapter will describe the approaches and methods used for describing nurses' relationships with their older patients.

Chapter Five: Methodology

This chapter provides an understanding of the methods used for this inquiry. Fairclough's framework for discourse analysis is presented followed by a description of Appreciative Inquiry. Appreciative Inquiry is important to this exploration because it guided the participant questions. There is a complete description of the participants and the interview approach, as well as specifics related to the approval process and participant enrollment. The final section describes an informal study that was conducted in the midst of this research that further clarifies the nurse and patient relationships as they have come to be experienced in this particular health care environment.

Discourse Analysis

Discourse Analysis, to begin with a claim of broad consensus, poses the question of how to analyse culture not as a question of behavioural variables or objective social structures, but as a question of understanding culture "from within" and it provides the cultural analyst with a concrete objective of investigation – the test. Its premises draw upon Wittgenstein's "language games" and upon Foucault's theory of "discourse", both of which view language as a constitutive component of the social world.

(Lillie Chouliaraki, 2008, p. 264)

Social constructionists are interested in how people interact with one another to construct, modify and maintain that which is considered to be real and true and they seek to show how understanding and experiences (and ultimately *truth* and *reality*) are derived from discourses and within relationships. Social construction is concerned with patterns of social meaning that can be found in the words, phrases, language and connotations. The language that we use is what constitutes our world and that language is not neutral or transparent but it does function to construct our reality. By using the concepts of social construction along with discourse analysis, I hope to create a different reality through the use of research methods that are both reflexive and productive rather than methods that are merely observational, enumerative or descriptive (Zeeman et al. 2002, p. 99).

Durrheim (1997) describes discourse analysis as a reflexive process that aims to provide an account of how "objects" are constructed against a backdrop of socially shared understandings. Discourse Analysis does not describe and explain the world and it does not make any claim on the truth. It does, however, allow the researcher to move from a

conceptual understanding and critique towards a social analysis. It allows her to understand the function of the discourse and how subjects and objects are positioned in relations of contempt and respect, domination and subordination, or opposition and agreement. Not only is this a reflexive process, it can also bring about change by showing how taken-for-granted, everyday subjects and objects are embedded in what is thought to be “the truth” (Zeeman et al. 2002).

Discourse is a form of social practice that creates the social world and it is created by other social practices. Not only does it contribute to the building of social structures, it reflects them. The aim of discourse analysis is to shed light on the discursive practices that promote social and cultural evolution (Jorgensen and Phillips, 2002).

Fairclough defines critical discourse analysis as an approach which “seeks to investigate systematically often opaque relationships of causality and determination between (a) discursive practices, events, and texts, and (b) broader social and cultural structures, relations and processes” (Jorgensen & Phillips, 2002, p. 63). Critical discourse analysis attempts to reveal the role of discourse in maintaining the social world, particularly the discourses that involve inequalities in power and endeavors to bring about social change resulting from more equality in power. It is not a politically neutral methodology because of its commitment to social change (Jorgensen & Phillips, 2002).

Discourse analysis was utilized because it provided a protocol for analysis that is “deliberately porous and contingent rather than being contained by a universalist procedure of strict and continuous explications of research choices” (Chouliaraki & Fairclough, 2010, p. 1217). From a social constructionist’s perspective, this seemed to be an ideal model for understanding the complex and intricate aspects of nurse-patient relationships that would not be revealed through surveys or structured interviews. Discourse Analysis functioned as the structure for bringing focus on the discourse that creates and sustains relationships between nurses and their older patients and it provided a “discursive point of entry” into these relationships in order to engage in critical reflection. Additionally, discourse analysis engages with questions of power within relationship in which discourse is produced. It was my belief that the question of power was relevant in nurses’ relationships with older patients and this could not be uncovered through traditional scientific methods.

The framework that guided this research was based on Fairclough’s three-dimensional model. In this model, Fairclough proposes that discourse 1) refers to lan-

guage use as a social practice, 2) is understood as the kind of language used within a specific field, in this case, nursing, and 3) refers to a way of speaking which *gives meaning to experiences from a particular perspective*. From a social construction perspective, this approach was appealing because Fairclough maintains that discourse contributes to the construction of social identities and relations and to systems of knowledge and meaning.

I referred to Fairclough's three-dimensional model (Figure 14) to provide the framework for the discourse analysis. This model is based on the belief that texts can never be analyzed in isolation but can only be understood in relation to social circumstances. For the purposes of this research, the *text* is the written transcription of several hours of interviews with nurses and older patients. In my analysis, I have attempted to focus on what I considered to be unique features of the text, the discursive practices of nurses and patients and how they use language to produce and consume text, and to the wider social practices where communication between the nurse and the older patient (the text) lives and breathes.

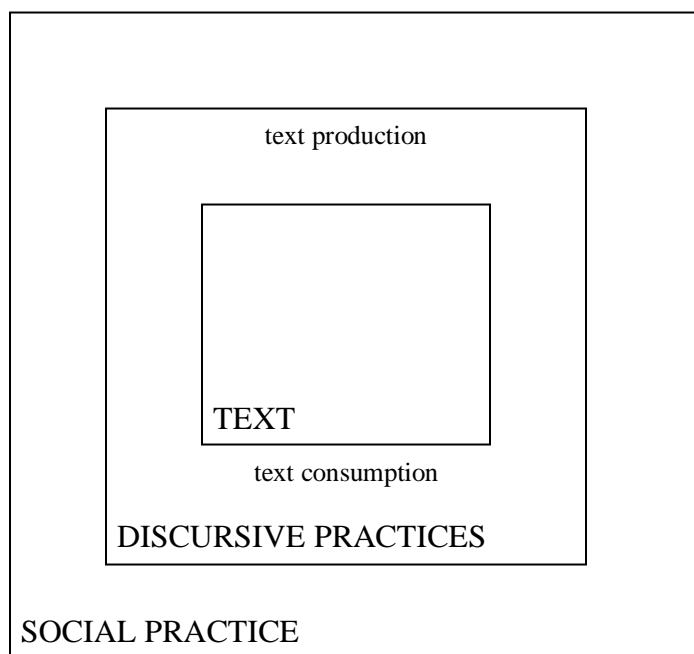


Figure 14: Fairclough's three-dimensional model for critical discourse analysis.

According to Fairclough, the relationship between texts and social practice is mediated by discursive practice. It is through discursive practice that texts shape and are shaped by social practice. The primary aim of discourse analysis is to explore the links between language use and social practice. Its focus is to understand the way people use

language to maintain social order and achieve social change. Every communicative event within discourse functions as a form of social practice in maintaining or changing the order of discourse (Jorgensen & Phillips, 2002).

Discourse analysis starts from the fundamental assumption that language is a medium oriented towards action and function and that people use language to construct accounts of the social world and that a connection exists between a word and its meaning. Rosalind Gill has noted, “it is much easier to explicate the central tenets of discourse analysis than it is to explain how actually to go about analyzing discourse”. Given such a statement, the quality criterion for my discourse analysis was that it be intelligible and accessible in its interpretations and explanations. Teun van Dijk suggests accessibility as a criterion of the quality of the research and findings should be accessible and readable for the social group under investigation. The value of findings and conclusions is anchored in the “endless openness and interchange between different types of data, participants’ and researcher’s interventions, interpretations and explanations, and diverse levels of analysis (individual vs. combination of texts, linguistic vs. context)” (Bondarouk & Ruël, 2004).

Initially I was more concerned about understanding why nurses used terms of endearment or spoke to their older patients with a particular tone of voice than I was about appreciating the thousands of connections that constructed nurse and patient relationships. I naively assumed that ineffective or non-therapeutic relationships existed because nurses were either un(der)educated or disrespectful. The extensive literature search that I conducted suggested that what was needed to “resolve this problem” was to wipe out ageism and the relationships between nurses and their older patients would be restored. I simply needed to conduct a survey or two, intervene with some awareness building, throw in a little sensitivity training, and provide ongoing education.

I came to a point where I knew that in order to contribute to the conversation about dignity and respect or power and coercion in the nurse-patient relationship and to expand the possibilities for deeper and more therapeutic relationships with our patients, I had to engage in meaningful dialogue (with patients and nurses). Armed with the belief that all actions take place in the context of other actions and within the realm of a network of interconnections and that all actions can be intelligible in certain contexts, I set out to understand and appreciate context, interconnections, and intelligibility. I shifted from seeing discourse as reflecting social reality to seeing it as a means of understanding the ways in which accounts are constructed and the functions they perform. I wanted to

explore the possibility of creating and sustaining relationships where everyone counts as a person toward whom there exists a moral responsibility.

There is a great need to appreciate the fabric of our social relationships and institutions rather than re-examine or further the existing research that enumerates measures, scrutinizes, and reaches conclusions about nurses and/or patients. My desire is to draw our collective nursing attention to 'observations which no one has doubted, but which have escaped remark only because they are always before our eyes'. In other words, instead of seeing everything through nursing's analytical, data driven eyes, I would like to call attention to, or attend to, how we actually do (or could) in fact 'go on' with each other in our daily lives, in practice – something that has escaped our notice for some time (Shotter, 2003, p. 10).

It is worth reminding ourselves that we are not seeking, as already developed individuals, to discover what something is but different possible ways in which we might relate ourselves to our surroundings – how to be different without ourselves, how to live in different worlds. Where the aim in such discussions as these is never merely theoretical, but in always being to do with implementing one or another form of life between us, is always to do with the politics of our social identities.

(John Shotter, 1995, spoken paper)

For the purposes of better understanding the relationships between nurses and older patients, I approached this project in an attempt to make sense of the discourse derived from eleven separate interviews. If discourse is a form of social practice that creates the social world and is created through other social practices, then understanding discourse and dialogue can bring about better understanding of the social practices and the social world of nurses and older patients. Additionally, I hope to better understand the power relations in their social practices and in the social world through the exploration of discourse and in turn contribute to social change.

Discourse analysis was attractive to me because it involves a critical approach to knowledge where knowledge and representations of the world are not viewed as reflections or explanations of reality but as ways of categorizing our world. The way in which we understand and represent our world is contingent and constantly changing and through discourse analysis I may possibly gain insight into the nurse-patient world through our

dialogue. Because I believe that the way we understand our world is created and maintained by our social interactions (relationships), then examining those relationships, as described by relaters can help me draw out some of what may be considered common truths. By understanding the discourse and relationships found in the discourse, I hope to outline social implications that could lead to opportunities and possibilities for changing and improving relationships.

Up until the very first interview, I held the assumption that ageist language and stereotypes about older people would be revealed; embedded in the words of the nurses and patients and providing insight into why nurses and older patients interact in the way a parent and a child would interact. I expected patients to tell me that nurses “at their best” were respectful and appropriate in their communication. Once the first interview began, however, I attempted to let go of or at least acknowledge as many pre-held assumptions as I possibly could. I proceeded with the hope of exposing socially embedded assumptions and ideologies in order to analyze how social realities are produced through discourse. I discovered that discourse is a relevant social practice, even in formal, research interviews and I discovered that power and resistance are key components of the language of patients and nurses. I proceeded with the knowledge that “we cannot easily hide the contents of our inner lives wholly inside ourselves, for, we display them in every movement of us living our lives responsively, amongst others” and the hope that I could interpret and make sense of that which was to be revealed through being responsive to my partners (Shotter, 2003, p. 12).

In addition to using a framework for understanding and analyzing the dialogue, I wanted to understand how to bring out the best from the nurses and patients. I wanted to ask questions that were generative and that evoked a sense of pride. For this, I turned to the methodology found in Appreciative Inquiry.

Appreciative Inquiry

Appreciative inquiry is a method for exploring the possibilities and dreams of who we want to be as individuals, professionals, organizations, or cultures. It is the study and exploration of what gives life to people and systems when they are at their best (Whitney & Trosten-Bloom, 2003). There are eight principles that inform Appreciative Inquiry that are derived from social construction, image theory and grounded research (see Table 4). Social constructionists suggest that communication and dialogue create, maintains and

transforms reality. Image theory suggests that the images that we hold of the future influence what we do today. Grounded research suggests that participant observation is the best way to gather data and that all research is intervention (Whitney & Trosten-Bloom, 2003). The highlighted principles influenced my decision to use appreciative questions for the nurse and patient interviews. It was my hope that by asking nurses to describe a story when they were at their best with an older patient, knowledge would be generated because it is “through language that we create the world, because it’s nothing until we describe it. And when we describe it, we create distinctions that govern our actions” (Whitney & Trosten-Bloom, 2003, p. 56). I believed that nurses and patients had stories that could bring about new knowledge and with new knowledge we could change the world of nurses and older patients.

Principle	Definition
The Constructionist Principle	Words Create Worlds
The Simultaneity Principle	Inquiry Creates Change
The Poetic Principle	We Can Choose What we Study
The Anticipatory Principle	Image Inspires Action
The Positive Principle	Positive Questions Lead to Positive Change
The Wholeness Principle	Wholeness Brings Out the Best
The Enactment Principle	Acting “As If” is Self-Fulfilling
The Free Choice Principle	Free Choice Liberates Power

Table 4: Principles of Appreciative Inquiry

The *Simultaneity Principle* tells us that change happens as soon as we ask a question and that inquiry is an intervention that can result in true transformation. Through this principle, it was my hope that new knowledge would develop if I could ask the right questions. I asked patients to tell me a story about the best interaction they had with a nurse or

to tell me about a nurse who stands out in their minds. The Simultaneity Principle posits that people move in the direction of what they ask questions about and I wanted people to move in the direction of decency and distinction.

The *Poetic Principle* suggests that we can choose what we study and what we choose to study determines what we learn and our areas of inquiry can actual help to bring about change. The process of Appreciative inquiry begins with a choice of an encouraging question; based on the belief that people move in the direction of what they study. I chose affirmative questions in order to evoke the positive images of nurses and to elicit the most heartfelt accounts possible because I wanted the participants to feel valued and respected. I hoped to hear stories that people were excited about sharing. I wanted to hear the rich, beautiful stories of nurses and their patients and patients and their nurses and I wanted to give nurses the opportunity to tell these stories because they simply don't get the chance or they don't take the chance to talk about themselves in a positive manner. The stories that I had heard years ago were stories of interesting, challenging, engaging, humorous, touching, and uplifting. I desperately wanted to hear those stories and to provide the participants with an affirmative experience, rather than an academic experience.

The capacity we have as human beings for generating useful change is our collective imagination and discourse about the future. The basic premise of the *Anticipatory Principle* is that it is the image of the future that guides behavior. Our positive images of the future lead our positive actions and this is the energizing aspect and assumption of Appreciative Inquiry (Cooperrider & Whitney. 2005).

I found the *Positive Principle* helpful in designing the interviews because I believe that this is really what appreciative inquiry is all about. Meaningful and sustainable change requires things like hope, excitement, encouragement, inspiration, caring, and enjoyment in creating something meaningful. Although I started my work with the approach that nurses relationships with their patients was a problem to be solved, I purposefully chose life-generating questions to elicit as much positive energy as possible and to have the participants feel better for having participated.

Appreciation refers to the act of recognition and enhancing value. Inquiry refers to learning about new possibilities, "being in a state of unknowing, wonder, and a willingness to learn" (Whitney & Trosten-Bloom, 2003). Through inquiry, we can build awareness and begin to share insight into a co-created future just by asking provocative questions. It was

my hope that the appreciative questions would help me understand what was perceived to be nursing at its best and evoke responses that would describe patterns of behavior thought to be desirable.

Ours is a time of acute problems and unprecedented opportunities. We shall be able to accomplish our historic task of developing our inheritance only if, irrespective of our political opinions, religious beliefs, or philosophies, we try to understand and help one another act in-concert for a better future.

(Mikhail Gorbachev, 1993, p. 67 in Whitney and Trosten-Bloom)

Following the typical Appreciative Inquiry method (Whitney & Trosten-Bloom, 2003; Cooperrider & Whitney, 2005), the following appreciative questions were used as a guide for all of the nurse interviews:

Tell me a story of you at your best working with older patients.

What is it in this story that features some of your strengths as a nurse?

We all know that communication is important. When you are interacting with older patients, what do you think is the best way to communicate?

What guides your practice with older patients?

What are your beliefs about taking care of older patients?

How would you say your interactions with older patients have affected you?

How would you say your interactions with older patients have affected your practice? Your ways of thinking?

The following appreciative questions were used as a guide for all of the patient interviews:

Tell me a story about the best interaction or experience you have had with nurses.

Is there a nurse who stands out in your mind? Can you tell me about him or her?

What was it about that nurse that made the interaction memorable?

We all know that communication is important. When you have interacted with nurses, is there a situation that comes to mind as being really good communication?

How would you say your interactions with your nurses have affected you?

How would you say your interactions with your nurses have affected your health?

Appreciative Inquiry (AI) interviewing followed by discourse analysis was the selected method to reveal underpinnings shared by the nurse/patient community, to better

understand how nurses and patients use language and to investigate whether power relations are reflected in speech. The practice of AI is the search for what nourishes people for better performance and excellence and what excites and inspires people to act in the best interest of their community or organization. Not only did I want to learn, I wanted to give nurses and patients the opportunity to talk about what is satisfying and noble in today's healthcare system because all too often, all they hear is what is wrong.

Interview Participants

After receiving IRB approval and presenting my proposal to the hospital research committee, I sought out willing participants (nurses and patients) from units and practice areas that have patients for longer or more frequent hospital stays including oncology, pulmonary, and geriatrics. Five of the nurses were women with whom I had interacted several times a year and had a professional relationship and one was a nurse who was referred to me by her nurse manager. I met with each participant prior to the interviews to explain my project and obtain consent.

Five of the six nurses were Baccalaureate prepared registered nurses with practice ranging from 3 to 35 years of experience and one nurse had an associate's degree in nursing with one year of experience. All of the nurses were female, age ranges from 30 to 58, and the average age was 43. All of the nurses worked at a 900 bed acute care facility in a suburban area of North Carolina in areas that would be considered specialty areas. Two were Cancer Navigators (the two with the most experience), one an oncology nurse (least experience), a pulmonary nurse, a wound-ostomy nurse and a geriatric nurse with an average of 18 years of experience. The nurses were all trained in nursing schools in North Carolina and have only worked at the facility in which they were interviewed. Although all of the nurses were known to me, none of them have what I consider close working relationships with me (none were direct reports) but two of the nurses reported to managers under my direction. They were selected for their practice environment that provided them the opportunity to develop relationships with some of their patients due to frequent interactions or interactions lasting more than 5 days of care. The participants were asked in person if they would be willing to be interviewed for my dissertation. Informed consent was obtained and they were oriented to the nature of the research. Every nurse who was recruited agreed to participate. The semi-structured nurse interviews were conducted in a private office and lasted anywhere from 30 to 50 minutes

For the patient interviews, I made requests via email to nurse leaders on the renal, pulmonary and geriatric floors seeking patients who would be willing and able to participate in a 30 minute interview. Requirements for patient participants were that they be cognitively intact, over the age of 65, able to speak without discomfort for a half an hour and had experienced frequent or lengthy hospitalizations. None of the patients who were referred to me declined to participate. Two of the patients did not have chronic diseases but were hospitalized for acute infections requiring intravenous antibiotics; the other three had chronic diseases requiring frequent hospitalizations. They were between the ages of 65 and 75. Four of the five were married and one was divorced. I approached the patients with an explanation of the project and a request for consent the day prior to their interviews. The patients were all alert, cognitively intact and able to freely communicate without any difficulty. Three of the patients had long term chronic illnesses (diabetes and COPD). Two of the patients were dealing with acute illnesses requiring short term hospitalization and all of the patients were in a medical surgical setting at the time of the interview. I introduced myself as a nurse conducting research on relationships among patients and nurses. None of the patients had family members with them at the time of the interview. Informed consent was obtained and they were oriented to the nature of the research. The patient interviews were conducted at the patient's bedside and the interviews lasted anywhere from 20 to 90 minutes. All of the interviews were digitally recorded and transcribed; resulting in 154 pages of transcripts. See table five for a summary of the research process stages.

Steps	Actions
1	IRB approval and consent of participants
2	Development of questions for interview guide
3	Conducting interviews
4	Recording and transcribing
5	Grouping of similar categories, phrases, and words; comparing differences and similarities, interpreting and exchanging ideas
6	Linking ideas with the literature
7	Synthesis of categories, words, phrases into themes
8	Selection of quotes illustrating the analysis of the themes

Table five. Summary of Research Process

Research within Research

In the midst of my research for this dissertation, I conducted a small, informal study that included more than three hundred professional nurses, ranging from staff nurses to the senior directors. The study asked participants to list the 5 elements of the nursing process, the core of the practice of the registered nurse. Less than 25 percent could list all 5 components. Many argued that they practiced them “all the time” but just “couldn’t list them”. When asked to describe a patient situation where they used the nursing process, it became clear to me that many nurses have minimal awareness of the principles of practice and are simply following orders. A classic example that was shared with me by several experienced nurses was related to pain medicine. The nurse would tell me that they “assessed” the patient’s pain level, called the doctor for pain medicine, administered the pain medicine, and went back an hour later to “reassess and evaluate the treatment”. This probably sounds like nursing to many people. Nurses, of course follow doctors’ orders don’t they? In part, nurses follow doctors’ orders. They cannot administer any medications or medical treatments without an order. They can, however, find out from the patient what kind of pain the patient is experiencing, the frequency, the intensity, what makes it better, what makes it worse and provided non-pharmacological interventions based on the responses to those inquiries. A nurse can teach the patient relaxation techniques or suggest repositioning or heat packs. She/he might also determine that the pain is spiritual or psychosocial and provide emotional support and comfort. She/he might even consider praying with the patient or consulting with the chaplaincy service. What nurses are trained to do encompasses the whole person; mind, body, and spirit, and range of interventions that require nothing but the nurse’s clinical judgment and expertise. Unfortunately, many nurses fall into the routine (culture) of the organization and practice by following rules, regulations, checklists, and orders. Based on my experience within my organization, it is not surprising that none of the study participants spoke about the nursing process or discussed the philosophies or approaches that guide their practice.

Chapter Six: Analysis

Chapter six provides the author's understanding of the participants' discourse. Themes of power, subjects, and objects are explored with specific excerpts from the recordings of participant interviews. Finally, there is a summary of what was most surprising about the findings. The singular perspective that I had expected to use to explain something is revealed to be incredibly complex and intricate.

Template for Analysis

After completing the interviews and listening to the interview recordings and reading and re-reading the written text, I considered the following questions as the template for conducting the analysis within Fairclough's (1992) framework:

- Why is the text interesting?
- How does the discourse conform to or challenge patterns of power?
- Who is attributed with power?
- How are objects constructed in the text?
- What are the subjects and how are they constructed?
- How are subjects constructed as text and what sets of relationships are assumed exist?
- What is in plain sight but unnoticed?

"The only really interesting thing is what happens between two people in a room."

Francis Bacon

In order to answer the question of why the text is interesting, I first looked at how the text came to be produced and then how I understood (consumed) it. Framing these discursive practices, I drew upon the social practices in which I am engaged. I interpreted the text through the social practices of a nursing executive as well as the social practices of experienced registered nurse, a patient's wife and daughter, a member of a community, a mother, and an advocate. My experiences and my relationships all come to bear on my interpretations and my understandings of the relationships of these nurses and these patients. According to Sampson, I am not the master of this interpretation because my interpretation is not mine alone; others have helped and continue to help shape this.

As an *executive*, I observed that the nurses engage in the language of their organization. The leaders of the organization have told nurses that the *little things* are what are truly important. Taking the time to get someone a cup of coffee, we tell them, can mean the difference in whether or not the patient is satisfied with their care. We spend a great deal of time talking to all of our employees about service standards, patient satisfaction results, and courtesy in order to meet targets around patient satisfaction (and get paid). The text reveals that these nurses have adopted this belief. *“Most of them, when you take the time to do just something, little things for them- they go ‘I feel so much better’. It makes you feel good; it might not be something you do every day but it’s something that you do for that one moment that’s enough.”*

In addition to telling nurses how to provide a satisfying patient experience, a great deal of attention has been paid over the years telling nurses what types of relationships are appropriate and what types are inappropriate, according to those in power (leaders, consultants, as well as state boards of nursing). Several nurses described crossing “professional boundaries” and the perception that somehow talking about themselves or their families or forming a close relationship with a patient was “unprofessional”. *“I know we’re supposed to have those boundaries, but it’s – I always – sometimes ask the question ‘what would Jesus do?’*

These interviews took place during the organization’s transition to an electronic medical record system so it was not surprising to me that the issue of technology framed the nurses’ responses but what was surprising as well as interesting was the concern that was expressed regarding the impact on older patients. There were several expressed concerns about the impact of technology on nurse-patient relationships. Many feared that further advances in EMRs would lead to more depersonalization and further compartmentalization of care. Several voiced concern about being able to tell the patient’s story and whether older patients would feel further alienated.

The most concerning thing for me as a nursing leader in evaluating the text was that not one of the patients could think of a situation that involved a nurse at her best. One was able to describe nurse at her worst, one described a therapist at her best, one a nursing student, and the others could not think of examples. Patients spend more time with nurses than other professional staff and not one of those interviewed could talk about a specific nurse. I felt that this was both quite interesting and a bit arrogant on my part but my social practices as a nurse thirty years ago are quite different from what is practiced in

our organization. It is possible that I have been conditioned to think that a nurse could (should) have a lasting impression and that his/her care can mean so much to patients and their families that they will be forever grateful and that nurse patient interactions can be transformative. For the five patients that I interviewed, that was not the case. Nurses who were viewed in a favorable light were the nurses who were described as being “nice”.

There were several points of interest to me as a professional nurse; 1) conversations about the importance of little things, 2) how nurses described their nurse colleagues, 3) the patients’ ability to recall a story about a nurse at her best, 4) the topic of professional boundaries, and 5) the similarity of all of the nurses’ stories about themselves at their best.

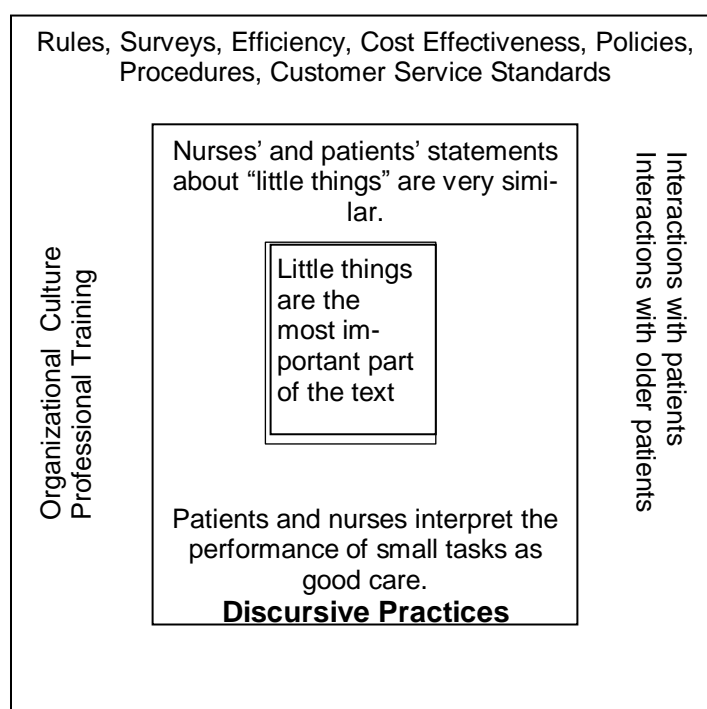


Figure 15: Diagram of the Discourse of “Little Things”

There was a common thread between all of the participants, nurses and patients. This was the discourse regarding the importance of the little things. Little things include sitting with a patient, getting a cup of coffee, responding to the call bell, and helping the patient to the bathroom. There seemed to be a common understanding that a good nurse was one who tended to the little things. Perhaps because of all the rules, safety procedures, and concerns over efficiency and pay for performance, when nurses do get to do

the little things, it makes them feel less isolated and more humanized and when “the best nurse” is viewed as someone who does the “little things” for her patients, or who is “just nice”, it should come as no surprise (see Figure 15).

Each of the nurses made critical references of other nurses who were not compassionate or who lacked respect for older patients. Self-awareness of shortcomings in communicating with older was not evident in the interviews, in spite of the presence of ageist language or stereotypes in their responses. This is consistent with what I have experienced as a leader of nurses. Many nurses readily criticize their colleagues yet see themselves as effective and appropriate.

The reluctance or inability of the patients to recall a story about a nurse who made a difference was disappointing. To these patients, nurses did not stand out from students, CNAs, or therapists. Even when asked appreciative questions, the patients recounted stories that described nurses who *did not* provide excellent care. This is interesting to me because in my practice as a bedside nurse, I believed that I strongly impacted the patients and families in my care. I developed relationships that I thought were helpful and therapeutic. Sadly, the patients I interviewed had not had this type of relationship or they could not recall a situation at that time. I recognize that this was a very small sample but it seems reasonable if nurses see themselves as more significant or relevant than do the patients.

Conversations about crossing “professional boundaries” were similarly discussed amongst several of the nurses. The nurse participants readily acknowledged their attachment to some of their patients as crossing a line, particularly when their patients got to know them more as a person than as a nurse. I was very surprised that the majority of the nurses felt that they had crossed a professional boundary in getting to know their patients on a personal level and by revealing personal information about themselves.

Perhaps what was most interesting was the common sharing of an end of life story as the essence of these particular nurses at their best. Each nurse spoke of a situation that involved patients and their families at the very end of life. I found this interesting because I asked nothing about end of life care. All the nurses used an example of a patient situation at the end of life because they have been conditioned to respond to this question in this way. Why else would all of the nurses talk about this type of situation? Why wouldn't they describe a life giving experience? Maybe it was because end of life and questions about older patients go hand in hand. All of the nurses worked in different

areas and their stories occurred in a variety of settings (outpatient, home health, inpatient, critical care) yet they all described similar situations.

After sharing these observations with my nursing colleagues I have arrived at an interpretation of this common “end of life excellence” discourse as significant because it may be one of the only remaining situations where nursing can be practiced as a caring, healing, compassionate profession. Currently, there are few if any regulations or requirements about care at the end of life. This is a time in our practice when we must rely on our intuition, our expertise, and our ethics and values. No one is watching over the nurse’s shoulder with time frames or assessment tools or policies and procedures. When I spoke with the participants about my interpretation, they could see how I came to this conclusion and seemed to agree with my theory. The relationship that exists with the patient and the family and the nurse at the end of life is pure and simple. No one measures it and no one prescribes our practices at the present time.

These findings will be explored further in the following paragraphs. While my perspective as a leader and executive influences my exploration and conclusions, most of my analysis is derived from my perspective as a professional registered nurse. This is likely due to the fact that I have always tried to remain a registered nurse first, and an administrator second, at least in terms of how I approach my daily work. I have never strayed far from the bedside, even as I have moved higher up in the chain of command. I take great pride in my work, in my profession and in my baccalaureate training. As a graduate of the baccalaureate program at Boston College I was prepared as a professional nurse who promotes, maintains and restores the health of individuals, families and communities and populations across the lifespan through evidenced based practice. I continue to use this frame as my professional mission in my role of a nursing leader in spite of ongoing pressure to disintegrate nursing in to smaller and smaller components.

Subjects and Objects

A subject has the faculties to observe and think of things while an object does not. A subject exists for itself and has autonomy and objects are to be observed and considered. Understanding the use of subjects and objects in the discourse can provide insight into the construction of the relationships.

The Subject of Nursing Practice

When asked “what guides your practice?” all of the nurses struggled with their responses. I had to clarify for all of the nurses what I was asking. In my role as a nursing leader, when I ask nurses this question I receive similar responses. The responses seem to indicate that there is a lack of critical reflection and clinical judgment in the practice of nursing at this organization because the organizational culture functions by rules, orders, policies, protocols, and procedures to guide practice and patient care. The responses to this question for the participants are very consistent with what I hear when speaking with my staff.

When I asked the nurses what guides their practice as a registered nurse, I heard responses such as:

“Respect your elders.”

“Just having respect.”

“Treating everyone the same.”

“Compassion and understanding.”

“The patient’s input on what their goals are.”

“That relationship sometimes that you build outside (of the professional relationship)”.

None of the participants’ responses were specific or unique to the practice of nursing and most struggled to just to understand what I was asking. Eliciting responses that highlighted the unique contribution of nurses was challenging. I’m not sure if this is related to the nursing programs in the region or if it is a result of the culture of the organization or a combination of both.

When I asked the nurses what guides their practice when caring for older people, their responses reflected more of the *soft* aspects of caring rather than a philosophy, scientific principles, or a professional practice model.

“You respect your elders, you say ‘yes ma’am’, ‘no ma’am’, and ‘thank you’.”

“Just having respect, just respect for them I think is mainly one of the biggest things that got my practice because they’re equal just like everyone else, try to treat everyone the same, no one any different.”

“It’s the compassion and understanding; to understand where they are coming from, understand what’s going on, and be patient.”

"It's something along the lines of in caring for others, we care for ourselves and that's kind of been my, I guess, mantra of sorts."

"I want them to be the best that they can be, like whatever their level is."

As a nurse, I expected to hear more about the nursing process, a professional philosophy, evidenced based practice, or a model of care. The "guiding principles" as, described by the nurses, sounded more like service standards that apply to all employees rather than as unique perspectives pertaining to the profession. The nurses responded to this question from the context of an organization that does not explicitly express interest in nursing theory or models of care. The newest nurse stated that she encourages patients to be the best they can be, which is consistent with a theory of self-care but was not explicitly stated as a nursing philosophy or a foundation of practice. The nurses easily recalled service standards dealing with courtesy and respect likely because in their organization, these are aspects that are typically measured and reported on. On the other hand, it is unlikely that these nurses are often (or ever) asked about their views on professional practice or clinical decision making which may be why this did not come to mind. I cannot recall a time beyond my formal education when I was asked what principles, theories or tenets guide my practice. I was disappointed in the lack of what I perceive to be a more sophisticated discussion about professional practice but I realize that the social practices within the organization do not endorse or encourage this kind of discourse. As we have seen already, nursing practice seems to be guided more by rules and regulations and, nurses' days are filled with thousands of checkboxes, hundreds of orders, volumes of policies and procedures, and frequent directives from organizational leaders in the form of memos, practice alerts, mandatory in-services, and computer based learning activities than theory of philosophy.

Since beginning this work, I have been observing nursing practice with new eyes. It now makes sense to me why those interviewed couldn't say what guides their practice. Nurses and nurse leaders regularly voice frustration over the lack of critical thinking or clinical judgment and the impact that this has on patient safety and well-being. Based on what I have observed, the nurse's practice has become so prescriptive; down to what to say and how to say it, there just isn't cause for or call for individual thinking. One nurse put it this way, *"they tell us what to do, when to do it, how often, and they punish us when we don't get it right. We have tools for almost every aspect of our work. I can't keep track of all of the acronyms, reminders, and slogans. We're professional people who are trusted*

to give potentially fatal medications and expected to save peoples' lives but we have to be told how to do things I already do." When I asked her why she thought the organization used reminders, acronyms, and toolkits, she responded, *"I guess it's for those people that don't do the things they're supposed to do. Maybe they use it to get them to do the right thing. It doesn't work that way, but maybe that's what they think."*

In one of the nurse's response, she used the word I or we 26 times and never referred to the patient by name. "I'd had this gentleman and, essentially, his wife, because it's never just a patient; it's the family". When referring to the patient, she used he or him, about half as often. "He's geriatric and dying", "he's at home and wanting to be maintained at home" were used to describe the older patient.

Similarly, the other nurses' stories were personal accounts about their practice with the patient serving as a prop (presented as an object). Patients were seen through the nurse's gaze. None of the nurses described the patients' ways of experiencing their situation, not even at the end of life. This could be because of the question that was asked, "tell me about *you* at your best". Or it could be because the patient is not the center of their practice. I found it interesting that none described the impact of the end of life from the patient's perspective, nor did they talk about how these stories impacted them emotionally. *"Maybe I'm most proud of that because that was the first time I'd done it and it went well"*, referring to sending a patient to hospice. *"When that time finally come (sic), it was just like you have to take a lot of medication, take a lot more of a med like, just to calm him down. I did what I have to do; it kept him calm, like I'm petting a kid"*. *"We made arrangements for her to get air conditioning in the van... and to me that was quality of life."* *"I didn't know exact primary or anything because I wasn't that involved in her care,"* referring to the patient's medical diagnosis. *"I vividly remember that thinking we could easily looked at maybe a lawsuit there. I don't know but it was that built up relationship in that family"*. Statements like these could indicate that there is a lack of insight into the patient's experience or the ability to empathize. It could also indicate that nurses are not skilled at telling stories that describe that patient's perspective.

Few of the responses from the nurses included the patient's voice. The nurses' dialogue described patients primarily as objects rather than subjects. Most often the discourse revealed the nurse as the subject. I wondered if patients were just props for nurses. I wondered if nurses do or can know the patients odyssey or if the nurses thought that that the patients' stories banal and insignificant or it could be that the nurses thought I

wanted to hear about them, instead of their relationships because we don't often talk about relationships, we talk about tasks.

Organizations rely on command and control through policies and procedures rather than investing time in developing critical thinking and clinical judgment and the subject of nursing practice in the discourse revealed this. None of the nurses spoke to policies or procedures, however. They spoke about techniques and traits. They used these words and phrases:

"Respect your elders."

"Respect caregivers of elders."

"Treat everyone the same, no different."

"It's about sitting and talking."

"Nursing is about caring."

"Relationships."

"Finding out who people are."

"Getting down on their level."

"Listen to their stories."

"Treat people as family."

"Giving good care so that it will be eventually reciprocated."

For me these words and phrases call to mind a time when the practice of nursing encouraged staff nurses to be seen but not heard as caregivers rather than professionals. Not too long ago, nurses were expected to behave submissively and to embody the values of purity and virtue. The wholesome image of nursing is not only a relic of the origins of nursing in its earliest religious practice is also a legacy of the 19th and 20th century movements to professionalize nursing. In a society where gender roles were very rigid and people prized modesty and innocence, it was necessary to make it safe for female nurses to work with complete strangers, especially men. Nurse reformers tried to desexualize nurses just as nuns had been before them. Nursing students wore shapeless, ugly uniforms, were not allowed to marry, and were placed dormitories in or near the hospital. Nurses were said to be self-sacrificing and morally superior and because of these qualities they could effectively manage that operations of the 19th century hospital.

The focus on the virtues of nurses and the profession of nursing also helped in the struggle with medicine within the highly contested terrain of the hospital. They had virtues that were much needed for the work of caring for the poor and downtrodden who found

themselves in the hospitals and clinics of the day. In the 19th century when *scientifically* oriented doctors were beginning to practice in hospitals in greater numbers and sought to control the hospital empire purity and virtue was seen as much needed. Physicians had no interest in sharing their sphere of influence inside the hospital with a group of women who wanted authority and education so nurses had to differentiate themselves as caring and compassionate. Decades later, nurses still struggle with the soft, emotional attributes that continue to define their practice (Gordon, 2006). The nurses interviewed characterized their practice more as personality traits than professional mores or scientific standards. This view could contribute to a sense of inferiority and could contribute to a sense of powerlessness.

Major Themes/Issues

The Subject of Power

Half the harm that is done in this world is due to people who want to feel important. They don't mean to do harm-- but the harm does not interest them. Or they do not see it, or they justify it because they are absorbed in the endless struggle to think well of themselves.

T. S. Elliot

Each of the six nurses spoke about “getting on the patient’s level”. It seemed as if these nurses believe that they have to lower themselves to speak and interact on the patient’s level both literally and figuratively. All of the nurses conveyed a level of power over their patients through phrases like: “*make them feel*”, “*want them to feel*”, “*get on their level*”, “*come down to their level*”, “*give patients permission*”, “*use my nurse language*”, “*give them a sense of independence*”, “*talk on their level*”, and “*give her as much control as possible*”.

Some of this can be explained with the understanding that all of these nurses have been told that it is better to communicate with patients at eye level so that they do not feel intimidated or threatened. In addition, the nurses have been trained with a tool that specifically describes a non-threatening, warm approach known as SOFTEN (**S** for smile, **O** for open posture, **F** for forward lean, **T** for touch, **E** for eye contact and **N** for Nod). This tool was developed in order to provide guidance around non-verbal communication to provide better patient satisfaction and to make nurse-patient communication more effective.

Many nurses spoke about their internal conflict with wanting to *allow* patients to maintain control and the desire to determine the best course of action for them. I was surprised to hear this from the older, experienced nurses who function as nurse navigators until I read their job description. The job of the nurse navigator is to *serve as a single point of contact for patients and their families throughout their entire cancer care experience and most importantly, is an advocate and personal care coach on the patient's behalf*. The primary role of the navigator is to remove barriers and obstacles that patients encounter. Barriers may be real or perceived barriers. The navigator functions as an advocate for the patient and provides education to patients regarding their disease process, treatment, and side effect management and treatment options. Navigators link patients with resources that enable them to complete treatment and maintain or improve their quality of life. Navigators facilitate communication and act as a liaison with the health care team on behalf of the patient. This description places the nurse, rather than the patient in a position of power in the relationship and it puts the patient in a dependent role in need of someone to speak on his/her behalf.

There were several statements that seemed to express a sense of superiority and reinforced the idea of hierarchical relationships.

"I love the complexity clinically and what you get to take from them socially and emotionally."

"Nurses (we) don't ever take time to figure out what the patient really needs."

"I give patients a sense of independence."

"You are their voice until they can find their voice. You are speaking for them."

When I asked nurse participants about my interpretation of this finding, they did not view this as anything other than the desire to be helpful. One nurse suggested that "nurses have knowledge that the patient does not and sometimes we have to tell them what is best for them". In an environment that values efficiency and effectiveness, it is easier to tell someone what to do than it is to explain, explore, engage or involve. Being the voice of the patient and speaking for them provides an avenue for nurses to exercise power and control in a workplace that consistently denies them authority and independence. The maintenance of the hierarchies that exist require certain behaviors

from members and it is likely that nurses “giving their patients a voice or a sense of independence” and “interacting on their level” is necessary to preserve the power structure.

As I entered into the analysis phase of my research, the topic of power consumed my thoughts and my conversations. I talked to dozens of colleagues about my impressions of the interviews and the implications for the nurses in our organization and tried to make sense of our current situation. The things we held in common were the issues around power and how we believe that the way nurses are treated by the organization impacts their practice. When the work is broken down into so many separate tasks that could ultimately (and may ultimately) be performed by anyone, there is little ownership and little sense of fulfillment. A colleague suggested “Twenty years ago, we didn’t have Electronic Medical Records, scripts, audits, or practice alerts. We didn’t measure the time it takes to reassess someone’s pain, whether or not you would recommend our facility to your friends, what someone’s fall risk score is, how many minutes late you were, or the refrigerator temperatures. Today we measure everything. I think that’s why there’s burnout. You don’t mind working hard if you feel like you’ve made a difference. There is no way in our world to tell if we’ve made a difference.”

Many nurses also acknowledge that they are treated like they treat their patients by others in the organization, particularly physicians and administrators. In a recent conversation with a nurse leader of thirty years, we spoke of the difference between “telling” patients what to do and “counseling” patients. She told me she had never thought that there was any difference. She also recognized that nurses and nurse leaders are often told what to do through policies, procedures, practice alerts, memos, 4 Ps, SBARS, order sets, etc. etc. Patients said things like, “I am at your mercy. I can’t get up by myself” and “I hate to take up their time. There are a lot of people that’s a lot worse off than I am”. This tells me that patients feel this power distance as well.

In follow up conversations with the nurse participants as well as other colleagues, they were not surprised with these findings or my interpretations of these findings. Many of them felt that the power distance between nurses and patients is a form of necessary paternalism, particularly with older patients, who they believe are used to doing what the doctors and nurses tell them to do. Many nurses also acknowledged that they feel like they are treated in a manner similar to how they treat their patients by

others in the organization; particularly physicians and administrators who assume that nurses need to be told what to do as well.

I recently went into a patient's room because a bed alarm was going off. When I entered the room, I found a lovely older woman helping her husband, the patient, to the bathroom (against nursing's orders). She had no idea what was alarming or why; her only focus was getting her husband to the bathroom. Once he was settled in the bathroom, she asked me what the noise was and how she could stop it. As I assisted them in getting tubes and lines untangled, I thought about dignity. I was a complete stranger to these people. The only reason they allowed me in to this very intimate moment was because of their vulnerability and my white lab coat and they needed help. I approached the moment with as much respect as I could bring. The gentleman never made eye contact with me, likely because he did not want me to see him as he was at that instant. I tried to be with them in an unobtrusive and respectful way but given the situation, it was impossible for this man to feel like a person instead of a patient. There are times when the power distance in the relationship is unavoidable but how the nurse and the patient experience its effects can be handled with dignity and compassion.

The Subject of Nurses at their Best

I asked each nurse to tell me a story about a time when they were at their best with their older patients and every nurse described an end of life experience.

"He was ready to go, cause I mean, he was a very stubborn man according to his wife. And, it was quite, it was, I felt like I did my best but I couldn't go against what the doctor and the family want. And, finally, I mean, even the wife was exhausted, she was like (sighs). I say maybe there's just a way of telling us he's trying to go home, and the home might not be the home we're thinking of, and it might be the home that he's thinking of." (Nurse C)

"I'm thinking back that because of that relationship of caring that we had established and I remember it was always somebody you sat down in the room with them because I remember it was just my habit." (Nurse S)

"She was in her eighties, and she had advanced stage cancer. She had siblings, older siblings, and she had older children that were very, very active in her care. And you could tell she was the matriarch of the family. I mean she held this family together. And, you know, they were still coming

to her for advice and things like that. She loved me and missed me when I wasn't there. She was the first person that ever put my name in an obituary." (Nurse A)

"She just touched my heart. When she was in the ICU, we visited her, me, along with another navigator and ... She wanted some French fries and we went and got her some French fries, and you would have thought we had hung the moon for her. I mean it was just – it's those simple things that touch people. And uhm.. She always told me she loved me." (Nurse SM)

I wasn't quite sure what to make of their universal narrative of caring for patients at the end of life. I shared this finding with several of the study participants and they too were surprised that the others described similar situations. They shared that they felt it had to do with the fact that this aspect of patient care is really the only time when a nurse can be truly autonomous and when others don't prescribe or dictate how this should happen. We don't have pages of policies or guidelines or risk assessments or order sets that guide our practice at the end of life. I have spoken to several colleagues (peers) about this finding and they are in agreement that this is likely due to the fact that in providing care at the end of life, we are truly able to practice nursing, unencumbered by time frames, policies, procedures, regulations and checklists. This is a time when we can call on the whole of our practice; when we can be fully present with another human being in need of comfort, compassion, guidance, and love. This sacred time with our patients is why many nurses went into the practice in the first place.

Patients and Power

"I try not to bug them, you know, about different things because I'm not the only one here."

"They just tell me pretty much that I need to eat right and stuff."

"It may be they really don't give a shit about what anybody thinks they just want to satisfy themselves."

"I understand. I am not a dumbass woman. I understand when they say you cannot get up without somebody; I'm not going to get up."

"You know, you just... you can't do that to someone that can't help themselves."

“Well, it makes you feel better that they are concerned and I will say this. I have to get somebody to help me to the bathroom. They won’t let me up. But I don’t have to wait for long. That’s important when you have to go to the bathroom.”

“They come in here when they get ready to change shifts, they do the reports and you know what’s going on with yourself because you’re listening to them.”

“And she was hooking up my IV at the time. And she said, ‘You don’t complain and it makes it easier for us’.”

“I didn’t want to stick the second time but I feel such a good vein I thought for sure I could get it,’ she says. ‘But I’m not gonna try anymore.’ She said, ‘I could use you as a pin cushion but I don’t want to anymore’.”

None of the patients expressed these statements about the nurses with anger or contempt; in fact, these statements were quite matter of fact. The patients didn’t seem to view these statements by their nurses as being negative or aggressive. It seemed as if telling patients what to do and expecting them to behave in an appropriate (compliant) manner is common in the nursing/patient culture of this organization. These patients seemed to expect to be told what to do and that the social practice of being a patient requires one to be submissive or passive.

One of the patients with whom I spoke was a chronically ill, morbidly obese, charming woman. Cathy talked to me for over an hour as she shared her life story. Threaded in her life story was the story of her illnesses, of which she had many. She has been dealing with diabetes, renal failure and depression for almost all of her adult life. She spoke *fondly* of the nurses who would use her as a *pin cushion* or who told her she was a good patient. She said that she knew the nurses at her dialysis center better than they know her. She knew about their families, their hobbies, and what they did over the weekend and she seemed to truly care about them.

It seemed though, that no one had ever taken the time to hear her story or inquire about much more than her blood sugars and why she was not compliant with her diet. I assume that many nurses have told Cathy what she should do and what she should eat. She believed that is simply what nurses do.

“They teach you the simple things. It’s like I came in, I guess it’s a month back I had cellulosis (sic) in my leg at that time before this trip.¹ And I couldn’t have cataract surgery because my temperature was up that morning. And they sent me to my doctor and he sent me here. And she (nurse) says, ‘Did you wipe your eye with the same finger?’ And I’m going. ‘Yeah, I’m bound to do that.’ Or if I pick a tissue up, I’ll wipe one and wipe the other. She says ‘You’ve cross contaminated your eyes.’ I said, ‘I never thought of that.’ She says ‘Just remember if you use one tissue throw it away and get another one.’ I laughed at her because that sounded funny.”

It sounded funny to me too. I wondered why, as sick as this woman was, why she was being taught how to wipe her eyes. I wondered why this particular nurse didn’t take the time to share with Cathy how important it is to keep her eyes healthy since many severe diabetics suffer from blindness.

Why didn’t the nurse take the opportunity to talk about how her skin infection (cellulitis) or tell her that her eye infections are probably caused by her high blood sugar levels? I wondered how many nurses had missed opportunities to hear Cathy’s simple view of her disease and who had approached her in a way that made sense (to the patient) so that she could better control her situation. My assumption was that not many nurses took the time to help Cathy manage her disease and help her understand the choices that she was making and how her choices impacted her body. I chose to believe that the nurses were not practicing as nurses. In the short time I was with her, I got the distinct impression that she did not know much about the disease that had destroyed her kidneys and was eating away at her limbs and clouding her eyes and this was due to a failure of nursing. This patient could not think of an example of how a nurse had contributed positively to her health. It seems likely that this woman does not know how to care for herself but she is trying to do what she is told. My assumption initially was that no one has ever tried to understand her, her life, her story. If they did they could help her understand why she is as sick and as unstable as she is with her diabetes. My assumption was that she doesn’t understand how sick she is. Without context and an understanding of the complex interactions and social practices that frame this woman’s life and the journey of her illness, it’s very easy to place blame. As

¹Cellulitis is a skin infection requiring antibiotics that is common with diabetes.

I listened to her story and implicated the dozens of nurses who were involved in her care, I began to see things very differently.

She didn't know what she didn't know and perhaps she believed or assumed that the nurse who taught her how to wipe her eyes was being helpful. It is too easy for me to believe that the nurses involved in this situation have never attempted to approach Cathy with consideration of her strengths, her culture, or level of understanding. It is also easy to assume that their approach was unhelpful because it was directive, brief, and rote. I make this assumption based on Cathy's level of understanding of her illnesses, her personal story, and her background/culture as well as my observations as a nurse (and a nurse leader) of hundreds of interactions with nurses and complex patients. Alternatively, it is possible that Cathy was too sick to respond to a thoughtful, helpful approach from very skilled, intuitive nurses who are able to meet patients where they are and move them towards a mutually constructed definition of health, suggesting a bias in my interpretation.

Much of what the patients relayed was about being highly dependent upon the nurses; particularly for awkward or embarrassing activities such as toileting assistance and bathing. It seems that when you are so dependent upon others for the most basic of human needs, it is difficult to feel as though you are on par with that other individual, particularly if they are telling what you can do, when you can do it, and what you cannot do. People are stripped of their dignity and identity when they enter a hospital and assume the role of a patient. They are told when they can eat, what they can eat, what they will wear, and they are isolated in a room, expected to stay there unless accompanied by a hospital staff member. Institutionally, this is often the expectation both of those receiving and providing care.

I heard several comments about how busy the nurses are; the patients talked about this, as did the nurses. One of the patients told me that a nurse told her "We hate for you to have to depend on our CNAs but with all our computer stuff, I don't get to interact with the patients." Every day that I interact with nurses and patients, I hear how busy the nurses are, no matter what is going on. The standard answer, when I ask how things are going is "it's really busy". When I visit patients and ask if they are getting what they need, if they have concerns, they often tell me they "know how busy the staff is". It's quite a predicament for patients; they are compelled to be dependent (physically or institutionally) on the nurse for the most basic needs but they know how

busy the nurses are. A sense of helplessness was evident in the discourse of both patients and nurses.

The inability to act on their own, which causes patients distress, also causes them to reject their impotence by attempting to restore their capacity to act. One way that patients try to restore their power seems to be to submit to and identify with a person or group that has power. By this symbolic participation in another person's life, through cooperation or cheerfulness or getting to know the nurses, patients have the illusion of acting independently, when in reality they only submit to and become part of those who act.

The Patient Who Kept his Power

David did not behave like a *patient*. He was in the hospital only because he needed intravenous medication and disliked immensely having to ask for anything or relying on others to have his needs met. His responses related to the best interaction with a nurse centered on responding to his requests in a timely manner. Because David was not physically dependent upon the nurses for any of his personal needs, he actively resisted entering into the role of a patient. He reminded me of my husband before he became physically dependent. Perhaps this is why I thought he responded to me differently than the others.

"They could recognize and tell what... or understand what needed to be done without being told. And some just did and some didn't." When asked what he thought made it possible for nurses to interact with him in a way that made him feel like they were interested, he said, "Well, I think with some people it's just a personality trait. They have a good understanding of the job responsibilities and they... they execute them well." He didn't assume caring or compassion; he desired competence. With this gentleman, who was not a *chronic patient*, defined by an illness, the dialogue was quite different. He wasn't trying to please me. He wanted me to know he was intelligent, capable of getting what he wanted, and had a life beyond his illness. I knew when I was speaking with him; I did not possess power over him. It was an unusual, somewhat unsettling feeling for me. Looking back over the transcript, I discovered that the reason for his hospitalization never came up. When I asked him to tell me about himself, he told me about himself as a person, not as a patient.

This gentleman was referred to me based on three criteria, he was over 65, he had no cognitive impairment, and he had been a patient three times in the past year. David was the first patient I interviewed and when I sat with him I felt uncomfortable with how casual/informal he was in our conversation. I had never interviewed a “patient” as anything but a nurse and this didn’t feel like that kind of interaction. My world with patients was one where I asked the questions as a nurse and you answered the questions as a patient. I asked for and wanted clinical information and I got detailed, friendly, personal information. At the point where I became aware of my inner (nurse) dialogue, I switched into the role of the interviewer and researcher. This realization was very powerful. I, the nurse, rather than an observer, had the expectation that the “patient” should respond in a certain way. I was “allowing” the patient his voice but I was expecting his voice to be that of a patient and not of a person. Nurses have the expectation that people who become patients will behave like patients.

They call themselves ignorant and say the professor is the one who has knowledge and to whom they should listen. The criteria of knowledge imposed upon them are the conventional ones. ... Almost never do they realize that they, too, “know things” they have learned in their relations with the world and with other women and men. Given the circumstances which have produced their duality, it is only natural that they distrust themselves.

(Freire, 1993, p. 45)

The Older Person Object

Any situation in which some individuals prevent others from engaging in the process of inquiry is one of violence. The means used are not important; to alienate human beings from their own decision-making is to change them into objects.

(Paulo Freire, 1993, p. 85)

Nurses’ Comments about their Older Patients

“Communication is difficult with cognitive impairment. The patient can be difficult to communicate with. It is more difficult for me than for the patient.”

“I tried to treat him no like he – like you said earlier, some people—you have elderly patients and it’s like they talk to them like they’re children or like

they're going back into that stage like they don't understand. They do understand. You just have to take the time to talk to them."

"Not to stereotype, but is there a deficit, are they confused? So first things first, is there any sort of deficit, impairment that I need to address?"

"How much it means for me to care for someone well because we're all going to need that at some point."

"I know that I have done something to make an, an impact on their life, and they're better, and they're healthy and they don't need me anymore."

"I engage them, I get on their level. I... a lot of times bend down to talk to them, I don't stand over. And I let them... complete the conversation; I don't try to interrupt them. I want them to tell me what their concerns are. And then I'm... I make every effort to get back to them, or at least solve the problem as much as I can."

"I see they're pitiful. It just makes you think, live every day to the fullest, do everything you can with your family and friends."

"I'll come in and I'll see spouses at the bedside with the person they love. It could be a spouse, it could be whomever. And when I see the love that people have for each other, that will tear me up. I can just look in the room and see them wiping their mouth or helping them eat breakfast."

"I respect the elders, and I know sometimes there are other things that are going on with them like dementia and Alzheimer's that are not really them."

"If you start the conversation and talk to them, they'll open up to you and then, that way, if they do, if they need any help at home or something like that, you can assist them and get the right people to help them."

"If you just go in and you just say 'here's your medicine' and just go back and check on him every once in a while, you don't take that extra time to get to know your patients, they just feel like they're another number."

"With this generation, we really have to be careful to realize do you really understand what they are telling you? With this older generation, we need to be more aware. You need to be a little simpler nurse."

"A lot of nurses think, 'oh, they're older, they don't know anything'. They're fragile too."

"Older people never question a doctor; would never ask why."

"I enjoy them anyway. I find some people (nurses) have a hard time. They just don't think older people are enjoyable."

"They just need somebody to take that extra 5 minutes. And it makes a big difference, because it makes them feel like, I'm so glad you're here. You know, it makes you feel good, really."

« I don't quite get that challenge from my older population. Older patients don't seem to have that vision (for better care)."

"Classmates were saying it (dying) has got to be easier with the older ones. It's you know, to say, 'oh well, they've lived a long life, it's okay for them to lose a battle with cancer'."

"You get the honey, baby, sugar, darling from other nurses."

"They're equal just like everyone else, try to treat everyone the same, no one any different."

It seemed obvious to me that the nurse as the oppressor does not perceive her control nor does she see having more as a privilege which dehumanizes others and themselves. Nurses have more information, better health, freedom to come and go. For them, having more is an inalienable right, a right they acquired through their own effort with their courage to take risks. According to Freire, the more the oppressors control the oppressed, the more they change them into apparently inanimate things, which is apparent in the nurses' dialogue (Freire, 1993, p. 41).

The nurse's task is to please her patients by handing out bits of information, small tokens of consideration, or brief moments of her time. Since many older patients have been constructed to receive "care" as passive entities, nursing's approach reinforced this and makes them even more passive; eventually making them completely dependent. A good, older patient is one who is passive and agreeable; who fits into the hospital routine and who appreciates the care they receive. This practice is well suited for staff (oppressors), "whose tranquility rests on how well people fit the world that the oppressors have created and how little they question it" (Freire, 1993, p. 57).

The Little Things

"It's the simplest things, just taking him a cup of coffee, just black because he just liked black coffee, just taking him some coffee."

"And it's just more the little things than it is anything that means the most to them.

Most of them, when you take the time to do just something, little things for them- they go 'I feel so much better'."

"It makes you feel good; it might not be something you do every day but it's something that you do for that one moment that's enough."

"They teach you just simple things."

"She wanted some French fries and we went and got her some French fries, and you would've thought we had hung the moon for her. It's those simple things that touch people."

"Most of them, when you, when you take time to just do something, little things for them and 'go how you feel?', and they go 'I feel so much better'. It makes you feel good, it might not be something you do every day, but it's something that you do for that one moment that enough."

"It's just those simple things that touch people."

Over the past five years, I have noticed that the words "the little things that make a difference" are often repeated discursive practices in my organization. Many nurses have told me that what the patients value most are a few minutes of the nurses time, or bringing them a cup of coffee, or remembering their dog's/child's name. I'm told that patients don't need much, which is good because nurses don't feel that they have much time to give. These interviews were consistent with what I have been hearing in my practice. My interpretation of this is that nurses do not see the larger contributions on patient's wellbeing because they have been constructed to practice and relate in a way that is fractured, piecemeal, and disconnected from a holistic, professional practice and all they can see is the little things as being meaningful. They have been focused on completing tasks rather than effecting changes and measured on compliance rather than outcomes. Additionally, because they believe that they are always busy, spending a few minutes with a patient or getting them a cup of coffee may seem like a grand effort.

The Nurse as Subject

"We don't ever take the time and figure out what the patient really needs.

You really don't take the time." (Nurse)

"People (nurses) always forget everything else. You know, even if they have to be on a bedside commode. People don't pull their curtain or shut the door." (Nurse describing other nurses)

"Nurses, they have a big heart. They have a caring heart." (Nurse; I found myself wanting to correct the nurse's grammar here but it is an interesting use of one caring heart for all nurses.)

"They're nice." (Patient)

"It makes me feel that I've done something good, and I can't do it for the who world, but I can do it with this one person." (Nurse)

"Talking to nurses takes my situation off my mind." (Patient)

"I never have the time to do what you need." (Nurse)

« I don't baby people that are healthy. I baby those that aren't. And my family noticed that I'm like, I'm like that, like I will care for someone that is, who needs me versus the one that wants me." (Nurse)

"They don't have time to socialize." (Patient)

"It wasn't just business. She would come in and talk personal stuff." (Patient)

"None of them seem to get upset." (Patient)

"Nothing sticks out." (Patient)

"Nurses are friendly and courteous." (Patient)

"Daytime people did the best job." (Patient)

"They care about the quality of the job they perform." (Patient)

Several of the nurses described *other* nurses as being disrespectful or not taking time with their patients. None of the comments made about other nurses were positive. When asked about a positive experience, one patient said that the nurses were "fantastic" but went on to describe a negative interaction. This and other comments from the patients were similar to what I hear when I visit with patients. Patients often will say, "I don't want to get anyone in trouble" when I ask them to tell me about their experiences. I heard a similar comment from one of the patients interviewed for the study when she explained how embarrassed she was with having to go to the bathroom with a male nurse watching her. There was nothing specific or unique about how nurses had impacted their lives or their health. The most common response from patients was that nurses were kind or nice. Only one patient could recall the name of a

nurse who made a difference in their health. Interestingly, however, the person named was not a nurse.

Patient as Object

"There is not fixing a lot of our patients."

"They just want someone to sit and talk to them."

"Make them feel like you want to be there."

"That is a huge responsibility. When you think someone cannot speak and you are speaking for them."

"I'm not good with people with mental health issues. Cause they can't tell you, cause half the time they're confused."

"You're their voice until they can find their voice."

"But once you talk and you realize she's just like everybody, she's not really a patient, even though we call them a patient."

"We were not going to cure her; we were going to buy her time."

"I usually let the patients set that relationship. And clearly she wanted; you know a deeper relationship with me."

'And I let them complete the conversation; I don't try to interrupt them.'

'I think they think that I'm sincere because I engage them, I get on their level.'

"Sometimes there are a lot of deficits when patients come in. Because they don't just come in with cancer; they come in with their whole history. And they say 'here, take care of me'."

"I think we project on to people what our thoughts are, where they need to be. And that really is not true. You.... You have to listen to what the patients are saying, and be in their moment, not dray them into your moment."

I got the sense that they were trying to convey intimacy but intimacy seemed to be directed more toward self than toward the patient. Several nurses spoke about their role as advocate or a voice for their patients when they were unable to communicate. Additionally, they focused on the relationship with the patients' families and for some of the narratives; the patients seemed to play a minor role in those relationships, truly an object rather than a subject. Much of the discourse conveyed the power that

exists in the nurse patient relationship where the nurse allows the patient to participate and where the patient willingly assumes the role of the submissive partner.

Patient as Subject

“She loved me, missed me when I wasn’t there. She was the first person to put my name in an obituary.”

“I knew he was in pain but I couldn’t go against orders. The second night the patient got pain medicine. I couldn’t take care of him the third night because I was exhausted. Then he pretty much died. I felt like I did my best but I couldn’t go against what the doctor and family wanted.”

“They give so much back to me than I could ever give to them.”

“I realize that at one time, someday, I’m probably going to be in their shoes.”

“I’m going to be looking up at a nurse and I’m going to hope that she’s going to be sensitive to me and my needs and respect her elders, and hopefully treat me the way I have tried to treat others.”

“I just want to make sure this woman in front of me has the best care that she can have so hopefully it’s reciprocated.”

I got the sense from the nurses that their relationships with patients fulfill a need for appreciation. Many comments were about how working with patients made the nurses feel better. Additionally, threaded throughout the conversations about patients (as subjects) was the idea of karma. They didn’t call it karma but spoke often about taking good care of others so if ever they are in need of care, there will be some sort of Karmic reciprocity when they become a patient. There seemed to be a sense of quid pro quo.

The patients in the nurses’ stories were rendered passive (subjected to) in the nurses’ accounts. None of the stories brought an image of a person to my mind. The faceless and nameless patients described in the nurses’ stories of them at their best were all depicted as cooperative, appreciative, agreeable, and “good” patients with good families. One nurse did describe an example of conflict resolution that centered on differences in opinions about the plan of care but not of challenges with difficult patients or families. One of the topics that I consistently bring to discussions about patient satisfaction or patient engagement is my belief that most nurses do very well and can perform at their best when patients are agreeable and cooperative. They struggle

to provide a remarkable experience when patients are confused, agitated, or disagreeable or if they are the unpopular patients that Dr. Stockwell described forty years ago.

The stories lacked emotion, excitement, and were fairly straightforward. There were no heroes or villains or ethical issues. The accounts of patients as subjects were fairly mundane. There seemed to be a lack of a sense of intimacy, wonder and awe. I expect that I interpreted the discourse in the way I did because I framed it from how I approach my work. I realized that my judgment of a lack of wonder and awe is just one view of many that is influenced by thousands of other conversations and relationships. There are multiple ways to interpret the stories of patients if we are open to the various possibilities.

The Subject of Professional Boundaries

In several interviews, when describing a “close” relationship with a patient or family, they felt compelled to tell me that they were probably crossing a professional boundary, but could be explained through altruistic motives.

“We had a special bond. There were so many days I came to work and I would have messages on my voicemail that she had put on there during the night.

And I usually let the patients set that relationship. And clearly she wanted, you know a deeper relationship with me and that’s fine with me.”

“Is it really my role to uhm... uhm... make sure she has stamps so she can write us letters? Is it really my role to make sure she has stationery so she can write on that?”

“It’s like she’s adopted me because she calls me her friend, she says she loves me.

She asks personal questions, and I don’t lie to her, I tell her things.”

“It felt more like a friendship, more like a, I’d worked in home care. And as a CNA, and that relationship it’s different than a hospital relationship, because you know, you are going in to their home, and you really are, you know.

And I would get birthday cards and stuff like that. You know, and Christmas presents and stuff like that when I worked in home care. But, I’d never felt that working in the hospital.”

“As long as that relationship-building you professionally build in the care of the patient but it’s that relationship that you build outside which we know that you as that nursing role is professional and should stay in the care of the patient. But sometimes there would be telephone calls or there would be visits with “how are you, thinking about you” and you find that patient people really appreciate something that may be outside the professional realm but as you know, it’s okay cause it’s their birthday or you find out from somebody that they have a special anniversary and we still send them cards.”

These nurses seemed to be attempting to define for their practice what a professional relationship looks like. They seemed to be experiencing confusion around the blurring of what they perceive to be solid professional lines of behavior while attempting to meet what they consider special, therapeutic needs of patients. According to professional nursing organizations, boundary *violations* can result when there is confusion between the needs of the nurse and those of the patient. Such violations are characterized by excessive personal disclosure by the nurse, secrecy or even a reversal of roles. When nurses are not autonomous in their practice and are fearful of making mistakes, words like excessive or personal may not be concrete enough.

It’s not clear to me that these nurses actually crossed a professional boundary but it is clear that they are aware that there is a boundary. In daily practice what constitutes a professional relationship has not been part of the dialogue as much as what constitutes a breach in that relationship has been.

What is in Plain Sight but not Obvious?

Many nurses spoke about the fear of aging and fear of death when I asked about working with older patients. It seems that working with older patients forces one to associate older patients with death and to face one’s own mortality.

“You gotta take care of yourself.”

“Time on earth is limited.”

“It just makes you think live every day to the fullest, do everything that you can with your family and friends.”

“I’ve already told my children what to do more, this is what your mother wants and this is what your mother doesn’t want.”

“Appreciate life; be happy with what I have, and not what I don’t have.”

All of these nurses deal with death and dying on a regular basis, because of the work that they do. It is possible that this makes it more likely for nurses to face their own mortality sooner or more often than those who do not. My interpretation of these comments as it relates to the nurse patient relationship is that these expressed thoughts about death and dying, particularly with older patients, could lead to a paternal/maternal or they could lead to a more compassionate approach to care. Perhaps thinking about one’s mortality influences caring in a positive way by making sure to leave a legacy of caring and of making a difference in the lives of patients and families.

What Surprised Me

What surprised me most was my realization of the monologic view of nurses and patients that I began with actually promoted inequality. I had a simple, singular perspective that I used to explain something incredibly complex and intricate. It is with great humility that I acknowledge that as a leader and as a practicing nurse, I distanced myself from other nurses and from patients and denied my involvement with an approach that was “hierarchically superior”. I was the expert and I was the oppressor and I had lots of advice and numerous solutions because I had transmuted what is fundamentally dialogic into a simple, basic monologue (Sampson, 1993, p.177).

I first recognized my monologic view with the first patient interview when I recognized my own, internal response to the patient who did not “act” like a patient. I was taken aback by his informal approach to me. (*The denouncers must distance themselves from those denounced.*) Upon recognition of this internal dialogue, I was bothered by my expectation that the people I was interviewing as patients would interact with me in a predetermined way. I expected a “patient story” versus a person’s story. When the first patient told me his personal story and used a *very* casual and what I interpreted as a somewhat *provocative* manner of speaking, I was a bit uncomfortable. I too, have come to expect a certain type of response from a patient, in spite of being “enlightened” because I am one of the denouncers. I was also surprised at how frequently power and the lack of power were mentioned by nurses and patients. People are immediately stripped of power when they enter the healthcare facility and most of the time, they do nothing to resist. They are given a unique patient identification (a random number), brought to a room and placed in a bed, stripped of their clothes and

told to send their personal belongings home with a friend or family member. They are given medications on a strict schedule, provided meals at prescribed times, and offered personal care assistance at the convenience of the staff. It seemed that patients recognized the power imbalance but seemed to believe it was necessary or somehow normal.

“They do the reports and you know what’s going on with yourself because you’re listening to them.”

“It’s almost like they can read your mind.”

“The nurses told me ‘You don’t complain and it makes it easier for us’.”

“I try not to bug them, you know, about different things because I’m not the only one here.”

“I like them really much because I need them. I can’t do it myself.”

“They care about the quality of the job they perform. And it may be that they don’t really give a shit what anybody else thinks – they just want to satisfy themselves. And I understand that.”

“And I understand. I am not a dumbass woman. I understand when they say you cannot get up without somebody, I’m not going to get up.”

“I can’t do anything without them. Nothing. You know, if I wanted that... a straw over there, I gotta call them. I can’t even get up and go get it. And that is frustrating.”

“I hate to take up their time when they could be doing it with other people.”

“Because there are a lot of people, right up here, that’s a lot worse off than I am.”

“See, I have to get somebody to help me to the bathroom. They won’t let me up. But I don’t have to wait for long.”

For four of the patients, dependency was a grave concern as was timeliness of responses to their needs. Physical dependency contributes to the power differential in practical and unavoidable ways. When you cannot do the most basic things for yourself, you are expected to be a patient (and be patient). You are expected to call for help, even if you think you could do that something for yourself. Betty described her situation that led to her hospitalization, “And it wasn’t like I was paralyzed. It was just like I didn’t have the strength to get up.” Doris said, “I just got myself so weak and run down.” The most *experienced* patient, Cathy, seemed to have embraced her role as a

sick person and spoke about the nurses with enthusiasm and pride. “I’ve discovered that I think I have it hard at times, but I listen to them and they have at home the same problems that I have.” I found this interesting, coming from a woman who spends several months out of the year in a hospital and a third of her life in a dialysis center. For her, being a patient is her life and she has adopted the role of a compliant patient and relating to her oppressors. “One time you would have nurses that come in and they do what they’re supposed to do. But I understand they don’t have time to socialize and all because it’s so in and out. So when the regular nurse would come in they’d tell me we hate for you to have to depend on our CNAs but with all the computer stuff, I don’t get to interact with patients. And she comes in one day and she says, ‘I never have the time to do what you need, I’ve got wound care coming up to see you.’ Had it not been for that nurse, I would have never got that leg healed.”

The fifth patient I interviewed was quite confused by my questions. He really struggled to articulate what he thought about the nurses. This gentleman had diabetes and was hospitalized to have his foot amputated. Amputations are a devastating though not uncommon surgical procedure for people with uncontrolled diabetes. This gentleman, who happened to be a farmer, had an unfortunate accident and injured his foot while trying to help another farmer get his cows out of the road. He got gravel in his shoe and didn’t feel it. First he had a toe removed, and then another and now he was having his foot removed. He told me quite frankly, “I’ll never get better.” When I asked him about the best experience he has had with nurses, he responded, “they’re nice, all of them. I just want to – none of them seem to get upset.” “If they’re not real, real busy, they’d be here right now.”

The oppressed, having internalized the image of the oppressor and adopted his guidelines, are fearful of freedom. Freedom would require them to reject this image and replace it with autonomy and responsibility.

(Paolo Freire, 1996, p. 47).

Chapter Seven: Reflections on Nurses and Older Patient Relationships

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.

(Paolo Freire, 1996, p. 51)

I have not come to any *conclusions* about the discourse of nurses and their older patients, nor do I have a well-defined theory. In fact, I have more questions than I have answers but for the purposes of this dissertation I will use Gergen and McNamee's description of a theory in terms of its potential uses. Instead of further restating what has already been shared through my examination of the dialogue between researcher and subjects, this section will describe how this collection of words, narratives, phrases, subjects and objects, as I understand them, can be carried into ongoing conversations of the nurse-older patient culture and use what I have heard and seen and understood as a resource for exploring possible ways of *going on together*.

Additionally, the readers of this work will undoubtedly further shape understanding as they consider its meaning. "In the actual life of speech, every concrete act of understanding is active . . . and is indissolubly merged with the response, with a motivated agreement or disagreement. To some extent primacy belongs to the response, as the activating principle: it creates the ground for understanding, it prepares the ground for an active and engaged understanding. Understanding comes to fruition only in the response. Understanding and response are dialectically merged and mutually condition each other; and one is impossible without the other" (Bakhtin, 1981, p. 282). Further contextualizing and perhaps discounting that the reader will do in light of this work will be as important as the work itself. Without ongoing dialogue, this work will be meaningless.

Bakhtin describes three characteristics of speech to consider in moving forward from this point in our journey:

- *It creates and maintains relationships*
- *All utterances bear reflections of the addressees.*
- *Speech forms its own context and backdrop of further speech and social relations*
(Riikonen, 1999, p. 141).

The speech, in the form of the text that I reflect upon has created the relationship between the nurses and the patients and between me and them. I am now part of that relationship in a very different way. The words of the text reflect the nurses and the patients from which the text was derived but they also reflect the nurses and patients who have influenced them and their dialogue and will work to influence further speech and social relations.

Until recently I have functioned, like thousands of other leaders, as if I have the power and the ability to determine causes for the problems I confront every day, assign responsibility for the causes and act accordingly with punishment, confrontation, or other types of corrective action. This approach to leadership has been pervasive throughout the thirty years of my career and as we have seen in an earlier chapter, is pervasive throughout the profession of nursing (see Figure 7 on page 80). Good intentioned leaders, scientists, and philanthropists have all engaged in the work of finding and naming the causes for nursing shortages or quality of care or patient dissatisfaction, for example, and have attempted to right the wrongs. As long as I have been a nurse, nursing supervisors, managers, or administrators have assigned blame or credit to individual employees and to those who are blamed, applied punishment; to those who are credited with good work, dispensed rewards. Assigning individual blame or credit, also occurs with patients. Nurses and other healthcare providers often attribute a patient's medical condition to something the patient did or didn't do and punishment or praise is delivered accordingly. This way of leading or practicing with the discourse of assigning individual responsibility is "severely limited – intellectually, ideologically, and pragmatically" and this way of leading and practicing will not allow us to realize a transformed system of health and caring that is so desperately needed in our country (McNamee, & Gergen, 1999). This dominant way of leading and practicing is efficient and requires little or no transformative dialogue while reconstructing relationships that have developed over the course of forty or fifty years is considered to be challenging, time consuming, and inefficient. So instead of proposing a well-defined theory that serves as a resource that permits some forms of action and suppresses others, I will explore the possibilities that exist in re-constructing nurses' relationships with older patients in a way that restores humanity, dignity and well-being for both.

Prescriptions, Problems and Possibilities

Every prescription represents the imposition of one individual's choice upon another, transforming the consciousness of the person prescribed to into one that conforms with the prescriber's consciousness. Thus, the behavior of the oppressed is a prescribed behavior, following as it does the guidelines of the oppressor.

(Paolo Freire, 1996, p. 7)

To be human is to actualize a self that is unique and that resists being reduced to a list of attributes and characteristics. Patients yearn to be seen as more than the sum of their parts yet healthcare systems and professionals actively seek to break them down into smaller and smaller pieces through diagnostic labels and rigid documentation systems. Nurses wish to be autonomous and respected professionals capable of functioning without the restrictions of protocols, scripts, or mandates while administrators and politicians seek to further limit, scrutinize and regulate even the most personal aspects of their care. Systems seek to de-emphasize a patient's uniqueness and the nurse's professionalism. In order to fit in, patients often adopt the role of a good patient and nurses frequently become obedient employees by acting according to expectations, being compliant, not complaining, and being generally agreeable and cooperative. Nurses and patients become objectified through an excess focus on how they fit into a diagnostic system or function as part of a statistical picture or any other strategy by which they are labeled and dealt with that does not fully take account of their individuality and personhood.

According to Freire, not even the best-intentioned people can bestow independence as a gift nor can they "implant" in the oppressed a belief in freedom in order to win favor or trust (Freire, 1993, p. 48). Moving forward, I would like to explore ways of promoting conversations that attempt to transform dependence into independence, that value a *balance* of power for patients and nurses, that recognize dependence as a failure, and that move from prescriptions to partnerships and from problems to possibilities. Many of the previously described initiatives that sought to *improve* the profession of nursing or *empower* patients were efforts to *bestow physical* independence rather than liberate or encourage generalized autonomy. Instead of engaging in more initiatives, improvement projects, or national collaboratives that seek to bestow power upon nurses and patients without nurses or patients at the table, it seems to make more

sense to facilitate transformative, collaborative inquiry with nurses and patients that promotes a better understanding of their world and that engages them in exploring ways that they can begin to reconstruct their worlds.

Arthur Frank describes the modern experience of illness that begins when “popular experience is overtaken by technical expertise, including complex organizations of treatment”. People no longer just go to bed and die, cared for by family members and neighbors who have a talent for healing; they go to paid professionals who reinterpret their pains as symptoms, using a specialized, technical language that is unfamiliar, overwhelming and impersonal. They accumulate entries in medical charts which in most instances they are neither able nor allowed to read, but which become the official story of the illness. They tell family and friends what the doctor said, and others reply by telling experiences that seem to be similar. Illness becomes a circulation of stories, professional and personal, but not all stories are equal. *The story that trumps all others in the modern period is the monologue of the medical narrative.* The story told by the healthcare team becomes the one against which others are ultimately judged true or false, useful or not. The core social expectation of being sick is surrendering oneself to the healthcare system where the patient not only agrees to follow all regimens that are prescribed; she also agrees, tacitly but with no less implication, to tell her story in medical terms. “How are you?” now requires that personal feeling be contextualized within a secondhand medical report. Doctors and nurses become the spokesperson for the disease, and the ill person’s stories come to depend heavily on repetition of what the healthcare team has said (Frank, 1995, p. 11). (One of the patients told me, “They come in here when they get ready to change shifts, they do the reports and *you know what’s going on with yourself* because you’re listening to them.”)

Rita Charon, authority and pioneer in the field of narrative medicine believes we are at a crossroads in health care. “Together, we have to discover means of sustaining the tremendous capabilities of our biomedical sciences while trying to ease the suffering and loss occasioned by serious illness. The price for a technologically sophisticated medicine seems to be impersonal, calculating treatment from revolving sets of specialists who, because they are consumed with the scientific elements in health care, seem divided from the ordinary human experiences that surround pain, suffering, and dying” (Charon, 2006, p. 6). Healthcare that is devoid of an awareness of the other may accomplish great things but is at best, “empty medicine” incapable of understand-

ing or honoring the meanings of what people endure in the face of serious illness (Charon, 2006, p. 9). Charon suggests that healthcare can greatly benefit from learning what literary scholars, storytellers, and anthropologists have known for some time – what narratives are, how they are constructed, and what they have to say about the world. Narratives allow healthcare providers to better understand another's situation by "participating in his or her story with complex skills of imagination, interpretation, and recognition" (Charon, 2006, p. 10). With the rapid adoption of electronic medical records and data mining, much is lost in terms of the patient's story. Until recently, nurses composed narrative notes and shared their stories at shift change. Today they check boxes and use templates (Smart Phrases). The following is an excerpt from a training manual for one of the more common Electronic Medical Records (Epic)

During an Office Visit / Working with a Patient's Chart in an Encounter

"Progress Note"

Highlight the text you want to transform into a "SmartPhrase"

Select "the green + sign" tab

"SmartPhrase Editor" is now opened.

Modify the SmartPhrase so you can use it for the next patient.

Put in wildcard "****" where it is appropriate.

"SmartPhrase Name" - the name you want to look for this SmartPhrase, make it intuitive for you.

"Short Description" - Describe what is in the SmartPhrase

"Accept" or "Alt + A" (Medical Tools, Inc., 2011).

This shortcut for documentation has been designed to save time. With this function, healthcare providers can create notes that, with minor modifications, can be used for all patients. Less than a decade ago nurses and physicians used pens and paper to describe their interactions with and observations of their patients. They signed their names, followed by their credentials instead of scanning a barcode that provides the system with their employee identification number. I can't help but think that the new electronic medical record has contributed to the depersonalization of both providers and patients but it doesn't have to. A clinical narrative can allow a provider to recognize, absorb, interpret and be moved by the stories of illness and disease (Charon, 2006, p. 4). Narrative healthcare can help repair some of the damage done by the anonymity brought about by specialization, biotechnology, and electronic documentation.

Mass General Hospital provides team members with the essential components of a clinical narrative by providing the following suggestions:

The following "tips" will help you write your narrative:

1. *Present your story as a first person account. Change the patient's name and any other identifying information in order to protect confidentiality.*
2. *"Tell" your whole story into a tape recorder. Then, transcribe the tape and edit it, removing unnecessary detail and adding any missing elements. Your story should be 1 – 3 pages in length.*
3. *Review your story with a colleague who also cared for the patient. This may help you identify additional details and information that should be included.*
4. *Have someone who doesn't know the patient read your narrative to see if you missed information or left questions unanswered. An outside reader can often help you identify details that you took for granted and inadvertently omitted.*
5. *Avoid vague summary statements or general phrases that do not communicate what actually occurred. Instead, state what happened in specific terms. This will help the reader better understand the situation and appreciate your actions* (Massachusetts General Hospital Patient Care Services, n.d.).

This approach, in contrast to entries in the electronic medical record, allow healthcare providers to develop insight into their practice, strengthen their skills of attention and construction of their patients and enhance their ability to develop relations with their patients. By using narrative practice, providers may also find themselves "more and more deeply tied to our fellow health care professionals" (Charon, 2006, p. 225).

The ill person who plays out Parson's sick role accepts having the particularity of his individual suffering reduced to medicine's general view. The nurse who enters into practice in acute care accepts having her unique philosophy of professional nursing reduced to pathways, protocols and procedures. Typically, neither nurse nor patient questions this reduction because its benefits are immediate and the costs are not immediately apparent. When a patient is cooperative and pleasant, the patient is rewarded with "little things". When a nurse is efficient and accommodating, she too is rewarded with "little things". The colonization of experience is judged worth the cure (or the attempted cure) for the patient and worth the salary and benefits for the nurse. However, illnesses have shifted from the acute to the chronic, and the nursing culture

is shifting. The post-colonial patient wants her own suffering recognized in its individual particularity and the post-colonial nurse wants her expertise to be valued for its contribution to healing (Frank, 1995, p. 11).

In postmodern times more and more people, with varying degrees of articulation and action, express suspicion of medicine's reduction of their suffering to its general unifying view... What they question can be clarified by drawing an analogy to people who were politically colonized. Gayatri Chakravorty Spivak speaks of colonialized people's efforts to "see how the master texts need us in [their] construction... without acknowledging that need."

(Arthur Frank, 1995, p. 11)

According to Galvin and Todres, there is long standing evidence of the *tyranny of institutional authority* where individuals develop a sick role and become accepting of and submit to the authority of expert knowledge. Something similar occurs when nurses enter into practice and assume what amounts to the role of a factory worker and submit to the regulations, rules and requirements of the employer. These situations significantly reduce the role of the individual in considering creative and or imaginative options that are open to the sick person or the professional nurse (Galvin & Todres, 2012). A 2008 study by Widang, Fridlund, and Martensson concluded that maintaining the self is necessary for people dealing with serious illness yet healthcare institutions continue to force patients to submit and comply (Widang, Fridland, & Martensson, 2008). The discourse from my interviews supports this view; not only for the patients but for the nurses. To be human is to experience meaningfulness. When patients and nurses feel as if they are numbers or statistics or diagnoses or diseases, they experience loss of meaning and many feel as if they are simply "cogs in the wheel" of the organization. "Contemporary medicine and the biotechnologies on which it relies increasing understand life at a sub-cellular level and with consequences that extend far beyond the old categories of illness and health, of pathology and normality, of treatment and enhancement" (Morris, 2010, p. 133). This molecular (and sub-molecular) gaze views patients as biological organisms. When people are viewed as organisms, or diseases or their pathology, the practice of nursing with its emphasis on

compassionate, holistic care becomes irrelevant and nurses become instruments who exist solely for the delivery of biotechnological treatments or procedures.

Efforts must be taken that allow nurses to practice in ways that promote a personal touch and that facilitate clinical judgment versus being scripted and “protocolized” and for patients to behave in ways that allow them to have a voice and to contribute to the relationship. Creating more elaborate tools or processes for enhancing the relationship between nurses and patients may actually create an increasing lack of intimacy between our human experience and the world around us. Several participants referred to this with increasing emphasis on EMR. At the time of the study, our organization was preparing for the implementation of the biggest technological investment in our organization’s history. “This could affect our sense of human identity, in that we become like objects ourselves, trying to fit into impersonal systems and the production line” (Galvin and Todres, 2012, p. 24) “The down side is a blinkered vision, concentrating our focus on ‘getting there quickly’ and ‘getting more’, quickly, whatever ‘there’ and ‘more’ are” (Galvin & Todres, 2012, p. 24). Human intimacy with our patients requires a more holistic and less means-focused approach, where nurses are not reduced solely to their use to the system and where patients are not seen as the target of the nurses’ efforts.

Foucault gave compelling arguments of how medical and technical conceptions of health and illness have become a language that is used in powerful ways to perpetuate depersonalizing and dehumanizing practices of care (Galvin & Todres, 2012, p. 24). It will be critical to facilitate meaningful conversations between and amongst nurses and patients regarding the discourses of both health and illness in order to illuminate how our language and our discourse enable powerlessness and submissive ways of being.

It will be important to promote dialogue that embraces a level of reflection and understanding in which the shared and unique aspects of peoples’ experiences become known. This can only happen when 1) we use a language that allows us to share in each other’s experiences; a language of I and thou (Buber, 1958); 2) we use an approach that moves from the particular to the general and honor both and 3) we remember the freedom of expression, “not as final and conclusive law-like absolutes, but rather as possibilities around which unique variations and actualities can occur. . . Truth in this perspective is thus an ongoing conversation which is not arbitrary but

which is never finish and depends on questions and context” (Galvin & Todres, 2012, p. 31).

Leaders in healthcare all over the world have begun to realize that healthcare needs to change towards a system that embraces patient participation. There is a push to increase patient involvement in their care. The possibility of giving more agency to people is likely a reaction to the historical medical model that has emphasized illness and disease along with professional authority and paternalistic practices which has effectively constructed patients as passive recipients of care. The move toward patient centered care is likely a reaction to this entrenched model. This type of care involves:

- Respecting people for their knowledge, experience, their physical condition and how the illness has impacted their lives
- Assuring that people feel valued and respected by their healthcare providers and the services are delivered with compassion and dignity
- Believing that the patient is the best judge of his or her experience.

Many organizations are now moving towards a delivery system that promotes increased agency. Unfortunately, many of the changes have been brought about for political, technological, or economic reasons and are somewhat limited in their approach, resulting in a slightly more inclusive model of disease, illness, and professionalism when what is needed is a holistic, collaborative, wellness oriented system. Health cannot be viewed merely as the absence of illness or in terms of cause and effect. Nursing cannot be viewed merely in terms of providing the little things or as functional technicians. Nurses and patients must be able to see their role in promoting, enhancing, and supporting well-being, healing, and health.

“Well-being as vitality means the capacity for movement in a sense of being able to move into possibilities of engagement that connect us with others, other spaces, other times and other moods. Heidegger and Merleau-Ponty identified the existential ways in which we can move vitally into different qualitative spaces, different relationships with time, different relationships with others, different embodied movements and different moods that colour the world in different ways” (Galvin and Todres, 2012, p. 40). Well-being may mean simply being at peace with what is. Galvin and Todres suggest an approach that demands that nurses and other caregivers be “open to the

life worlds of their patients, to listen to their stories, to touch and be touched, without avoiding the ambiguities of existence” (Galvin & Todres, 2012, p. 43).

Yoga Practice and Relational Responsibility

In the beginner's mind there are many possibilities, but in the expert's mind there are few. *Shunryu Suzuki*

Nurses can no longer just offer technical support or carry out “the little things” and patients must no longer be satisfied with accepting them. The nurse must be able to offer paths of healing for the patient to step into throughout their life’s journey, leading to the patient feeling more ‘deeply met’ in their vulnerabilities and their possibilities. This type of practice must be guided by a generative understanding of wellbeing (rather than the absence of disease) and by an interactive approach that is grounded in what it means to be human. I would like to propose a framework built on the six branches of Yoga to describe how nurses and patients could make sense and meaning of their relationships and thus go on together in new and different ways with the beginner’s mind. The word yoga has the same root as the English word, yoke, meaning to bind together and to unite. The image of a yoke conveys an image of hard working beasts of burden. For many, yoga is the difficult, unifying path to the growth of consciousness. Similarly, the reconstruction of the nurse-patient relationship will be extremely difficult and will require growth of consciousness.

Change requires purpose, focus, intention and humility. The main enemies of purposeful change in healthcare have been objectification practices related to various ways of ‘already knowing’ for example, already knowing the patient by her diagnosis or knowing the nurse by her list of tasks (Riikonen, 1999, p. 141). Already knowing is a tremendous barrier to one’s yoga practice because it prevents learning and growth and it rejects openness because knowing already dissolves the need to look beyond what is visible or conventional and it is the prime source of non-participation (Riikonen, 1999, p. 141).

Over the past several years there has been an incredible resurgence in the practices of yoga, mindfulness and meditation. Millions of yoga students experience the profound benefits of the physical aspects of yoga practice. The emphasis for many has been on the physical aspects of these practices. According to Harvey and Erick-

son, a potential shadow of the concentration on the physical benefits of yoga, is to limit the vision of its transformative potential as well as a tendency towards self-absorption (Harvey & Erickson, 2010). I can go to a gym and take a yoga class that takes participants through yoga poses without practicing yoga. Similarly, I can hand out medications and enter documentation without practicing nursing, fully absorbed in my own issues and concerns. Genuine dialogue between nurses and their patients, like yoga, is impossible if participants do not believe they have joint responsibility for its inspirational quality and are simply going through the motions. Participants must see themselves as “we” with a responsibility to be interested in each other.

There are so many things that I have learned from my yoga practice that I believe can be useful in approaching the intentional change that will be necessary for more relationally responsible practices between patients and nurses. In my view, the goal of yoga practice is an intentional change of the spiritual, physical, and mental body that is achieved through breathing (inspiration), practice, a sense of wonder and awe, and connectedness with the universe and all things in it. Additionally, yoga practice is based on strength and balance rather than deficiencies and power. Inspiration, wonder and awe, connectedness and strength will be necessary for intentional change in relationships between patients and nurses.

Most yogis know that 1) the quality of yoga is the quality of one’s attention rather than the depth of one’s postures; 2) yoga is not a competition and comparing one’s self to others is unhelpful; 3) everybody and every practice is different; 3) yoga is about focus and relaxation, not a physical performance; 4) it is not for flexible people, it helps to create flexibility; and 5) every single practice is new and presents an opportunity to learn even more. These tenets can be applied to the work of encouraging relational responsibility. The quality of the interaction between nurses and patients is not based on how much depth of knowledge the pair brings to the relationship but rather the depth of the dialogue. Each person that enters into a relationship is unique and special, comparing one patient to another with a similar profile undermines the ability to enter fully into a relationship. At this time in healthcare, we need the “ancient practices and wisdom of yoga to sustain, inspire, and encourage us to respond in healing ways” (Andrews & Erickson, 2010, location 201).

Love

is the free and imaginative outflowing
of the Spirit over all unexplored paths.

It links those

who love in bonds that unite,

but do not destroy, causing them to discover in their mutual contact
an exaltation capable of stirring in the very core

of their being all that they possess

of uniqueness and creative power.

Love alone

can unite living beings

so as to complete and fulfill them,

for it alone joins them by what is deepest

in themselves. All we need

is to imagine our ability to love

developing until it embraces the totality

of the people of the Earth.

Theoretically

this transformation of love is quite possible.

What paralyzes life is failure to believe

and failure to dare.

The day will come when,

After harnessing space

the winds,

the tides,

and gravitation,

We shall harness for God the energies of love.

And on that day, for the second time

In the history of the world

We shall have discovered fire.

Pierre Teilhard de Chardin (1964, p. 42)

In ancient times, yoga was often referred to as a tree, a living entity with roots, a trunk, branches, blossoms and fruit and the six branches of the yoga tree include hatha (physical practices), raja (meditation), karma (action), bhakti (devotion), jnana (knowledge), and tantra (rituals). Each of these practices has provided me with inspiration for ways of being more relationally responsible. Just as in the practice of yoga, some may find one particular branch more inviting than another and some may actually find something appealing in each but application of one approach does not preclude activity in the other. Similarly, transformative dialogue, the dialogue that will be necessary for reconstructing our relationships with our patients, places emphasis on resources available in the moment rather than tools, scripts, or techniques.

Hatha is the most familiar type of yoga and it involves the physical practices (poses), breathing, and meditation and it serves as the preparatory state for higher practices. For many yogis, it is one of the best ways to gain physical and spiritual health and it could easily serve as a model for teaching and learning dialogue. In today's monologic healthcare environment there is no place similar to a yoga studio where we could encourage the *practice of* discourse or dialogue and no one helping to facilitate the practice. Instead, nurses are basically told what to say and do and patients are expected to comply with the rules of the organization. Efforts to promote and guide the physical practice of dialogue along with breathing and meditation for nurses and patients in a space that is peaceful, safe, and supportive could bring about different ways of being together. Initially, nurses and patients will need direction and support from an experienced practitioner who will teach the principles, adjust as needed, and reinforce correct performance. Not only will the experienced practitioner assist with the actual performance of the dialogue, he will provide instruction in breathing and meditation to promote internal focus and reflection that can serve as useful tools in ongoing practice. With ongoing practice both patients and nurses may be able to experience improved physical and spiritual health.

Raja yoga meditation is based on directing one's *life force* to bring the mind and emotions into balance in order to bring focus to one's life. In this type of yoga, there is no physical struggle with the body as the practitioner works to still the mind and free the self from misery. Freedom from misery is the desire of all human beings, particularly those with physical illness or impending death. Nurses seek to relieve suffering brought on by physical and emotional pain. Patients wish to have their suffering re-

lieved through whatever means possible. By bringing balance to their relationships, nurses and patients can experience stillness and minimize suffering and misery. Meditation is a state of thoughtful awareness; one that can bring about a reflective consciousness of the differences in power and privilege and the inequities that exist in social relationships in order to create new relationships. Similarly, reflexive inquiry brings about consciousness of patterns of feelings and interpretations that are experienced in relationships. When we are reflexive, we are accountable and responsible for our actions, choices, and contributions in our relationships. When we practice meditation, we are responsible for our thoughts and our actions. Furthermore, meditation is used widely by both clinical populations and the general public to treat stress and stress-related conditions, as well as to promote health. Many hospitals and healthcare providers offer courses in meditation to patients and caregivers who seek additional or *alternative* methods to relieve ailments or to promote health. (AHRQ, 2011).

A practice of disciplined consciousness may bring thoughtful awareness to observations which *no one has doubted because they are always before our eyes* and foster the development of the cognitive and emotional process of “conscientization” (Freiere, 1996). Contemplative practices could lead to more engaged discourse, collaborative problem solving and the “rehumanization” of interpersonal relationships meditation is not unfamiliar to healthcare.

Karma yoga is concerned with the path of service to help, to heal and to share and it is practiced whenever we experience our lives and our work as a way to serve others where the ego is given up to the desire to minister to others or to the world. Relationships where there is no ego and a desire to see oneself as an expression of love would be very different than relationships of power and submission. Karma yogis believe that solutions are as illusory as their problems. “The only help one can give is in promoting truth and spiritual growth, the only end to real suffering” (Sanatan Society, No date). In the discourse of nurse patient relationships, numbers, tasks and things are promoted. We seldom speak of love, ministry, spiritual growth or ending suffering. We speak of outcomes and issues or about dependency and weakness. Seeing oneself as an expression of love could transform how a nurse and a patient relate to one another because what we speak of, we become.

Bhakti (love) yoga describes a path of devotion; a way to cultivate acceptance and tolerance for everyone we come in contact with through establishing a foundation

of selflessness. This practice requires determination, patience, and complete surrender. Complete surrender and spontaneity is necessary for “discovering the future” that actions create as they unfold. Frank Barrett (1998) has suggested that the ability to be spontaneous and innovative is essential for twenty-first century leaders who are faced with leading in organizations with unprecedented access to and growth of information. Leaders, like jazz players (and yoga practitioners) must learn to respond in unique new ways without “a prescribed plan and without certainty of outcomes; discovering the future that their action creates as it unfolds” (Barrett, 1998, P. 605). Some practice by offering up their effort, compassion or devotion to someone who is struggling or suffering. This contrasts the relationships that have been described in this work, where well-being is not achieved unless one maintains the upper hand. When a relationship is based on avoidance, fear, rejection, and suppression, there is no selflessness, there is only selfishness and there cannot be genuine dialogue. Sampson tells us that the gift that the other gives us is our own selfhood. Yet when the other declines our offer to roll over and play dead, this is a gift we may not want to receive. As long as the others quietly submit to our determination of who they are, we gladly accept the gift of our selfhood that they provide. *Women who remain in their proper place, people of color who fit our view of who they must be; primitives who remain exotic and quaint; gay and lesbian groups who remain securely in the closet; nurses who perform the tasks determined by the organization; and patients who remain docile and cooperative in order to receive care have all accepted the self that has been provided by others with power. When the determination of who you are is made by another there is rarely a need to examine critically. It is when the other’s gift invites us to take a second look at ourselves, however, that many balk at the selfhood they are now asked to consider* (Sampson, 2003, p. 155). If we change the story, we change the self so if we change the story to one of love and service instead of illness and submission, we can invent new identities and new ways of being (Cotter & Cotter, 1993).

Jnana yoga is the yoga of knowledge where the jnani uses the powers of the mind to discriminate between the real and unreal, the permanent and the transitory (Vedanta Society of Southern California, 2015). Practitioners believe that the universe and our perception of it have only a conditional reality, not an ultimate one and whatever is taken in through our senses, our minds, our intellects, is inherently restricted by the very nature of our bodies and our minds much like our world is limited by our words

as Wittgenstein (1953) has suggested. They also believe in self-affirmation; as you think so you become. If one thinks of himself as pure, perfect and free, one will also act accordingly. When the jnani is no longer confined to the painful limitations of I and mine, she will see the one Brahman (essential building material of all reality) everywhere and in everything. The painful limitations of I and mine plague the relationships of nurses and their older patients and rarely are they able to experience a sense of freedom, purity, or perfection instead of restriction, adulteration and deficiencies.

When most people think of tantra yoga, they think of sexuality. Tantra teaches followers about integration with the whole, of which sexuality is part. Traditionalists believe that the goal of tantra is to end attachment to the ego because when the ego is no longer the driving force in one's life, life offers abundance. "One who is spiritually mature sees the whole world of people as extensions of themselves. This forms the foundation for true love" (Shri Kali Ashram, 2009). The tantric practitioner best learns from an acarya (educated teacher) because the traditionalist always puts the student's life first because he has unconditional love. Our systems are fractured, specialized, and broken because of our inability to see the whole. Restoring a sense of wholeness and integrity to patients and nurses would go far in restoring well-being and humanity to our institutions.

With focus, integrity, knowledge, love, service, and balance along with the principles of spiritual and physical well-being, we could bring relational responsibility into our way of being together. None of this can be learned in a workshop or with an informational packet or through imposing new guidelines, policies or procedures. In a meeting today, I heard that a new tool was being developed by a corporate team to help improve the discharge process. This tool is going to be given to the patient and it will be reviewed on admission and every twelve hours so that the team is focused on getting the patient discharged in a timely manner. As I sat there listening to the details, I was recalling how many nurses I speak with who don't know what their patients were like before they got sick, where they came from (home or long term care) or what their hopes and expectations are once they leave us. Adding a brochure and a policy will not make nurses more curious about their patients. Telling nurses how and when to interact with their patients will not transform relationships and providing patients with a brochure will not empower or engage them. Nurses and patients are rarely viewed as relational meaning makers, so our approach continues to be one that results in disrup-

tions in relationships rather than in new ways of thinking and acting. We must create space that allows for meaning and intention.

Genuine dialogue must be interesting or inspiring to continue and to be of use. Handing out a tool or brochure or attending an in-service is not typically interesting or inspiring and change is not possible if the participants are not curious about what you are speaking. Our work will need to spark interest and curiosity about ourselves and others. The logic of service production obscures the fact that well-being is a joint product. Enhancing relational responsibility would require that the concepts of care and service be defined interactionally and dialogically. The authoritarian interaction based on objectivist notions has close links to disease and defects orientation and this narrows the view of well-being to one of the absence of illness and puts an emphasis on analysis of symptoms and diagnoses. Today, cures or treatment for symptoms are not sought by looking at what can be done (discovering or uncovering resources) but from analyzing negative antecedents (McNamee & Gergen, 1999). This focus on pathology not only creates a tendency to bypass existing or potential competence of the patient; it prevents us from seeing how important peer groups and social support systems are in their contributions to health and well-being. Well-being is not taken away or provided by a group of experts; it is the result of complicated interactions of a person and his environment. It's meaning cannot be explained in terms of what creates it because it is different for every human being and it is created and maintained in a web of relationships.

We must keep in mind that contemporary philosophies of well-being are very important politically and economically. According to the World Health Organization, since 1948 health has been defined as *a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity* (Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948). Mental health is defined as a state of well-being in which "every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (World Health Organization, 2014). This definition serves as an economic and political framework from which to promote utilitarian solutions and

approaches where people can contribute and be productive. Those believed to be experts in the field can and do claim the right to use public and private resources that they assert as supporting well-being or alleviating its absence (McNamee & Gergen, 1999). “A catastrophic amount of this type of power is actually in the hands of people and institutions who look at well-being from the objectivistic and narrow perspective of medicine and psychology” (McNamee & Gergen, 1999, p. 144). It is because of this influence and control that we find the absence of power in the dialogue of nurses and patients.

We know that previous attempts to achieve change with principles and initiatives imported from the outside have not been successful. Attempts to create new discourse with tools or scripts or other “how-tos” have led to dull, flat and uninspired dialogue about tasks, statistics, and little things. The generalizations about nurses and patients are obsessed with static, objective, systems of knowledge and they haven’t changed in at least forty years. What if well-being was about creating dialogue and conversations about trust and about a shared sense of inspiration or possibilities? What if we moved from talking about what the absence of well-being is to what it could be? What if well-being was defined by those who have no power? What if nursing practice was guided by *ahimsa*, rather than the ethical principle of nonmaleficence (do no harm)? *Ahimsa* is the ancient Sanskrit word that is usually translated as nonviolence but it really stands for “love in action”. It is likely that the word *ahimsa* is what linguists call a ‘desiderative’ and should actually be translated to “the force unleashed when desire to harm is eradicated” (Metta Center for Nonviolence, No date).

Efforts to *consciously* develop interactions and relationships have led to harmful dialogue because relationships ideally grow and flourish with a living spark that occurs in the moment. Barrett (1998) outlines seven characteristics that foster improvisation when faced with “playing unrehearsed ideas” that occur in the moment. It will be critical to interrupt patterns and habits, embrace errors, create structures that allow flexibility, promote ongoing give and take between nurses and patients (and nurses and colleagues), cease reliance on controlling outcomes and emphasis on tasks and promote resourcefulness and bricolage, create an environment that allows for communities of practice, and support the development of supportive behaviors (Barrett, 1998). We need actions that support and catalyze well-being work but few in the field have the time (e.g. money) or the patience to carry out the demanding efforts that are required

to achieve relational responsibility. If we believe that talk constitutes social reality, that it is open to revision, that it recognized the right of others' interpretations to exist and that its meaning is never complete, we can create common episodes, commonplaces, and common temporary worlds (McNamee & Gergen, 1999). Expert language and scientific thinking, because they reproduce power differences and "obstruct the visibility of the metaphorical, inspiring, living dimensions of talk" must be shunned. All patients and nurses should have the right to participate in rewarding interactions, as these are the foundations for well-being (McNamee & Gergen, 1999 p. 148).

It will be essential to create places of inspiration that promote the art of relevant, interesting, fulfilling, and enabling conversation. This cannot be done with abstract principles, detailed scripts, or continuing education units, nor can it be viewed as an individual activity because these approaches limit the possibilities for true dialogue. Within these centers of inspiration, nurses and patients will come together to learn, develop and practice the art of talking and relating, guided and nurtured by practitioners skilled in Appreciative Inquiry and Relational Responsibility. Both students and guides will have to keep inspiration at the heart of all learning. Evaluation and feedback will be relevant, useful and interesting. It will be important to understand what patients and their nurses really want—not what we want them to want. Appreciative inquiry can serve as a method of moving forward with these efforts. With this type of approach, nurses and patients can come together as co-inquirers who share common interest in relevant questions that must be framed by the inquirers with no outside interference. The designs and methods used by the group should be created by them. The only constraint will be that all inquirers take action on the questions and be willing to participate openly in reflection on their experience to build shared meaning. This may seem farfetched or fantastic but without creating a place for inspired dialogue and discovery we are faced with the traditional (scientific) approach that has yet to achieve meaningful change because of its sickening, disempowering, and uninspired practices.

For nurses and patients to approach their relationship with the belief that the human body is the most sacred of sanctuaries, the creation of sacred spaces, setting of intentions, and establishment of sacred rituals and ceremonies will be essential. Sacred spaces In today's healthcare environment can provide the foundation for bringing much needed calmness and clarity to our relationships. Creating sacred space can be as simple as de-cluttering work areas and patient rooms, using pleasant aromatics,

providing natural features and lighting, and encouraging patients to bring personal belongings.



Figure 16: Nurse capping ceremony

Ceremony refers to a set of actions that are performed with the intention of connecting people to the spiritual. It is an experience involving body, mind, emotions, and spirit that consists of symbols, stories, feelings and thoughts (Neale, 2011). Thirty years ago, nursing practice was steeped in tradition. I received a nursing cap during a Capping Ceremony (See Figure 16) upon successful completion of my second year of nursing school. The nursing cap symbolized the dignity, dedication, and educational achievement of the student nurse. It marked the transition from student to student nurse and occurred prior to the first clinical experience. Students were “crowned with the nurses’ cap, symbolic of their formal acceptance as students into the nursing profession, and symbolic of the honor and privilege they would soon be granted as they left the confines of the nursing skills lab to provide nursing care to patients in the hospital” (Ball & McGahee, 2013, p. 59). I recall the pride and excitement that my fellow students, faculty and family members experienced during this significant milestone in

our nursing careers. During the week following the ceremony, we donned our uniforms and caps for the second time and went to the hospital units for our first clinical experience where we were immediately recognized as part of the nursing profession by patients, families, staff, and physicians. *The celebration of this rite of passage ended in the late 1990s when nurses stopped wearing caps as part of their uniform.*

There are few, if any rituals or ceremonies for students or practicing nurses other than the pinning ceremony held on the day of graduation and the graduation ceremony. The symbols of practice that I received as a new nurse are gone, for the most part. White uniforms and nursing pins have been replaced by scrubs and ID badges. The license to practice in the form of a certificate has been replaced by an online license verification process. The sacred rituals of bathing and preparing bodies after death have been relegated to certified nursing assistants and, if performed by the nurse, are done through sterile gloves. Many of these traditions and ceremonies were abandoned in an attempt to establish nursing as a science and let go of the subservient, feminine image of a caregiver.

Ceremonies provide meaning for so many events in our lives; baptisms, graduations, and weddings are a few examples of meaningful ceremonies that “socialize, stabilize, and reassure the participants, while conveying to the community that a rite of passage has been achieved” (Ball & McGahee, 2013, p. 59). Linda Neale suggests that a rich ceremonial life helps people maintain internal balance in the midst of chaos and where, besides healthcare, is there more chaos? She believes that ceremonies serves as touch points that reinforce the connection between the self and the greater universe (Neale, 2011). A return to ceremony in nursing practice could provide nurses and patients with a renewed sense of meaning and connection.

If we believe or even suspect the past determines the future, it can feel futile to try and change. However, if we believe that we organize ourselves as people and organize the world in which we live through the stories we create together in our myriad of relational contexts, when we are – in perception, belief, and action, the stories we tell. Who we are then, changes as the story changes and the story changes as our multiple relationships change.

(McNamee & Gergen, 1999, p. 143).

Finally, if nurses and patients were to organize through stories of strength and compassion rather than tasks, diseases, and deficits, our relationships would change and the face of healthcare would be transformed. We can alter the relations to a point where stories of “failure, stupidity, hostility, dishonesty, injustice, brutality, and so on” are replaced with stories of understanding, curiosity, and possibility (McNamee & Gergen, 1999, p. 10). When we engage one another through multivocal inquiry and move away from individual blame, we can bring healing and caring to a system in desperate need of both which can result in the creation of “relevant, interesting, and enabling conversations” (Riikonen, 1999, p. 148).

Chapter Eight: Reflections and Limitations

Discourse analysis can be used to reveal unspoken or unacknowledged aspects of behavior and expose significant hidden or dominant discourses that preserve and uphold marginalized positions. It can help to expose a variety of alternative social subject positions that are available and it can provide a generative social critique under the gaze of the researcher. It can also help to construct new ways of being. I selected discourse analysis as a methodology because I believe that meaning is never fixed and that everything is always open to interpretation and negotiation. Discourse analysis has relevance as well as practical applications for any given time, in any given place, with any given subject or group and it presents a critical challenge to traditional theory, policy and practice in many contexts.

The researcher involved in this type of analysis must incorporate a reflexive stance because she simply cannot be a neutral observer. Not only did I have to assume a reflexive stance towards my research, I had to be reflexive in my world outside of the research. Understanding the function of discourse enabled me to experience positive individual change that I hope will lead to transformative social change.

One limitation of discourse analysis is that there are so many different options and approaches and each tradition has its own epistemological position, concepts, procedures, and a particular understanding of discourse and discourse analysis. I took parts from each tradition in my approach. Another limitation of the study was the small sample size of patients and nurses from one particular facility. For this reason, these findings may not be generalized to the broader community based on this study alone. Finally, there is the presence of the researcher's gaze and imposition of meaning throughout the analysis. Because of these limitations, the door will never be closed on the topic of nurses' relationships with their older patients and the work will never be complete. I hope that each new interpretation will give rise to a further critique and further dialogue. For some reading this dissertation, that may be a limitation; as a social constructionist, that was the primary reason for selecting the methodology. It is my hope that this analysis will lead to the disruption of longstanding notions of selfhood for nurses and patients, autonomy, identity, choice and I realize that this type of disruption can be uncomfortable for some. I hope that even if there is disagreement, discomfort, or rejection there will be further conversation.

The awareness and awakening that I have experienced through this work have led me to rethink my work as a nurse executive and I am currently exploring faculty positions in schools of nursing. I would truly enjoy the privilege of teaching a new generation of nurses how to be in responsible, supportive relationships with their patients while balancing the technological and regulatory challenges that are inherent in today's health system. I strongly believe that most people who enter into helping professions truly want to do amazing things for those in their care but are faced with what seem to be insurmountable obstacles for *truly being with* others. With the approach described above, I believe I can help facilitate that type of approach to care. Yoga practice can be uncomfortable or even quite painful at times but with practice, mindfulness, and courage, it can be very rewarding. Reconstructing nurses' and patients' relationships will require the same type of approach. I have no doubt the approach will be uncomfortable and even painful but will result in the creation of wholeness, flexibility, and healing.

Chapter Nine: Recommendations for Future Research

Given the importance of the relationship between nurses and their patients, I believe that further discussion and exploration of the subject is warranted. Dr. Jean Watson's Caring theory can provide an evidence-based foundation for this continued study. The core concepts of Dr. Watson's theory are:

- *A relational caring for self and others based on a moral/ethical/philosophical foundation of love and values.*
- *Transpersonal caring relationship (going beyond ego to higher "spiritual" caring created by "Caring Moments").*
- *Respect/"love" for the person—honoring his/her needs, wishes, routines, and rituals*
- *Heart-centered/healing caring based on practicing and honoring wholeness of mind-body-spirit in self and each other.*
- *Inner harmony (equanimity)—maintaining balance.*
- *Intention of "doing" for another and "being" with another who is in need.*
- *Authentic Presence (honoring/connecting human to human).*
- *Caring Occasion/Caring Moment: Heart-centered Encounters with another person.*
- *Multiple ways of knowing (through science, art, aesthetic, ethical, intuitive, personal, cultural, spiritual).*
- *Reflective/meditative approach (increasing consciousness and presence to the humanism of self and other).* (Wagner, 2010, p. 1).

I recommend using these principles as the foundation for reconstructing the nurse-older patient relationship in a small hospital that has adopted Watson's Caring Theory as their professional practice model. A smaller hospital would be more conducive to the intimate training that would be required to practice new ways of being with others. Nursing staff and patients on a small medical unit could work with the researcher who would guide and coach the participants. This approach could be com-

pared to a control group from the same hospital. Qualitative outcome measurements could include:

- Practices of caring for the person/families/self
- Perception of the difference the nurse makes in the patient's life and suffering
- Perception of the patient as a unique individual (by the nurse and the patient)
- Perception of the quality of people's healing or dying process

Healthcare challenges are abundant but meaningful solutions are rare because of the intensity of the focus on disease treatment, payer source, and cost containment. What is needed to truly transform healthcare is an emphasis on the nature of relationships between providers and the people who seek their services. Knowing what makes a nurse-patient relationship beneficial and healthy is essential for healing, prevention, and for dying. Having the ability to help grow and develop that relationship can change the face of healthcare.

Passion is the supreme alchemical elixir, and renews all things.

No-one can grow exhausted when passion is born,
so don't sigh heavily, your brows bleak with boredom and cynicism and despair—
look for passion! passion! passion! passion!

Futile solutions deceive the force of passion.

They are banded to extort money through lies.

Marshy and stagnant water is no cure for thirst.

No matter how limpid and delicious it might look,
it will only stop and prevent you from looking for fresh rivers
that could feed and make flourish a hundred gardens,
just as each piece of false gold prevents you
from recognizing real gold and where to find it.

False gold will only cut your feet and bind your wings,
saying "I will remove your difficulties"

when in fact it is only dregs and defeat in the robes of victory.

So run, my friends, run fast and furious from all false solutions.

Let divine passion triumph, and rebirth you in yourself.

- Rumi (translated by Andrew Harvey)

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Samenvatting

In dit boek is een poging gedaan om communicatie patronen tussen geregistreerde verpleeg(st)ers en oudere patiënten te doorbreken. Ook zal er een voorstel worden gedaan voor methoden om de manier waarop verpleeg(st)ers en oudere patiënten in relatie tot elkaar staan beter op te bouwen. Het aantal Amerikanen boven de leeftijd van 65 groeide van 3,1 miljoen in 1900 (ca. 4% van de bevolking) naar 35,3 miljoen (12,4%) in 2001 en de verwachting is dat de bevolking zal verdubbelen in 2030. Omdat ouderen met chronische gezondheidsproblemen kampen, ontvangen velen van hen klinische zorg en worden ze door geregistreerde verpleeg(st)ers verzorgd. Deze mensen worden vaak behandeld op een manier dat als respectloos en zelfs kleinerend kan worden omschreven. De meerderheid van de ouderen melden dat ze te maken hebben gehad met wat overdreven aangepaste communicatie wordt genoemd, waarbij gebruik wordt gemaakt van een simpele woordenschat, een hoge toon, langzame spraak, het gebruik van imperatieven, herhaling en snoezige termen. Deze manier van communicatie kan resulteren in het gevoel bij ouderen van een toenemende afhankelijkheid, een gebrek aan controle en een gevoel van incompetentie.

Dit project onderzoekt hoe verpleeg(st)ers dusdanig met ouderen kunnen communiceren dat onafhankelijkheid, een toenemende controle en competentie worden bevorderd. Verder spitst het zich toe op hoe onafhankelijkheid, controle en competentie de gezondheid en het welzijn kan verbeteren (allebei zijn essentiële functies binnen de verpleging). Effectieve, persoonsgerichte communicatie kan leiden tot een aanbod van zorg waarin mensen op gepaste wijze worden beoordeeld en behandeld en waarin mensen de informatie die hen wordt aangeboden begrijpen en wat de invloed van die informatie is op beslissingen. Mijn hoop is dat de communicatie in de verpleging met oudere patiënten gebaseerd zal zijn op ik-u relaties (Buber, 1958) waarin wederkerigheid en eerlijkheid overheersen in plaats van een ik-het relatie waarbij een persoon wordt gebruikt als een hulpbehoevend object. Als oudere patiënten zich gewaardeerd en geëerd voelen kunnen verpleeg(st)ers de deur openen voor genezing, inspiratie en zelfbeschikking. Door gebruik te maken van een waarderende benadering worden verpleeg(st)ers gewezen op en geconfronteerd met de kwaliteit en karakteristieken van hun communicatie en de invloed ervan op de deelnemers. De bevindingen in dit project kunnen van invloed zijn op de manier waarop de verpleegkundige gemeenschap denkt zodat de norm voor de benadering van oudere mensen er een zal worden van respect en waardigheid in plaats van paternalisme en controle.

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