The Social Organization of Nurses' Educative Work

by

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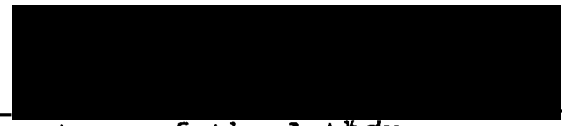

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DEDICATION

In memory of my mother,

Helen McKean Pullen (1908-1981)

and for my children,

Allison, Laura, and James Gregor.

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ABSTRACT

Nurses claim an educative function for nursing and have done so from the earliest days of the profession. In this study, and using the method of institutional ethnography, I analysed the social organization of nurses' educative work from the standpoint of the hospital staff nurse.

I observed the work of twelve female surgical nurses for up to three complete work shifts per nurse, interviewed each nurse twice and seven other nurses once (5 nurse managers, 1 nurse educator and 1 staff nurse), analysed periodicals and texts on patient teaching, patient instructional material, and hospital documents that nurses used in their work or that organized their work. The key question that emerged for analysis was this: How is the visibility and invisibility of educative work constructed?

Nursing is an occupation undergoing professionalization through scientification. Nurses learn and practice teaching within a discourse that trains them to understand educative work as the systematic instruction of patients in practices to promote compliance with medical regimens, self-care, and independence from professional caregivers. Work of this sort (for example, pre-operative teaching) is visible to nurses as teaching. However, my observations revealed that nurses teach inexperienced health care workers as well as patients, and they teach both of them to participate in hospital work processes. Furthermore most of nurses' educative work emerges in the course of everyday work routines, such as measuring vital functions. Work like this is invisible to nurses as teaching until it is brought to their attention. I contend that this is because such work has the character of "women's work".

Management of nurses' educative work is exercised through documentary processes that are oriented to control of nursing labour costs, quality of nursing care and protection of the hospital against liability from inadequate nursing care. Managerial documents build in professional conceptualizations of teaching. They do not take account of the teaching nurses do to produce the smooth organization of hospital work nor to teach physicians.

The invisibility of nurses' educative work with physicians, and with patients in the domains of medical diagnosis and therapy, is organized through their subordinate location in the gender and knowledge hierarchy of the hospital. Nurses' knowledge is masked through practices of deference and referral to physician knowledge, and through other communicative and documentary practices that obscure what they know.

This study revealed the range of nurses' educative work and its organization through professionalism, managerialism and gender. The findings have implications for the training of nurses and physicians, the theory and practice of teaching in nursing, nursing unions and nursing managers.

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The completion of this dissertation brings to a close eight years of doctoral study in the School of Education at Dalhousie University. I want to acknowledge the contribution and support of the following individuals and institutions to my work and to my development.

I thank the members of my supervisory committee. Dr. Ann Manicom, my supervisor, introduced me to the work of Dorothy Smith and carefully and patiently guided my use of the method of institutional ethnography. Her exacting standards have made this a better piece of work than it would have been otherwise. Her commitment to her students, to critical inquiry, and to excellence in scholarship is unquestioned. Professor Ruth Gamberg helped me to write my analysis clearly and simply. Dr. Marguerite Cassin encouraged me throughout my work and helped me make several important leaps in understanding how to go about an institutional ethnography. Dr. Barbara Keddy helped me to see the significance of my analysis in the long struggle by nurses to gain control over their work.

This dissertation could not have been written but for the willingness of members of the Nursing Department of "Study Hospital", both nurses providing direct patient care and managers, to participate in a study of nurses' work. I thank them for allowing me to observe and interview them,

and for their friendship during the period of fieldwork. Ultimately, this analysis belongs to them.

During my time as a doctoral student in the School of Education I have also been a faculty member in the School of Nursing within the Faculty of Health Professions at Dalhousie University. I acknowledge the practical support that Directors of the School and Deans of the Faculty have given to faculty members undertaking doctoral study.

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The friendship of Jill Shlossberg, and Dr. Richard Lauzon, formerly of the Heart and Stroke Foundation of Canada, have helped me enormously. Patricia

Sinclair-Faulkner threw me a life-line when I needed it the most. My sister, Margo Sly, listened to me. Loreen Gilby prepared the final copy of the dissertation and several earlier drafts to her own high standards.

My children, Allison, Laura, Jamie and my husband, Ron, deserve the highest praise for sustaining me, body and soul, throughout the past eight years. Their belief that I would finish this dissertation and that my analysis of nurses' work was important kept me working through times of struggle and frustration. I thank them for their love and support.

Chapter One

The Background

Introduction

Nurses claim an educative function for nursing, and have done so from the earliest days of the profession. This claim is evident in the writings of early nurse leaders (Henderson, 1966; Peplau, 1952; Wald, 1915) and in the statements of professional nursing associations in both Canada and the United States about the role and function of the nurse (Canadian Association of University Schools of Nursing, 1980; Canadian Nurses Association, 1980; National League of Nurses, 1919, 1937, 1981). Nurses who teach the sick and their lay caregivers, whether in hospital, clinic, or home, call this function patient teaching or patient education. It is the practice of instructing or teaching about an illness, a treatment regimen, the recovery process, and care of the self (Redman, 1993). Teaching a person with diabetes how to regulate and administer insulin, or a person with cancer how to manage the side effects of chemotherapy are examples of this work.

Within the last twenty-five years a substantial discourse[1] on patient teaching has developed through the medium of texts and articles in professional nursing journals. For the most part this discourse has been constructed by nurses working as educators, managers or clinical specialists rather than by nurses working as direct providers of nursing care, so-called "staff nurses". The dominant focus of this discourse is the process of patient teaching which is described as a systematic and rational process and by implication, planful and under the control of the nurse-teacher (Haggard, 1989; Rankin & Duffy, 1983; Redman, 1968, 1972, 1976, 1980, 1984, 1988, 1993a). It appears, however, that nurses' working conditions and their assessment of themselves as not competent to teach makes it difficult for them to practice patient teaching in this way. Nurses want to teach their patients (Tilley, Gregor, & Thiessen, 1987) but consistently report that they lack the time to teach, that physicians interfere with their teaching, that management is not supportive of patient teaching, and that they, themselves, lack confidence in

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[1] A discourse is like a conversation among persons on a particular matter. The discourse of teaching is about the nature, purposes and methods of teaching in nursing practice, the conditions under which it occurs, the persons involved, and the impediments to, and facilitators for, teaching. The discourse is available to nurses for analysis and for participation through a variety of textual modes (books, journal articles, presentations at conferences, personal communication between participants). I examine the teaching discourse in Chapter Four.

their teaching skills (Murdaugh, 1982; Pohl, 1965; Runions, 1988; Winslow, 1971).

I am a nurse and a university teacher of nurses. My interest in the educative function in nursing arises from my own early experience as a student and as a hospital staff nurse in the 1960s and 1970s and, more recently, from my experience as a designer and evaluator of teaching materials for nurses' use in teaching patients recovering from heart disease (Gregor, 1984). This study is an attempt to understand my own experience as a nurse and the longstanding difficulties faced by nurses in doing teaching work. The focus of the study is most readily understood through some preliminary glimpses into my dissertation fieldwork. The set of questions that are visible in these glimpses provide a frame for understanding the thesis problem.

Revealing Disjunctures in Nurses' Teaching Work

I began doctoral study located squarely within the professional discourse of teaching in nursing. My objective was to "find" patient teaching and to analyze the difficulties hospital nurses faced in doing this work with a view to correcting them. To do this I sought entry into a mid-size tertiary care teaching hospital in eastern Canada and was given permission to invite nurses working on a general surgical unit to participate in a study of teaching work.

When I first explained my proposed research to the nurses on the ward several of them told me that they did very little patient teaching because they were too busy with other work. These nurses said that the major teaching work that occurred on their ward was what they termed "pre-operative teaching", and that this was done mostly by certified nursing assistants (CNAs), members of the nursing staff with less training and responsibility than the registered nurses (RNs), but with apparently more time to teach. The explanation of these nurses appeared to fit with my own experience and the reasons given in the literature for nurses' difficulties in teaching patients.

However when I started to observe individual nurses at work, and to interview them about their work, I began to see the issues around patient teaching somewhat differently. I especially began to question the nurses' claim (and my own at the time) that, aside from pre-operative teaching, not much patient teaching took place on the ward. I questioned this claim because I saw that throughout the day and night, and in the course of doing their work, both RNs and CNAs constantly gave and gathered information from patients and other health care workers on a whole range of matters. Indeed the majority of their interactions with patients, physicians and other nurses, and a great deal of their actual work, took the form of questions, explanations, information or instructions on these matters. Some of these

matters were traditional topics of patient teaching, such as the expected action of a drug. But other matters were not, they were matters related to hospital work routines and policies.

For example, on the first visit of the morning, so-called "rounds", nurses would ask patients about their physical condition and they would explain to patients the probable cause for a rise in temperature or a pain the patient might be suffering. But they would also tell patients of diagnostic tests, or other procedures, or changes in the treatment plan. A nurse might say to a patient, "Mr. Brown, you'll be going for an x-ray of your stomach at 10 o'clock this morning. Please don't eat or drink anything until the test is over". This "organizational" talk also went on with physicians. During the course of the day a nurse might report the results of a diagnostic test to a doctor, for example a patient's hemoglobin level, and then add "If you want to order blood for Mrs. Smith you'll have to do so before the Blood Bank closes at 4pm".

I was forced by my observations of nurses to think about my own ideas of patient teaching and about the prevailing discourse of teaching in nursing. The talk that I heard nurses do while they made rounds, or spoke to physicians, didn't seem to be entirely consistent with my ideas of teaching, or with ideas of teaching present in the

discourse. This talk wasn't separate from other nursing work as suggested by the discourse. Instead, the talk seemed to be what actually accomplished nursing work and hospital work. Nurses didn't seek out and use audiovisual material to do this "teaching work" as they did when they carried out what they called pre-operative teaching. Moreover my nurse-participants, when I queried them about the work of giving and gathering information about hospital routines and policies, didn't call it "teaching". And they especially didn't refer to this work with physicians as "teaching".

I felt confused. Was this teaching that I observed? If it wasn't teaching what was it? What name should I give it? My uncertainty increased when I realized that this work that I believed helped patients and physicians function appropriately in the hospital was not counted as teaching, or as work of any sort, in the systems used to account for nurses' work in the hospital. A set of questions began to form in my mind: what shapes my ideas of teaching in nursing practice? What shapes nurses', and nursing management's, views? Why isn't the work of getting patients and health care workers to participate appropriately in hospital work processes or to abide by hospital policies counted as teaching?

It seemed to me that this talk that nurses did as part of their routine work of checking on patients or

implementing physicians' orders was purposeful. It was not mere conversation. It was intended to shape the behaviour of patients and physicians consistent with medical work or hospital policies and routines; those to whom it was directed were supposed to act on it. Moreover hospital work got done because of it. In a word, it was educative. In this dissertation, therefore, I assign the label "educative work" or "teaching work" to the work that nurses call "patient teaching", such as pre-operative teaching, and also to the work that nurses do to teach patients and health care workers, especially physicians, about health and illness practices, and about hospital work processes and policies. My concept of teaching in nursing practice therefore extends the current professional concept in definite ways: the educative function in nursing is exercised with both patients and health care workers, and its focus is both health and illness practices and institutional policies and procedures.[2]

As I continued to observe nurses a second set of questions formed in my mind. These questions concerned the comments nurses had first made to me about pre-operative teaching, and the character of this teaching I witnessed.

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[2] My ideas of what consitituted work were challenged through exposure to feminist scholarship, especially the work of Dorothy Smith (1987). Smith's view of work is that it is what a person does, and means to do. It was this enlarged view of work that allowed me to "see" teaching where previously I had seen just "talk".

Why did nurses identify it as their major teaching work? Why was pre-operative teaching routinely mentioned when a shift of nurses reported their work to an on-coming shift (the change-of-shift report) yet other teaching was not? Why did it "stand out" for them as teaching in a way that other teaching apparently did not?

I observed that pre-operative teaching was carried out faithfully by the nurses, being seldom, if ever, omitted, and that it frequently had a rote, and sometimes, hurried character. When I listened to nurses doing this teaching I found they said virtually the same thing to each patient, as if they were delivering a prepared speech, and they always used the same teaching material, a small cardboard flipchart. I wondered why pre-operative teaching was like this; why it was almost mechanical in nature; why nurses went to such ends to find and use the flipchart even though all of them were experienced surgical nurses.

I became curious about the document authorized by the hospital to record pre-operative teaching on the patient's chart. It was a type of checklist and I wondered if there was a link between this document, the flip chart, and the character of the teaching I observed, especially the faithfulness with which it was performed.

The character of nurses' pre-operative teaching stood in contrast to other teaching I saw them do. The latter seemed to display more attention to the individual needs of

patients. For example, I observed nurses instructing patients on how to move safely and cough properly after abdominal surgery. On these occasions nurses did not use a text, they appeared to rely on their own knowledge and experience of the matter at hand, they seemed to work at the pace of the patient, and they used their own bodies to model the behaviour they wanted the patient to try. I also noted that nurses did not record this teaching in the patient's chart, and that, unlike pre-operative teaching, there was no document authorized for this purpose. I wondered how teaching could vary in this way, how it could be, on the one hand, a skilled practice, responsive to the individual learning needs of many different patients, yet obscured as educative, and on the other, a highly structured and uniform activity, but thought to be teaching.

Yet a third set of questions came to me as the result of listening to nurses respond to patients' requests for information, and in examining a textual device they used to communicate with physicians. In general nurses responded directly to patients' questions about hospital routines, the expected action of a drug, etc., but there were certain questions to which nurses replied, "You'll have to ask your doctor", or "What has your doctor told you?" The questions that prompted these responses were often about the results of diagnostic tests, causes of illness, or procedures to follow at home after discharge. These were matters that I

knew nurses were knowledgeable about because I observed them reading patients' records and I heard them discussing patients' progress, yet they were very restrained in their talk with patients. For example, one patient asked a nurse, "I'm going home today. When can I take the bandage off my incision?", to which the nurse replied, "Who is your doctor? What did he tell you to do?" In this instance, however, once the nurse learned the physician's name she directed the patient to remove the wound covering in six days. I became curious: Why does it matter who the physician is? What is the link between the instruction that nurses give to patients, and physicians? Why are nurses so circumspect in displaying their medical knowledge around patients?

One of the ways nurses on the study ward communicated with the house staff (clinical clerks, interns and residents) was through a device they called "The Problem List" (see Figure 3, page 73). On this sheet of paper, constructed anew every day, and continuously revised throughout the day, nurses recorded facts about the condition of patients, and posed questions about medical therapy. This device was left in a central place on the ward for members of the house staff to find as they came to see patients. It was explained to me by the nurses that this device ensured that these physicians who were responsible for the day-to-day management of patients' medical problems were made aware of problems in the event

that a nurse was unavailable to relay the information herself. I became curious about this document; it seemed to me that it was, among other things, more a set of directions to the physician than a list of problems. It was a form of communication from nurses to doctors about work they wanted them to do, or information they wanted them to attend to. I wondered whether the label given it by the nurses and its textual form implied something about the communication between nurses and physicians.

These initial observations and sets of questions reveal three major disjunctures in the teaching work of nurses. First, there is the disjuncture between the work nurses call patient teaching and the actual teaching work they do, and who they teach. Second, there is the disjuncture between the character of nurses' pre-operative teaching, teaching which is highly specified and accounted for, and the character of their other educative work which is neither specified nor accounted for in the same manner. Finally, there is the disjuncture between what nurses actually know of medical work and patient problems and what they appear to know and feel free to say in the information and instruction they give to patients and physicians.

Each of these disjunctures speaks to an organization of teaching that makes some work visible as teaching while it obscures the educative character of other work. It is in

order to understand this organization that I have produced this dissertation.

Explicating the Social Organization of Nurses' Teaching Work

My objective in this dissertation is to explicate the social organization of nurses' teaching work. I want to discover and display the ways in which the teaching work of nurses is shaped such that some work becomes visible as teaching, and has a particular character, while other work does not. This is not a matter of finding out how nurses, somehow, keep parts of their work secret from others; rather it is a matter of discovering how work, as work, is hidden from the very people who perform it.

In Chapter Two, I describe my approach to the task of explicating the social organization of teaching work. The approach is substantially different from usual approaches to the study of nurses' work because it begins in the everyday work experience of nurses rather than in nursing discourse. I use the work of the Canadian sociologist, and feminist, Dorothy Smith.[3] Smith seeks to provide women, and men, with the conceptual tools to understand how their everyday experience of the world is organized but in a way that preserves their presence as active in producing that world.

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[3] My use of the work of Dorothy Smith draws chiefly from three sources: The everyday world as problematic. A feminist sociology (Smith, 1987), The conceptual practices of power. A feminist sociology of knowledge (Smith, 1990a), and Texts, facts and femininity (Smith, 1990b).

In this regard her method diverges radically from that of established sociology. In Chapter Two, I describe the approach she has formulated and how I applied it to the analysis of nurses' teaching work.

Nurses teach through their talk, and through their use of documents and texts, in the context of everyday work routines and as a specific educative work process (pre-operative teaching is an example). In Chapter Three, I describe nurses' teaching practices, I argue for their educative character, and I show what these practices accomplish in the hospital.

In Chapter Three, I also begin to analyse the social organization of teaching work, focussing on the first disjuncture I see in this work, the disjuncture between nurses' perceptions of their teaching work and the actual teaching work they do. I describe a feminist analysis of work, and the work that women ordinarily do, and show how such an analysis, when applied to nurses' educative work, begins to reveal how the invisibility of parts of this work is constructed.

In Chapter Four, I begin to look at several broad social processes and how they organize teaching work. I remained focused in this chapter, however, on those processes I judge to be implicated in the first disjuncture. The process examined is the professionalization of nursing, as evidenced in nursing texts.

In Chapter Five, I take up the second disjuncture I see in nurses' educative work, the disjuncture between the character of their pre-operative teaching and their other teaching work. The focus is on the organization of teaching work through managerial processes and practices. Three concerns dominate the management of hospitals in Canada in the 1990s. These are control of costs, quality of care and institutional liability. In Chapter Five, I show how these concerns organize the character of nurses' educative work. I display the nature of this organization as a set of documentary practices.

Nurses, to a greater degree than other health care workers, work in close association with physicians. My purpose in Chapter Six is to show the organization of educative work arising from the historical, and hierarchical, relations between physicians and nurses. These relations are at the heart of the third disjuncture I see in this work, the disjuncture between what nurses actually know and what they appear to know and tell about medical work. I argue that nurses' teaching work is substantially organized by their subordinate position in the health care hierarchy, and that when they teach, they construct a hierarchy of knowledge and skill in which their own skill and knowledge is essentially invisible, or represented as assistance, helpfulness, or the performance of duty.

Chapter Seven concludes the dissertation with a discussion of the implications of my analysis for research into nurses' work, and the theory and practice of teaching in nursing.

Summary

The problematic for this study is the everyday teaching, or educative, work of nurses who provide direct patient care in hospitals, so-called "staff nurses". Preliminary glimpses into this work reveal three disjunctures: the disjuncture between what nurses call patient teaching and the actual teaching work they do, the disjuncture between the character of their pre-operative teaching and the character of their other teaching work, and the disjuncture between what nurses actually know of medical work and patient problems and what they appear to know and feel free to say to patients and physicians. Each of these disjunctures expresses an organization of teaching work that obscures some educative work while making other educative work visible. The purpose of this dissertation is to analyse and display this organization. In Chapter Two, I begin this task by describing the method that undergirds the analysis and the research procedures I followed.

Chapter Two

The Method of Investigation

Introduction

Teaching as a nursing work process has not been studied to any degree by nurses, or sociologists. Where studies have been done on teaching (Minnick, 1982), or that bear on teaching (Benner, 1984), they have used established sociological methods. I began this study of teaching in the actual work of nurses and sought to develop an explication of the social relations organizing their educative work in which they were fully present. This is a key point of difference between the approach I used and established sociological approaches in which the work of actual persons "disappears" into abstract concepts and categories derived from theory. The purpose of this second chapter is twofold: to set out the method I used and to describe the procedural steps I followed to investigate the social organization of nurses' educative work.

Objectifying Practices, Sociology, and the Ruling Apparatus

To explicate the social relations organizing nurses' educative work I used the method of institutional ethnography developed by the Canadian sociologist Dorothy Smith. Smith, as a feminist, has been concerned to develop a sociology for women. By this she means a systematically

developed knowledge of society that shows women how their everyday experience of society is organized and that provides them with the knowledge they need to make changes to it.

Smith rejects established sociology on several grounds. She claims that it does not inform women, nor men, about the structuring of their everyday world, that it cannot help them to change their lives, and that it is, in effect, not knowledge for ordinary persons but for governments and other organizations that rule and regulate social life. Within and fundamental to contemporary capitalist societies is what Smith (1987) terms "the ruling apparatus" (p. 3) or "the relations of ruling" (p. 3). This is the network of administrative, management and professional organizations[4] and their associated discourses, which, in effect, govern society. The term relations of ruling, Smith (1990b) says,

> designates the complex of extra-local relations that provide in contemporary societies a specialization of organization, control and initiative. They are those forms that we know as bureaucracy, administration, management, professional organization, and the media. They include also the complex of discourses, scientific, technical, and cultural, that intersect, interpenetrate, and coordinate the multiple sites of ruling. (p. 6)

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[4] The ruling apparatus for nurses working in hospitals includes the hospital administration, but also governing practices outside the hospital such as the provincial professional nursing association, the Health Departments of the Provincial and Federal governments, and the Canadian Council on Health Facilities Accreditation.

Traditional sociological theorizing has contributed to the development and function of the ruling apparatus. Smith argues that it has done this through the practices it has established for transposing the activities of real people into an abstract or conceptual mode, a mode in which people's activities can be entered into a discourse. These are the objectifying practices of established sociology.

The ruling apparatus operates in the same conceptual mode as established sociology. The same practices of objectification used by the sociologist are used also by the ruling apparatus in its various sites. These practices accomplish the transformation of the actualities of everyday life into the conceptual mode, such that they can be entered into discourses of governing or ruling.

Within the various sites of the ruling apparatus, as within sociology, discourses are chiefly textual.[5] By virtue of their textual character discourses have the capacity to organize the "same" understanding in separate sites. Smith (1990b) explains that this feature is the essence of their power. She says,

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[5] A discourse is like a conversation among persons on a particular matter. It is about the "concepts, methods, relevances, and topics" (Smith, 1987, p. 61) of the matter and goes forward in and through text; in Smith's words it is a "conversation mediated by texts" (1991, p. 159). As I noted in Chapter One the discourse of teaching is about the nature, purposes and methods of teaching in nursing practice, the conditions under which it occurs, the persons involved, impediments and facilitators to teaching. I examine the teaching discourse in Chapter Four.

> The simple properties of the documentary or textually mediated forms of social organization involve their dependence upon, and exploitation of, the textual capacity to crystallize and preserve a definite form of words detached from their local historicity .... Texts speak in the absence of speakers; meaning is detached from local contexts of interpretation; the "same" meaning (Olson, 1977) can occur simultaneously in a multiplicity of socially and temporally disjointed settings (Benjamin, 1969). In the distinctive formation of social organization mediated by texts, their capacity to transcend the essentially transitory character of social processes and to remain uniform across separate and diverse local settings is key to their peculiar force (though that transcendence is itself an accomplishment of transitory social processes). (p. 211)

Smith uses the term textually-mediated social organization to explain the capacity of the text-based discourses of the ruling apparatus to organize people's daily lives. She explains,

> The practice of ruling involves the ongoing representation of the local actualities of our worlds into the standardized and general forms of knowledge that enter them into the relations of ruling. It involves the construction of the world as texts, whether on paper or in the computer, and the creation of a world in texts as a site of action. Forms of consciousness are created that are properties of organization or discourse rather than of individual subjects. (Smith, 1987, p. 3)

To summarize to this point in the chapter: Smith's critique is that traditional sociological theorizing has objectified people's lives, transposing their actual practices and activities into a conceptual mode. The ruling apparatus makes use of the conceptual mode to do the work of ruling, chiefly through textual and discursive practices.

A New Approach: Making the Everyday World Problematic

In contrast to what she describes as typical, for Smith the task of the sociologist is to work from the standpoint of persons, living and working in the real world of time, space and materiality, and not from a standpoint outside of it in the realm of theory, and furthermore, to preserve in sociological knowledge the presence of persons as active in producing their world. Thus the focus, or problematic, of sociology must be the everyday world of experience, and sociological knowledge must be developed to aid ordinary persons in understanding how their everyday experience is organized.[6]

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[6] In developing a sociology for women Smith uses the materialist method formulated by Marx and Engels (1970) in The german ideology. These 19th century social thinkers proposed that to understand social life one had to begin in the actual activities of individuals and not in the discourse. Of the ideas of Marx and Engels, Smith (1987) writes,

> They insist we start in the same world as the one we live in, among real individuals, their activities, and the material conditions of their activities. What is there to be investigated are the ongoing activities of real people. Nothing more or less. We are talking about what actually happens and can be observed, spoken of, and returned to check up on the accuracy of an account or whether a given version of it is faithful to how it actually works... (p. 123)

In taking up the problematic of the everyday world of experience Smith contends that an understanding of it is not fully discoverable within it.[7] She says,

> We experience the world as largely incomprehensible beyond the limits of what we know in a common sense. No amount of observation of face-to-face relations, no amount of commonsense knowledge of everyday life, will take us beyond our essential knowledge of how it is put together. Our direct experience of it makes it (if we will) a problem, but it does not offer us any answers. We experience a world of "appearances", the determinations of which lie beyond it. (Smith, 1990a, p. 7)

She argues that the organization of everyday experience lies beyond it in broader social and economic processes of a capitalist society. An investigation into the organization of the everyday world of experience is thus an investigation into how it is shaped and determined by these broader social and economic processes, that is "through the relations of society founded in a capitalist mode of production" (Smith, 1990a, p. 27).

Social relations organizing the everyday world. The concept of social relations, borrowed by Smith from Marx, is the device or vehicle she uses to explicate the organization of the local and particular everyday experience of persons

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[7] This point is fundamental and can be understood by asking oneself how one's immediate experience of the world comes to be; for example, how is it that I sit at a computer, which I own, in a single office at the university where I hold the rank of associate professor? The answer to this question cannot be found within the realm of my immediate experience. In the words of Smith (1990a) "I must posit a larger socioeconomic order in back of that moment." (p. 25)

from a site beyond it. Smith argues that it is through our participation in social relations that we are connected to larger social processes. Thus an investigation into nurses' educative work is an investigation into the social relations structuring it.

Social relations are the actual activities, practices and processes that persons engage in, in a coordinated manner, that can be observed, investigated and described. Smith (1987) describes social relations as "social courses of action" (p. 167). She says,

> When we talk of social relations in the context of Marx's thinking, we are not talking of social relations as sociologists are accustomed to do. Social relations for the sociologist refer to the abstracted forms of normative structures held to link positions or roles, the relations between husband and wife, between positions in an authority structure, the interpersonal relations of group members, and the like. For Marx, by contrast, social relations are the actual coordinated activities of actual people in which the phenomena of political economy arise. Relations are not norms, concepts, or structures apart from activities, determining and being expressed through activities. They are coordinated or articulated processes of action among persons taking place in time and having determinate form. Social relations are thus sequences which no one individual completes. (Smith, 1990b, p. 4)

The concept of social relations is difficult to grasp because social relations are not things, or entities, but activities, practices, procedures. In describing the social relations of nurses' educative work I am not describing something that can be located, or found, on a hospital ward. The social relations of teaching don't exist as a thing, or

a set of things but as the activities and practices of nurses and others, who may not be known to one another and who are in separate locations, but whose activities, concerted and coordinated as they are, bring into being the social relations of educative work.

Manicom (1988) makes the concept of social relations clear when she says,

> First, there is not one set of reified social relations which can be found in the world and used for the analysis of the past, present and future ....
>
> Second, we can speak of a **social** relation because any set of social relations can be seen to be the product of practical **human** activity; social relations are courses of action enacted by real individuals. Individuals participate in, enter into, produce social relations at every moment ....
>
> Third, any social relation must be seen as a **process**, an ordering of actual practices, not a **thing**; social relations are processes, occurring through time. Temporality is a central feature of social relations ....
>
> Fourth, social relations bring the work of various individuals into an organized relation one with another. Any social relation, although it can be seen as produced by men and women daily in their work and living, is not to be understood as produced fully by particular individuals; rather it is entered into and produced by the practical activities of many individuals ....
>
> Fifth, and related to the last point, social relations arise with us, yet are articulated to social processes beyond our control. We all are engaged in producing and accomplishing a given social relation, and not one of us can see the fullness of the social relations nor see the totality of the way many individuals produce the social relation in a determinate way. We do not control it or determine its direction. As such, a social relation has a determinate character, a determinate form. However, despite the fact that it works in a particular way, the social relation is not to be seen as causal, as operating outside of, and upon, human beings. (p. 48-49)

Textually-mediated social relations. Our activities and practices are everywhere shaped by texts or documents of one sort or another. This feature of social life is so commonplace that we fail to notice how it works to organize our experience. Smith (1990b) says, "our lives are, to a more extensive degree than we care to think, infused with a process of inscription, producing printed or written traces or working from them" (p. 209). In the case of nurses' educative work the discourse is found in texts of all kinds in which educative work is described, theorized and accounted for.

As I described earlier (pages 16 to 19) in summarizing Smith's critique of sociology, discourse as a form of textual mediation is active in the work of ruling, not only in academic disciplines such as sociology, but in a whole range of institutional sites. The power of discourse to organize social relations lies in its capacity to hold and preserve the meaning of words detached from the time and place where they were first uttered. So preserved words, through texts, operate across sites invoking the "same" meaning wherever they are "read".

Institutional Ethnography: Investigating the Social Relations of Ruling

The research method that Smith proposes to explicate social relations organizing the everyday world of experience

she calls "institutional ethnography" (Smith, 1987, p. 151). She uses the word institution to mean a complex of social relations around a particular function of the ruling apparatus, for example, education, law, health care. In this study the relevant social relations are those of health care, and in particular those that organize hospital health care and the work of nurses.

The term ethnography refers to the procedures used to explicate social relations from a standpoint in the everyday world of experience. The standard ethnographic techniques of observation and interview are two of the procedures that can be used. The selection of research procedure is a matter of discovering the technique that will reveal the social relations as a set of actual practices and could include recollection of work experiences, use of archival material and textual analysis as well as observation and interview.

In summary institutional ethnography is concerned with disclosing the social organization of the everyday world. Its focus is the investigation of actual processes and practices. Smith (1987) likens it to mapping a terrain. She says,

> The terrain to be explored and displayed is one of work processes and other practical activities as these are rendered accountable within the ideological schemata of the institution. The latter are not merely in thought but are also practical activities and in some context work processes, organized in relations of textual communication. (p. 160)

Three key procedures. A research project based on institutional ethnography employs three procedures. First, the everyday work world is examined to see what it is that people do and to see how their work is organized by and maintains the institutional process. Work, as Smith (1987) defines it, includes but extends beyond waged work, and more particularly, extends beyond the definition of work set by institutional ideology. It is "what people do that requires some effort, that they mean to do, and that involves some acquired competence" (p. 165). This broad idea of work is intended to locate institutional ethnography in what people actually do on a daily basis under definite conditions and to provide for a consideration of the work that is not made "observable-reportable as work" (p. 165) but that nonetheless is both organized by and maintains institutional functions.

Second, the concerting of work processes that bring the institutional process into being is scrutinized. The work processes of many individuals, located in different sites, acting under different resource conditions, and not necessarily known to one another, together maintain the ongoing nature of the institutional process. Work processes intersect, the work of individuals at one site organizes, and in turn is organized by, the work of individuals at another site. Work processes are coordinated, they are brought into order, one with another. Institutional

ethnography analyses the intersection and coordination of work processes to determine in what ways the institutional process is produced. The tracing of work processes beyond the local setting is what begins to bring social relations into view.

Third, institutional discourses are analyzed to see how they make certain activities visible, to determine their "accounting" practices. Institutional discourses provide the concepts and categories by which individuals analyze their work. They render visible those activities which fit the concepts and categories they provide but obscure or ignore those activities which do not. Smith (1987) describes this function of discourses by saying, "The accountability procedures of institutions make some things visible, while others as much a part of the overall work organization that performs the institution do not come into view at all or as other than themselves" (p. 162).

Institutional discourses operate through a textual mode. In Smith's words, "The categories and concepts of ideologies [discourses] substitute for actual relations, actual practices, work processes and organization, and the practical knowledge and reasoning of actual individuals, the expressions of a textually mediated discourse" (p. 163). Thus a textually mediated reality (a "virtual reality" Smith, 1990a, p. 62) is produced through individuals' use of the concepts and categories provided by institutional

discourses. Institutional ethnography examines textual communication of all kinds to see how institutional discourses operate to produce this textually mediated reality.

Description of the Study

The purpose of this study was to explicate the social relations organizing nurses' educative work. To do this I studied (over a period of 6 months) the work of 12 nurses[8] working on a surgical ward (hereafter called "Study Ward") in a medium size acute care hospital in a city in Eastern Canada. I observed each nurse for 2 to 3 complete workshifts and I interviewed her (all participants were female) on two separate occasions. I also collected documents that were used by these nurses in the course of their work. As well, I interviewed 7 other nurses in the hospital whose activities as nurse managers or educators, and in the case of one staff nurse her activities as a volunteer member of a committee, appeared to shape in some way the educative work of these 12 nurses. In what follows I describe first how I implemented the procedures of institutional ethnography. In the final segment of the

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[8] Ten Registered Nurses and two Certified Nursing Assistants volunteered to participate in the study but at all times I refer to them as "nurses". It was not my purpose to look for differences, or similarities, between the educative work of these two categories of nursing workers.

chapter, I provide more specific information on research participants, the research site and the documents I collected.

Doing an Institutional Ethnography

Gaining entry into the study site. I began the study by seeking the participation of the RN's on Study Ward who gave direct care. Over a period of two weeks in November 1989, I met with them in small groups of two or three in the course of their workday or evening. On each occasion I explained the study purposes and gave each nurse a consent form which explained the study procedures in full (Appendix A). Three of the 16 RN's who attended these sessions agreed to participate and in late November I began a period of observation with one of them. Over the following five months nine other members of the nursing staff (7 RN's and 2 CNA's) either responded to my invitation to participate or asked to become part of the study until at the end of April, 1990 I had 12 participants. Their average age was 28 years, their duration of employment on Study Ward was 3 years (the range was 14 months to 9 years) and the average number of years they had been working in nursing was 6 years (the range was 18 months to 15 years).

Observing and interviewing: Understanding coordinating work processes. In explicating the social relations of nurses' educative work I followed Smith's direction. I

first attempted to discover what it was that nurses did, that is, what was their work, and in particular their teaching work. I did this by becoming the "shadow" of my participant for up to three consecutive workshifts, either observing her as she cared for patients,[9] or remaining discreetly within earshot.[10] As a shadow I wore the uniform of a nurse (white dress, hose and shoes) and I followed the same work hours as my participant, arriving and leaving the hospital when she did. During each period of observation I made fieldnotes in a small pocket-size notebook. From time to time a nurse participant asked to read the fieldnotes I was making of her work and in every instance I obliged.

Over the course of the winter and spring of 1990, I observed nurses on both workshifts and on every day of the week, for a total of 28 complete workshifts of observation. Of these 28 workshifts 25 covered the period from 7am to 7pm, 1 covered the period from 3pm to 11pm, and 2 covered the period from 7pm to 7am. At the same time as I observed nurses I gathered new copies of the documents that they entered patient information into, or worked from. These

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[9] In order to "fit in" to the ward I periodically helped my nurse participant in small ways, fetching clean linen or ice water, making an empty bed, acting as a porter. I believe this helpfulness contributed to my acceptance by the nurses and may have influenced some to participate.

[10] In order to remain with my participant while she did her work I obtained, or the nurse obtained, the consent of each patient to my presence as an observer. This consent also allowed me to examine the patient's record. See Appendix B for the Patient Consent Form.

documents were either directly related to their work with patients, for example, the nursing cardfile, or they appeared to organize their work in some way, for example, the nursing workload measure. Periodically I also abstracted information from patients' records.[11]

Following my observation of a nurse I met with her and interviewed her using a set of questions (Appendix C) as a guide. These questions were designed to clarify and elaborate work practices I had observed. The interview was tape recorded, transcribed and a copy of the transcription given to the nurse. Every nurse I observed was interviewed for a total of 12 interviews at this stage; each interview was approximately 1 to 1.5 hours in duration (see Figure 1 for a list of the dates of observation and interviews).

After I had observed and interviewed all 12 nurses I embarked on interviews with other nurses whose work related to the management of nurses' work, and in one case, the management of their teaching work. This group included nursing managers with responsibility for the quality assurance and workload measurement systems, for the education of nursing staff, and for the management of the study ward. I also interviewed a staff nurse who was the

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[11] I was not permitted to copy information directly from any part of patients' medical records. Therefore I used a technique of abstraction, summarizing in my own words the information that was in a document that appeared to be relevant to understanding the educative work process.

Code Name of Nurse	Date of Observation	Interview	
		1	2
1. Jill	21/11/89 22/11/89 27/11/89	11/12/89	16/06/90
2. Judy	25/11/89 26/11/89	16/12/89	04/06/90 J*
3. Mary	04/12/89 05/12/89 10/12/89 14/02/90	20/12/89	---
4. Barb	22/01/90 23/01/90 24/01/90	08/02/90	13/06/90 J
5. Betty	12/02/90 13/02/90	20/02/90	20/06/90
6. Anna	24/02/90 25/02/90	26/02/90	22/06/90
7. Lise	05/02/90 06/02/90	01/03/90	13/06/90 J
8. Susan	21/02/90 22/02/90	19/03/90	04/06/90 J
9. Ellen	12/03/90 13/03/90	29/03/90	20/06/90
10. Laura	22/03/90 27/03/90	03/04/90	04/06/90 J
11. Marie	07/03/90 08/03/90	08/04/90	27/06/90
12. Louise	28/03/90 29/03/90	12/04/90	23/06/90

*Joint interview.

Figure 1. List of the dates of observation and interviews.

ward representative to a committee of the Nursing Department called "The Patient Education Interest Group", the clinical development nurse on the study ward, and a person whose sole work, in both the study hospital and other hospitals in the city, was the education of patients undergoing special bowel surgery. These interviews, 7 in all, were also tape recorded, transcribed, and the transcriptions given to the interviewee. These interviews, too, lasted approximately 1 to 1.5 hours (see Figure 2 for a list of these interviews).

	Date of Interview
Clinical Development Nurse	25/01/90
Head Nurse	11/04/90
Patient Education Co-ordinator	17/04/90
Enterostomal Therapist	18/04/90
GRASP© Co-ordinator	06/08/90
Quality Assurance Co-ordinator	08/07/90
Member, Patient Education Interest Group	20/07/90

Figure 2. List of other interviews.

My purpose in conducting these interviews was to begin to understand work practices beyond the ward that shaped nurses' work. In doing these interviews I began to fulfil Smith's second directive, that is, to scrutinize the concerting of work practices and processes that bring the institutional order into being.

By the beginning of May 1990, I felt I had a satisfactory understanding of the nature of nurses' work and of their teaching work, and I had formulated, to some degree, the disjunctures that I described in Chapter One. At this point I sought further clarification of the practices inherent in the disjunctures by interviewing, again, either individually, or in a small group, the 12 nurse participants. A total of 8 interviews, single and joint, were conducted at this time. Again each interview was about one hour in length (a list of these interviews is also provided in Figure 1). In this interview I was especially interested in having nurses talk about the teaching work that was embedded in other work and that appeared invisible to them as teaching. To accomplish this I assembled from my field notes descriptions of 8 separate instances where I judged teaching to be embedded in a nursing routine such as checking vital functions, "rounds", the removal of a tube or the discharge of a patient. I gave these descriptions to my interviewees and I asked them to circle a "yes" or "no" response to the question, "Would you call this teaching?" placed below each description (see Appendix D for these descriptions). Their answers to this question, for each instance of teaching, provided the point of departure for a subsequent discussion of their perceptions of teaching in nursing practice. In addition, during the second interview, and on the same form with the

descriptions of "embedded" teaching work, I provided two actual exchanges of conversation (see Appendix D), the first between a patient and a nurse whom I was observing at the time the exchange occurred, and the second between a nurse participant and myself during the first set of interviews. The purpose of providing these exchanges was to stimulate discussion around two features of nurses' educative work that have been problematic for nurses, teaching in the context of the nurse-physician relationship, and the issue of time to teach.

Analysis of documentary practices. The third procedure of institutional ethnography is the analysis of institutional discourse and textually-mediated practices. This procedure was ongoing from the beginning of the study. My analysis of institutional discourse involved an analysis of two types of textually-mediated discourse: first, the professional discourse which I analysed through the examination of texts and periodicals about teaching in nursing practice and second, the managerial discourse which I analysed through the documents used by nurses, and authorized by the Nursing Department, to manage the teaching function. The way in which the discourse operates will become visible in Chapters Four and Five.

Researcher subjectivity and stance. Before concluding this description of the study procedures it is important to describe my stance as a researcher during the period of time

from November 1989 to June 1990 when I was in the field. My stance differed deliberately according to whether I was observing a nurse at work on Study Ward, or interviewing her in an office, restaurant or her home.

When I observed a nurse at work I tried to be as unobtrusive as possible in order to see and hear the nursing work process unfold. When the nurse I was observing attended to a patient I either remained with her or stayed outside the curtained area surrounding a patient's bed but within earshot of conversation. In deciding whether to remain within or outside the curtained area I relied on the nurse's judgement of the patient's comfort with my presence and my own sense of what was appropriate. My concern for patient safety also entered into the stance I adopted on the ward. I did not wish to distract nurses during their observations of acutely ill patients, nor during the administration of medications and treatments to patients, and in their conversations with physicians. Therefore I asked nurses only those questions I needed to make sense of the immediate situation and saved my other questions until a free moment occurred or until my interview with the nurse. In summary my stance during periods of observation of nurses' work was more that of an observer than participant (Patton, 1990). I attempted to be a quiet bystander, interested but uninvolved.

The record of the observations I made are the detailed fieldnotes I constructed as I observed. They include verbatim notes of verbal exchanges between nurses and patients, and nurses and physicians, as well as detailed descriptions of activities and sites. Unlike the interviews that I will describe next, the fieldnotes I wrote are solely my creation. I decided what observations to describe and what dialogue to record. The nurses who participated in this study are "in" my notes, as are the patients and physicians, but they are in on my terms. While I gave my fieldnotes to any of the nurse participants who asked to read them, it was I, alone, who constructed them.

The interviews, however, are joint productions of myself and the nurses I interviewed. Accordingly my research stance at this time was different than during my observations of nurses. During each interview I was both interested and involved in the conversation, and I used my own experience of patient teaching and my interpretation of nurses' work to engage them in a dialogue about their work. I maintained this same stance with the seven other nurses whose work connected with that of the twelve nurse participants. While my interests in educative work established the frame of these conversations the substance was produced jointly and depends both upon the participants' experience and interpretation of this work and my own. In the course of these conversations new understandings

developed about nurses' work, and educative work, for both myself and the nurse I interviewed. For example, the nurses I interviewed came to see, with some ambivalence, that the scope of their teaching work was wider than they had thought; I, in turn, learned of the extent of nurses' educative work with physicians. These new understandings are evident in the interview data I report in Chapter Four.

My involvement with the participants in constructing an account of educative work is consistent with the feminist research methods that I used in this study. Armstrong and Armstrong (1990) point out that feminist methods have often been "explicitly subjective" (p. 12). They say, "Instead of attempting to separate themselves from their subjects, as most social scientists have done, feminist theorists have frequently identified with those whose work they were trying to explain." (p. 12). Oakley (1981), in writing on the subject of a feminist interviewing women writes " ... it becomes clear that, in most cases, the goal of finding out about people through interviewing is best achieved when the relationship of interviewer and interviewee is non-hierarchical and when the interviewer is prepared to invest his or her own personal identity in the relationship" (p. 41). Finally, Smith (1987) whose method of institutional ethnography I followed in this study makes the point that inquiry "must be considered as a work of cooperation between sociologists and those who want to

understand the social matrices of their experience" (p. 154).

The Research Participants, Site and Documents

The research participants. The acknowledged participants in this research were 12 members of a 31 person nursing staff, however in this section I also describe the other major social actors in the situation, physicians and patients.

At the time of my field observation the all-female nursing staff of Study Ward consisted of 23 RNs and 8 CNAs. These women worked a 12 hour shift (7am to 7pm, or 7pm to 7am) and a 37.5 hour work week. During the day shift from 7am to 7pm the nursing staff who gave direct patient care numbered from seven to nine, but at 7pm, when the night shift replaced the day shift of nurses, this number was reduced to five, and further reduced to four staff after 11pm. Two of the RN group who were not involved in direct nursing care to patients, and who worked an eight hour day, were the head nurse and the clinical development nurse. This latter person was responsible for the orientation of new nursing staff and for the education of all nursing staff in new procedures and hospital policies.

The medical staff[12] on the study ward consisted of six attending physicians who had the right to admit patients to the ward, and three resident physicians, two or more interns and three clinical clerks, known collectively as the housestaff. Physicians made rounds on their patients either early in the morning, around 7am, or about 5pm. In the hours between, attending physicians were either in the operating room area or in their offices. Physicians in training (residents, interns and clerks) were on the ward if there was work to be done (a new patient to be admitted, a sick patient to be attended to); otherwise they were in the operating room or elsewhere.

There were seldom medical students on the ward despite the fact the hospital was a university teaching hospital. Nursing students from the hospital's own School of Nursing occasionally came to the ward for a two or three day period to practice the care of patients. Other health care workers such as dietitians, physiotherapists, etc., were attached to the ward but were present only as their services were required.

In all respects Study Ward was "typical" of other surgical wards. To the ward were admitted patients to undergo surgery for a variety of conditions, some

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[12] All of the attending physicians and the majority of the housestaff on Study Ward were males. In this study when I refer to a physician I use the masculine pronoun. When I refer to a nurse I use the feminine pronoun.

life-threatening such as cancer of the lung, breast and pancreas, others relatively benign, such as hernia, appendicitis and varicose veins. The "medical condition" of the patients on the wards varied from stable and improving to unstable and deteriorating. Their average age was 50 to 55 years and despite the serious illness of some of them the average length of stay on the ward, as estimated by the Head Nurse, was five days. From two to six new patients were usually admitted every week-day, but unplanned, or emergency, admissions were common.

The research site. A senior nursing manager selected the ward where I conducted the study. Study Ward accommodated 37 patients at the time of my field observation. The physical lay-out of the ward was a long corridor and placed along it were two and four-bed patient rooms, with one five-bed room at the "open" end of the corridor, and other rooms (the Medication Preparation Room, the Teaching Room, the Utility Room, the Nurses' Lounge, the Ward Kitchen, a Storage Room). In the middle of the corridor, on the right side, was an area called the "Nursing Station". This was a two-stage area: an open area, separated from the corridor by a counter top and desk structure, gave entrance to a separate room, about 12' x 12', lined with shelves above a counter, and holding several chairs. The Nursing Station was in many ways the "nerve center" for the ward, housing all the documents

(forms, patient records, procedure and policy manuals) used to record and initiate work, and acting as a central gathering place for exchange of information between health care workers. The room in the Nursing Station was the place that nurses gathered for the report that occurred twice a day at the change of nursing shift. Two small wheeled chart carriers, holding patient records in racks, and carrying, on the top surface, the medical order book and the nursing cardfile, were kept in this room, except for those times when staff physicians visited their patients, at which time they were pushed from room to room as part of the process of making "rounds". Across the corridor from the Nursing Station was the Utility Room where certain supplies were stored and where other material used in the care of patients was brought for disposal. Placed along one side of the corridor were several wheeled carts, a small one holding surgical supplies like needles and suture material, a middle-sized one, the "Crash Cart" holding resuscitation equipment, and 2 large ones, holding linen and more surgical supplies like plastic bags of intravenous fluid and surgical dressing trays.

The ward was a busy place, especially between the hours of 8am and 4pm, Monday to Friday, when each of two telephones rang frequently and physicians, nurses, other health care workers, and patients, came and went from the ward. It was during these hours that patients were prepared

and taken to other parts of the hospital for surgery or diagnostic tests, and then received back, often in a state that required a high degree of nursing attention. It was during these hours that patients were admitted and discharged, that consulting physicians, dietitians, physiotherapists and other health care workers attended to patients on the ward, and that the routines of nursing care such as bathing, feeding, ambulation and monitoring of vital functions took place.

The research documents. The documents I examined were of two types: first, hospital forms found on Study Ward and used in the process of either performing or managing nursing work (including educative work), and second, nursing texts and articles from nursing periodicals that describe the theory and practice of patient teaching in nursing. The first time that I refer to a hospital form in the chapters that follow (Chapters Three, Four, Five and Six) I describe it and either display it within the chapter or indicate its location in the Appendix. In what follows I first list the hospital forms found on Study Ward that I analysed and, second, the texts and articles from periodicals.

The direct care of patients by nurses, and others, and the management of nursing work on Study Ward, relied heavily on documentary processes and practices for its organization. There were many different types of textual materials stored and used on Study Ward. These included nursing and medical

textbooks, indexes of pharmaceuticals, hospital policy and procedure manuals, patients' medical records (old and current), and a large number of forms and requisitions used to initiate and report on diagnostic and therapeutic work. In addition there were several notice boards where routine and urgent notices about hospital polices and events were posted, and a large amount of patient instructional material (pamphlets, brochures, videotapes, flipcharts) stored on shelves in the Teaching Room.

Among all of the documentary material that was used, or stored, on Study Ward two categories of hospital forms were germane to my research. The first category included forms that related to the care and education of patients, and the second category included forms that related to the organization of nurses' work. Forms that related to patient care that I collected were the Problem List, the Nursing Assessment (Parts I and II), the Nursing Care Plan, the Nursing Flow Sheet, the Nursing Notes and the Pre-operative Patient Education Record. Nurses caring directly for patients either worked from or entered information into these forms on a daily basis. Patient instructional material was used by nurses in teaching patients. Some of this material was prepared commercially and purchased by the hospital, but most of it was designed and produced within the hospital. I display one instruction sheet for surgical patients that was designed by several nurses on Study Ward

entitled "After Abdominal Surgery Discharge Instructions". The form that I gathered that was germane to the organization of nurses' work was the Patient Care Hour Chart used to estimate nursing workload measurement.

I examined articles from nursing periodicals and nursing texts on the theory and practice of patient teaching in nursing. The articles I analysed were "Beyond procedures - incidental teaching" (Bowe, 1958); "Notes on patient teaching: A neglected area" (Monteiro, 1964); "Recognizing opportunities for informal patient teaching" (Palm, 1971); "Teaching activities of the nursing practitioner" (Pohl, 1965); "Patient education as a function of nursing practice" (Redman, 1971); "Patient education at 25 years: where we have been and where we are going" (Redman, 1993b); "The nurse's responsibility for teaching patients" (Streeter, 1953) and "The role of the nurse in patient education" (Winslow, 1976).

The texts I examined were Handbook of patient education (Haggard, 1989), Patient teaching by registered nurses (Minnick, 1982), Patient teaching in nursing practice: A patient and family-centered approach (Narrow, 1979), The teaching function of the nursing practitioner (Pohl, 1968, 1973), Patient education: Issues, principles, practices (Rankin & Stallings, 1983, 1990), The process of patient teaching in nursing (Redman, 1968, 1972, 1976, 1980), The process of patient education (Redman, 1984, 1988, 1993a),

Nurses as health teachers: A practical guide (Rorden, 1987), Patient teaching in critical care (Storlie, 1975) and Teaching in nursing practice: A professional model (Whitman, Graham, Gleit, & Duncan Boyd, 1986). While there are in 1994 a considerable number of texts on the educative function in nursing, Redman's text, now in its seventh edition (1993) and entitled, The process of patient education, dominates the field. It is widely used in baccalaureate and diploma level nursing programs to teach new practitioners. I make use of Redman's texts in my analysis of the discourse of teaching in Chapter Four.

Summary

In this chapter I described my method of investigation of nurses' teaching work. This method differs substantively from that of established sociology. It makes problematic the everyday experience of nurses and seeks to explicate the organization of the everyday in a way that preserves their presence as agents.

The procedures I used are the procedures of institutional ethnography as described by Smith (1987) and used by others (Campbell, 1984; Cassin, 1990; Manicom, 1988; Reimer, 1987). These procedures involve the examination of work practices and the concerting of work practices in extended courses of social action, and the examination of institutional discourse and textually-mediated practices.

In doing an institutional ethnography, these three procedures are intertwined. But the fundamental starting point is in the activities of everyday life, and it is to this that I now turn. In the next chapter, Chapter Three, I describe the actual teaching practices of nurses, I show what they accomplish in the hospital, and I begin to reveal their social organization.

Chapter Three

The Teaching Practices of Nurses

Introduction

Most people think of hospitals as places of care and treatment for the sick, where one group of persons -- physicians, nurses, and others -- administer to the needs of another, patients. This is the "common-sense" view of hospitals. Consistent with this view is the idea that physicians, nurses, and other workers, are active in the hospital while patients are passive, that hospital staff "work" to care for patients, while patients "receive" care (Wadel, 1979).

Within the last ten years this common-sense view has been challenged by Anselm Strauss, and his co-workers who have examined the experience of persons with chronic illness (Strauss, Fagerhaugh, Suczek, & Wiener, 1985). On the basis of detailed studies of the experience of such persons, both in hospital and home, and with different kinds of illnesses, Strauss et al. assert that, infact, chronically ill patients do work. They work in order to manage the course of their illness within the context of their daily lives. They work to maintain their own composure, comfort and safety, as well as a host of other conditions.

Strauss et al. acknowledge that their view of patients as workers is not the view of physicians, nurses and other hospital workers, and that, as a consequence, the work of patients remains invisible. On this point they say, "the sick work, but their work is not necessarily conceived of as more than acting properly or decently in accordance with the requirements of their care by professional or assisting personnel" (Strauss, Fagerhaugh, Suczek, & Wiener, 1985, p. 192).

On the basis of my observations, and analysis, of the activities of nurses and patients, I concur with Strauss' view that patients work. It is a central assumption of the analysis presented in these pages. Unlike the common-sense view that holds that hospitals are places where doctors and nurses work, but patients do not, I treat the hospital as a workplace for both health care workers and patients. A further assumption I make is that nurses teach patients, and inexperienced health care workers, how to participate in hospital work processes and in so doing they accomplish the care and treatment of patients.

This chapter has a number of purposes. The first is to describe the specific teaching practices that nurses engage in and to show what these practices accomplish in the immediate context of their use. A second purpose is to show how teaching practices are part of and accomplish ongoing hospital work processes that involve many persons, patients,

nurses, physicians, and others, and that extend beyond the ward. A third purpose is to analyze nurses' teaching work from the perspective of recent insights into work customarily performed by women, insights developed by feminist scholars and by others who study work. The analysis in this chapter will begin the development of a major theme of this dissertation, the explication of the invisibility of nurses' teaching work. The chapter begins, however, with a brief description of the nature of work in hospitals and the central place of nurses in ensuring it goes forward.

Hospital Work Processes

The hospital is a site of multiple intersecting work processes. Some of these accomplish the admission of patients, the investigation and treatment of their health problem and ultimately their departure. Still other work processes account for and manage the work that is done on and for patients. Different processes, yet, attend to patients' need for food and a comfortable, safe and clean environment. Taken as a whole, hospital work processes produce what health care workers call "patient care".

Patients, nurses and physicians participate differently in the work of patient care. However, the work itself is of two general types: work on the body of the patient (I will call this "body work") and work that produces the

organization of patient care (I will call this "organizational work").

Patients do, and must do, a great deal of work on their own bodies.[13] Examples of body work are the work of producing a specimen of urine, ingesting a medication, enduring pain, coughing, maintaining the posture of a limb, mobilizing after surgery and taking up self-care tasks after a period of dependency. Patients do this work on their own bodies as part of the process of diagnosis, treatment and recovery. They do it until they recover and leave hospital or until they lose consciousness and can no longer participate actively in it.

Organizational work is the work patients do as participants in a complex organization of work in the hospital. It is the work of connecting or articulating themselves to the work of health care workers and others, and of being in the hospital in ways that are sanctioned by the institution. Examples of organizational work are the work of providing information to nurses and physicians on admission to hospital, monitoring and reporting changes in body function to nurses and physicians, following hospital

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[13] My use of the term body work differs from that of Strauss et al. (1985). They use the term to refer to the work of hospital staff on patients, and they place all the work that patients do, both body work and organizational work, under the general rubric of patient work. I contend, and show, that work on the body is the central work process for patients in hospital and the term is more appropriately applied to what they, rather than staff, do.

policies regarding the safekeeping of money and other personal items and being available for tests or visits from physicians. If patients do not do this work, the work of the hospital cannot proceed smoothly.

Like patients, health care workers also do body work and operate within a work organization. Where body work is concerned, however, their work differs from patients' work. For the most part health care workers, particularly physicians, ask patients to do body work; the patients are the ones who actually do it. But health care workers also act directly on the body of the patient, and they also act through an intermediate technology applied either on its own or through the work of a third person, for example, a nurse. Health care workers, like patients, also do organizational work. They do this when they adhere to hospital policies and procedures in carrying out medical work. An example of this are practices that physicians and nurses follow concerning the writing and fulfilling of medical orders or in the arrangements they make for diagnostic tests.

Patients are often unfamiliar with the work they must do on their bodies, and their lack of knowledge about this work gives rise to teaching by nurses. Nurses teach so that patients may perform body work correctly. Furthermore patients may not want to perform this work when they feel pain, nausea or feelings of tiredness or malaise. Nurses coach and exhort patients to do body work in the face of

discomfort.[14] Institutional safety, and the efficiency of work within hospital departments, depends upon patients doing organizational work but patients generally do not know about hospital policies and work routines. Nurses educate them on such matters.

Inexperienced health care workers are usually nurses who are new to the ward and physicians-in-training (clinical clerks, interns, residents) who work on the ward as part of a rotation through several hospitals. These persons are trained in the principles of their work but they may lack experience in their practical application. As well they lack experience of doing medical work within the work organization of a particular hospital. Experienced nurses (both RNs and CNAs) teach inexperienced health care workers on both medical and organizational matters.

In summary, patient care is a series of work processes that address both the body of the patient and the organization of work in the hospital. Because of inexperience or lack of knowledge, patients and health care

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[14] It is important to note that patients are expected to work and to work despite how they may be feeling. Pain, nausea, weakness, fever, and a variety of more local discomforts, are experienced by the acutely ill. Yet ever with these miseries, as I will show, patients are still expected to work: to wash, to cough, to walk, to drink. A considerable amount of energy is expended by nurses to encourage action in the face of these discomforts. This is particularly so in cases where discomforts are regarded as transitory, for example, a "routine" appendectomy or gallbladder removal. I observed that nurses were far less aggressive with patients known to be dying.

workers may require teaching to participate in these work processes. Experienced nurses are their teachers.

Nurses teach because they occupy a central position in the work organization of the hospital. Nurses are at the hub, or center, of patient care. The central position of nurses has been recognized by the medical essayist, Lewis Thomas (1983), who calls nurses the "glue" that keeps the hospital together. Without the work of nurses, Thomas claims, the hospital would "fly apart". Nurses are present on hospital wards twenty-four hours a day and their work is to act directly on, and with, patients and with patients' families. They are aware of if not directly involved in most of the work processes that affect patients. They act as agents for both physicians and hospital administrators in implementing medical orders and hospital policies. Nurses are thus strategically located, both geographically and organizationally, within the hospital.[15] Because of their strategic location, and with work experience, nurses develop knowledge of "how things work" in the hospital. This is knowledge not only of policies and procedures but also of the work habits and preferences of fellow workers,

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[15] Nurses, and nurse managers, identify coordination of the work of others as a nursing function, and this is consistent with Thomas's claim that nurses are the glue that keeps the hospital together. However the nature of the "glue", of coordinating work, is poorly understood (Thibault, 1988). I argue that the glue is the teaching work of nurses embedded in routine work processes, and its skilled character arises from the knowledge of experienced nurses about how work gets done in the hospital.

especially attending physicians, and of the location of seldom used equipment or materials. It is from their strategic location and with knowledge born from experience that nurses educate inexperienced workers and patients.

The Educative Process in Nursing

Nurses teach through their talk, and through their use of text.[16] Nurses' teaching work goes on in the context of routine work processes, as is evident in the following excerpt from my fieldnotes:[17]

> Judy (RN) and Marie (CNA) together measured "the 10am vitals" on each female patient in a four-bed room, Judy taking the temperatures and Marie the blood pressure, moving from patient to patient as a team. Three of the four patients had a slight fever and Judy explained to each in turn that the rise in body temperature was to be expected after surgery, that it was a normal occurrence. One patient expressed dismay that her temperature was up. She told Judy what she had been doing since her surgery to help her recovery: walking about the room and in the hall, drinking lots of water, taking deep breaths and coughing. Judy told her these were all the right measures to take and to keep doing them. In the meantime Marie urged one of the women to take several deep breaths and cough. She told her to splint her incision and

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[16] Nurses teach patients primarily through their talk. When they use text it is in the context of authorized teaching work, such as pre-operative teaching. Nurses teach health care workers through both talk and text. This teaching work is generally embedded in other work processes. This will become more evident in the examples used in this chapter and in Chapter Six.

[17] To display the teaching work of nurses I make extensive use of my fieldnotes and documentary material collected on the ward. When I quote a specific nurse directly I provide the pseudonym for the nurse and the date of my observation.

> showed her how to do it by wrapping her arms around her own midriff. The patient gave a weak cough. Marie said, "Not like that, a deep cough, from your boots". (Judy, 25/11/89)

Judy and Marie are engaged in routine nursing work, measuring the vital functions (blood pressure, pulse, temperature, respiratory rate) of a group of patients recovering from surgery. As they do this they talk to patients about what they find: Judy explains the meaning of a rise in temperature and gives feedback to a patient on her own efforts at recovery; Marie demonstrates the proper way to cough. They both offer encouragement. Together Judy and Marie draw these patients into the work of recovery by informing and instructing them about it; their teaching of these patients, however, is embedded in the work of measuring their vital signs.

As I described in Chapter One, the first disjuncture that propelled my analysis was that while nurses name some of their work as teaching work (pre-operative teaching, diabetic teaching, colostomy teaching) the educative character of much of their work seems invisible to them, especially when it is embedded in routine work processes such as measuring vital signs. Nurses call the work that Judy and Marie are carrying out "doing the vital signs"; they don't call it "teaching about recovery". The teaching that these nurses are doing is "swallowed up" in other work that is somehow more privileged in terms of being recognized by them as work.

Unlike teaching work in other settings, the teaching work of nurses seldom takes place in the traditional teaching context, the classroom, nor with the degree of organization found in, for example, elementary school curricula. Moreover, teaching in the context of the nursing care of hospitalized patients often seems like nothing more than fragments of conversation, uttered in the same space of time as a comment about a patient's flowers or a message delivered from a relative who has phoned the ward to say she will be late in visiting the patient. However the communicative practices of nurses shape significantly the behaviour of patients and health care workers and, it is for this reason, that I assert they are teaching practices.[18] As well, these practices are consistent with definitions of teaching:

> Teaching is a broad, general term. It is sometimes referred to as a polymorphous ("many-shaped") word, since it may encompass a wide variety of more specific activities such as lecturing, instructing, drilling, eliciting responses, asking questions, testing, providing information, encouraging, and conducting seminars. (Barrow & Milburn, 1986, p. 221)

Further support for the educative character of these practices is found in definitions provided in The international encyclopedia of education (Husen & Postlethwaite, 1985). Five definitions of teaching are

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[18] The practices that I assert are teaching practices resemble practices that have been termed socialization.

provided in this text: teaching in the conventional sense, or the descriptive definition; teaching as success; teaching as an intended activity; teaching as a normative activity; and the emerging scientific [illegible]tion of teaching. The communicative practices of nurses, such as Judy and Marie, are consistent with these definitions, especially the descriptive definition: nurses impart knowledge and skill to patients; they intend to induce a change in their behaviour; and their teaching is intended to be beneficial to the patient.[19] Judy and Marie provide these patients with knowledge of recovery, they motivate them to keep up their own efforts, they teach them the skill of coughing, and all within the context of a routine piece of work, measuring vital functions.

In summary, nurses teach patients and inexperienced health care workers in the process of, and to accomplish, the care and treatment of patients. I name certain of their activities teaching because they resemble, in character and intent, the activities that teachers name teaching. In what follows, specific kinds of teaching practices are discussed, based on fieldnotes of my observations of the twelve nurses who participated in the study.

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[19] While nurses intend to benefit patients through their teaching it is important to note that beneficence is not a criterion of teaching. Not all teaching that is done in society is intended to benefit those taught.

Nurses' Teaching Practices

I analyzed over one hundred and fifty verbal exchanges between nurses and patients, and eighty verbal exchanges between nurses and other health care workers. The majority of the exchanges with health care workers were with physicians.[20] I extracted these exchanges directly from the fieldnotes I made while observing the twelve nurse participants. In analysing them I looked first at the direction of the exchange (who initiated it), next at the form of the exchange (was it a question, explanation, etc.) and finally at the content (what did it appear to be about).

I identifed six separate forms of exchange between nurses and patients, and nurses and health care workers. These were asking questions, offering explanations, giving information, providing instructions, setting expectations for work to be done, and finally, demonstrating the correct performance of work. These are nurses' teaching practices. These practices are devices for getting medical work done and for continuously orienting patients and workers to hospital relevances of cost control, quality and

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[20] I analysed substantially fewer nurse-physician exchanges than nurse-patient exchanges and this is evident in the preponderance of nurse-patient exchanges analysed in this chapter. The smaller number of nurse-physician exchanges arises from the fact that nurses interacted most frequently with patients. Physicians were only present on the ward when there was work for them to do - make rounds, admit patients, attend to the acutely ill patient - therefore the opportunity for nurses to engage in educative work with them occurred less frequently than it did with patients.

institutional and patient safety.[21] Nurses' teaching practices are both embedded in routine work with patients and other health care workers and are used explicitly in work processes that nurses name teaching work. Sometimes a nurse uses a single teaching practice, for example, she asks a question or gives information but without explanation. More commonly she uses two or three practices in combination, such as she asks a question then gives information and instruction. While in my analysis I display particular practices to emphasize them, it is important to remember that they generally occur in combination and as part of an exchange between the nurse and patient or health care worker. Nurses' teaching practices are part of an ongoing and seamless work process and must be understood as such. In this section I lift particular practices out of this work process and separate them one from another to label them a "question", or an "explanation". They, therefore, appear to stand alone as instances of "teaching". But they are not; they are part of a flow of conversation around a piece of work. This point will become clear in a later section when I show teaching practices as parts of a course of action.

Asking questions. Nurses ask questions of patients, physicians and other nurses. The questions nurses ask

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[21] The organization of teaching work by hospital concerns for cost control, quality and safety is the subject of Chapter Five.

provide them with the information they need to know to do their work and they teach patients what is relevant about themselves that physicians and nurses should know. Questions draw patients into the work of monitoring and reporting on their own bodies, and draw other health care workers into the work of caring for patients.

The practice of asking patients questions is especially evident in the admission of a new patient to the ward and in the work nurses call assessment. In this example, Mary is admitting a patient for a surgical procedure.

> "Are you allergic to anything?" The patient replies that she is allergic to anaesthetic gases and Mary tells her to tell the doctor when he comes to see her. "Have you any valuables?" The patient says "No." Mary continues, "What brings you into the hospital?" The patient says that Doctor XXX[22] did a biopsy on her breast. "I don't know what will happen after that." She hands Mary her pills. "Do you know the names of these pills?", asks Mary. The patient responds with the name and dose of each one and the nurse asks her if she took these pills this morning. Mary continues asking questions of this patient she is admitting to the ward: "Do you take Halcion every night to get to sleep?", "You wear eye glasses. Do you have any eye problems? Do you have any problems now?" She asks the patient about some eye drops she handed over with her other

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[22] The exchanges that I analyse in Chapter Three contain direct references to physicians and patients, and the location of patients in the rooms on Study Ward. The identity of these persons and the precise location of patients in rooms on Study Ward is not relevant to my analysis. To protect the anonymity of physicians and patients, and the location of patients, I use triple letters in place of their real names, and, in the case of patient location, triple letters in place of actual room numbers. The location of a patient within a four-bed room, however, is established by using the label Bed 1, Bed 2, Bed 3, or Bed 4.

> medication. "Any problems with your breathing, with your heart?" To these last two questions the patient replied "no" and the nurse asked "Why do you take Persantine?" Mary continues to ask the patient questions, "How did you discover your breast lump?". (Mary, 04/12/89)

In this example, Mary is gathering information from the new patient to enter into various documents and to carry back to other nurses who will care for the patient. This information allows Mary to begin the patient and institutional safety work that nurses are responsible for (for example, she will record the allergy in a way, and in a place, that the anaesthetist will see; she will indicate that the patient has no valuables). The information provides her, and other nurses, with knowledge about the type of assistance this patient will need from them.

Mary's questions teach this patient that what is relevant about herself, and what she must tell nurses and physicians about, is her physical condition, and not, for example, the fact that she plays the piano, or speaks a foreign language. Questions act as indirect instructions for patients; they orient them to the medical and managerial relevancies of the hospital.

Questions draw patients into the work of monitoring and reporting on their own bodies, and on the effects of treatment. Nurses ask patients questions to assess the progress of their recovery and to establish that medications or other interventions are having the desired effect. This is especially evident in the first round of the morning when

each patient is asked to report, for example, on the quality of her night's sleep and the state of her pain or nausea.[23] Information obtained by nurses through questions is used by nurses to modify treatments, or some other feature of the patient's stay in hospital, for example a dietary regimen or the location of the patient on the ward. Nurses report patient information to physicians and other workers, for example, dietitians, and they use the information directly to make changes in their nursing care.

Questions also keep patients focused on the work of recovery or diagnosis that they alone can do (cough, produce and save a specimen of urine). In this regard the questions act as indirect instructions. In this example, Anna queries patients as she completes the 10am vital sign routine:

> We go into Room VVV, to Bed 3 and Anna asks the patient "How is your breathing?" The patient responds "The same." Anna says "What's the same? I have nothing to compare it with." The patient replies, "It hurts when I breathe in." We move on to the next room and again she asks the patient, "Why are you coughing up blood clots?" The patient, "I don't know." Anna again, "How long have you had the hiccoughs?" The patient replies, "Since I came back from surgery." Anna comments, "It's time we did something about this", and turns to the nurse beside her and suggests she get an order for Largactil. (Anna, 25/02/90)

While most of the nurses' questions concern patients' physical state and response to treatment, their questions are also about what other health care workers may have said

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[23] In this dissertation the feminine pronoun is used to refer to both male and female patients.

when the nurse herself was not present to hear. In this regard they make patients participate in information work on the ward. In this example Anna asks a patient she admitted on the previous day to report the opinion of her doctor concerning the significance of information she had given Anna at the time of admission:

> "How are you this morning? Was Dr. UUU in?" The patient replies in the affirmative. "Did he have anything spectacular to say? Did you tell him about your concern about the propane?" [The patient has had an accidental exposure to propane in the past which concerns her.] (Anna, 25/02/09)

These questions draw patients into the work of communication and the sharing of information. Physicians may well visit a patient without a nurse being present. Nurses, knowing this, make patients participate in the transfer of information on ward. The patients do liaison work between nurses and physicians.

Nurses also ask physicians questions. Many of these are straightforward requests for explanations on, for example, the meaning of diagnostic tests or unusual symptoms. More frequently, however, nurses ask physicians questions about their intentions for patients. These questions are devices for teaching, or instructing, the physician in the work of managing the patient's care, for example, adjusting drug regimes or responding to changes in the patient's condition. This is obvious in the following interaction between Betty and a staff physician:

> Betty and I are back up at the Nurses' Desk and Betty is speaking to the attending physician about various orders and concerns. The patient in Room SSS, Bed 1 has swollen legs and she asks the physician if he wants this patient to receive Hydrodiazide [a diuretic]. She tells the physician that he was on this drug at home. "Yes", replies the doctor. Betty then queries the physician about another patient's TPN [a type of intravenous solution], should it, or should it not, have Heparin in it? (Betty, 02/12/90)

This nurse knows what needs to be done for these two patients, and is instructing the doctor (albeit indirectly) on the course of action to take.[24]

In summary nurses' questions are, firstly, devices through which patients come to know themselves and be known by hospital staff in medically and managerially relevant ways. Through questions nurses teach patients to see themselves as physiological organisms that must be reported upon, and as components of a process of communication among health care workers. Secondly, nurses' questions teach physicians that patient care is a joint work process, and of the share of it that concerns nurses.

Offering explanations. Nurses offer explanations to patients on many matters, for example, their symptoms, the side effects of drugs and treatments that they experience, and the intentions and actions of physicians. In this example, Anna offers an explanation to a patient for her post-operative pain.

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[24] The indirectness of nurses' teaching work with physicians is analysed in more depth in Chapter Six.

> On to Room RRR and the patient in Bed 3 asks Anna why she is having so much pain. Anna offers an explanation, "You have a lot of gadgets in there [the patient has a surgical drain and other tubes], your incision, your ostomy. And you are just lying there, more or less seizing up." (Anna, 24/02/90)

In this instance Anna's explanation both draws on what has happened to the patient as a result of the surgery (the placement of tubes, the incisions) but also suggests that the patient's own action, or lack of it, may be the reason for her pain.

Explanations are sometimes given in response to patients' questions, yet at other times offered freely while the nurse performs some task on the body of the patient, as in the following example.

> Anna and I go into Room TTT, to the patient in Bed 4, where Anna will change the dressing over a wound on this woman's ankle. This is a Dakins dressing and Anna tells the patient what the solution will do: "It will clean out the dead skin, it may cause the new skin to bleed a bit but that is a sign that it is 'working'." Anna asks the patient several questions as she proceeds with the dressing, how long has she had the injury and how did it happen. (Anna, 24/02/90)

This explanation seems intended to reassure the patient that the appearance of blood is normal and a desirable thing. It is likely that the Dakins solution caused a stinging sensation in the wound as it was applied. Anna's explanation and further questioning of the patient seems designed to both obtain her cooperation with the procedure and to divert her from the discomfort that accompanies it.

In this next example, Lise uses both a verbal explanation and a demonstration to reassure a patient.

> Lise and I enter Room CCC and she says to the patient, a young man, "Hi, there. I have to put an IV in you. I understand they told you you were going for this test. Have you ever had an IV before?" The patient confirms that he has and asks Lise how long he will have it for. She tells him until after the test, "They'll take it out tonight....you know there is a little poke, eh?" The patient asks if there is a drug in the IV and Lise tells him, "No, it is just a protocol for the test, a precautionary measure, they have access to a vein in case they need to give you a medication. Have you ever had a dye test?" The patient says no and that he doesn't like needles. Lise responds to this expression of dislike by showing him what is actually inside his vein as a result of having the IV. She opens a new IV set and demonstrates how the needle with which she punctured his skin actually slides off the plastic catheter which in turn remaines in his vein. She demonstrates how flexible the catheter is by bending it backwards and forwards with her finger. The patient seems both interested and relieved by this explanation. (Lise, 05/02/90)

Explanations are one more way of obtaining and maintaining the involvement of patients in the work of patient care. Explanations answer patients' questions such as, Why do I feel this way? What is this test about? What did the doctor mean? Explanations enlist the cooperation of patients and call upon them to endure in the face of discomfort. They ask them to positively anticipate experiences.

Nurses offer explanations to physicians who ask for help or who in otner ways display their lack of knowledge. These explanations help the physician to work or point him towards work that needs doing.

Nurses are usually more aware than trainee physicians of the policies and routines that shape patient care on the ward, and about commonly used equipment. They use this knowledge to guide novice physicians. In this example Mary responds to a question by a clinical clerk about the correct IV starter set to use.

> Mary asks the female clerk if she intends to put in IV meds. The clerk says yes and Mary suggests that she choose a different set than the one she has in her hand. She tells her that if she sticks with that one, and puts in IV meds, she will find that they go up the line into the bag rather than down into the patient. Then Mary asks the clerk the patient's age. Hearing "70" she suggests yet another set, one with a burrette. She explains that with the burrette it will be easier to regulate the flow of fluid and prevent overload in the patient, yet they could give the patient a "bolus" of medication if they need to. Mary gets an IV bag, tears off the seal and hooks up the tubing. She finds an IV pole and pushes it into the patient's room. She hangs the bag of fluid and allows 75cc to enter the burrette, explaining to the clerk that the use of the burrette in older patients makes certain that they never get large amounts of fluid due to an oversight by staff in regulating the IV rate. (Mary, 04/12/89)

In another example, Lise explains to an inexperienced physician how an x-ray requisition must be completed and who has the authority to initiate what forms of work in the hospital.

> Lise has just asked the clinical clerk to fill in the requisition for a CBD exploration, an x-ray procedure. She tells him what to write on the form (a brief history of the patient's problem) and where to write it and sign it. She says, "They won't accept a nurse's signature." The clerk signs it and hands the form back to Lise who in turn gives it to the ward clerk to send to the Radiology Department. (Lise, 05/02/90)

In summary, explanations given by nurses provide reasons for *why* patients feel as they do and why work proceeds as it does in the hospital. Explanations also instruct patients and inexperienced physicians about how to do things. By offering explanations nurses draw people into the work process, either as direct participants as in the case of physicians, or, in the case of patients, as cooperative recipients of the work of hospital staff, willing to endure the discomforts that often accompany medical work.

Giving information. Nurses give information. This is probably their most significant teaching practice. They give it on the most prosaic of matters (the location of the ward bath tub, the times for visiting by family and friends) and the most significant (the scheduled time for an operation, the visiting habits of a surgeon). Giving information is similar in intent to offering explanations; the purpose is, among other things, to enlist the cooperation and compliance of the patient with the rules of hospital life and the plans of the physician by telling the patient what these are.

Nurses give information throughout their work shift but this practice is particularly evident at certain times. The periodic rounds that nurses make to check on patients' conditions, especially the round that follows a change-of-shift report, are particular occasions for

information giving, as are the admission or discharge of a patient, and the giving of a medication.

Nurses give two kinds of information to patients, information that is relevant to all patients and information that is relevant to a single patient. Information in the first category is of a general nature and orients patients, for example, to nurses' work routines, hospital policies and the variety of hospital workers. Information that is relevant to a single individual acquaints that person with her treatment plan and changes to it.

General information is often about seemingly mundane matters like where to purchase a newspaper. In the following example Jill responds to a patient's request for information about renting a TV and the likelihood of a visit from her family doctor (not a mundane matter).

> Jill and another nurse are making a patient's bed. She asks the two nurses when the person in charge of TV rentals will be around. Jill replies "About 2pm." The patient asks again "Would my family doctor be notified when I come in?" The other nurse says she doesn't know, that the nurses don't usually see them on the ward. Jill adds "They can visit but they can't do anything about your care." (Jill, 27/11/89)

Nurses give patients general information to help them settle in to the hospital and to anticipate the usual practices and routines of hospital workers to which the patient will, with exceptions, have to accommodate. Information is especially important in getting patients to participate in ongoing work processes of the hospital.

Individual orienting information can be on a range of matters but is almost always on matters concerning the patient's reason for being in the hospital in the first place, that is, some physical malfunction. During rounds, especially the mo. ning rounds, nurses give orienting information to specific patients about upcoming events of the day, diagnostic tests, visits by specialists, the time of an operation, etc. The following are further examples of orientating information on matters specific to an individual patient.

> We go into Room XXX, to Bed 4, and a relative or family friend asks me (FG), "Can you tell me what is ailing this fellow?", pointing to the young man who is lying in the bed. I pass this comment onto Marie, by saying, "I'm sorry, I can't but perhaps this nurse can." Marie turns from her inspection of the IV and says, very smoothly, that the blood work is not back from the lab, it should be tomorrow, and that this will let the doctors know what is going on. I then ask the patient what the doctors have told him, and he replies, "They told me something but I didn't understand it." Marie then advises him to ask the doctors questions. The patient says he has done this but he still didn't understand. Marie tells him to ask that a nurse be present when the doctors are there so that she could explain it to him after they have left the room. (Marie, 08/03/90)

Nurses give information th specific to an individual patient to help th on understand and cooperate with measures or plans that are specifically for her. More often than not information is linked to instruction to the patient to take a certain action. In this next example Louise delivers information and

instruction to a patient on a diagnostic test she is to undergo. She says,

> "Mrs. XXX, Dr. OOO wants you to have a mild laxative for your test tomorrow." The patient replies "Is that the one where they give you that sweet stuff?" Louise responds "No .... If your bowels move let the girls see it - don't flush it." (Louise, 28/03/90)

In summary, information giving is a frequent teaching practice of nurses which is used to orient patients to the general routines and policies of the hospital and to their own course of therapy. The purpose of information giving is to guide the patient in proper conduct in the hospital and to enlist cooperation in medical work directed specifically at the individual.

Physicians, too, are frequent recipients of information from nurses, given face-to-face, over the phone and via various documents. An example of the latter is the textual device my nurse participants called "The Problem List". This list was constructed once a day, on scrap paper, usually by the night nurse in the early hours of the morning, and modified or constructed anew throughout the ensuing hours as old "problems" were solved and new ones identified. It was placed over a spindle in a prominent place on the desk in the Nursing Station, where house staff coming on to the ward would see it. An example of one such scrap of paper is shown in Figure 3. I copied this list in the course of observing the work of Barb (22/01/90).

Team A	Team B	Team C
Rm.AAA - d/c tube? Rm. DDD(2) - PT/PTT? Rm. FFF(3) - wants to see Dr. KKK ? R/O Colace, Senekot (no BM since OR)	Rm. GGG(1) - reassess K+ in TPN restart IV Rm, LLL(3) - R/A NTP vomited 500cc, leave IV in?	Rm. WWW(2) - reassess Fleet? [enema] K+ is 5.4 Morphine 15mg. Rm. WWW(4) - R/O TPN T. 39 ? melena R. ZZZ(1) - ? calories for diabetic diet

Figure 3. A typical problem list.

This example tells physicians on three separate teams about patients located in various rooms. It is a mixture of both information and questions that nurses have about patients. For example, in the instance of the patient in Room FFF, Bed 3, a nurse, most likely the team leader, informs the physician that this patient wants to see the attending physician who is in charge of her medical care. In addition she asks the physician, "Do you want to re-order ("R/O") either Colace, or Senekot [laxatives]?", and informs him that the patient has not had a bowel movement since her operation. The Problem List thus informs the physicians about the condition of his patients and also suggests the action that he might take. Nurses give physician information on the assumption that they will attend to it, that is, that they will act on the concern, or need, that lies behind it. Through the information provided, nurses instruct physicians, "This is your work."

Providing instructions. Nurses instruct patients and inexperienced health care workers. Instructions are a request to work specifically in the way directed by the nurse.

Where patients are concerned, nurses instruct in terms that are clear and unequivocal in their intent because they often involve patients in work on their own bodies that produces discomfort. Instructions are often combined with encouragement, admonitions to work, and feedback on work that is done, in recognition that it is hard to do. Nurses can appear as severe task masters in giving instructions to patients, as in the following examples.

> Laura is looking after a male patient who had his operation the day before. He sits in an armchair as she makes his bed. This task done she turns to him and says, "We're going to go for a walk in the hall. Stand up and keep your eyes open." She drapes his housecoat around his shoulders, placing one arm through the sleeve and securing the belt. She tells him to hold onto the IV pole and walk straight ahead. This he does with Laura guiding him from the back, her hands at his waist. They walk down the hall, almost as a single unit, Laura's arm around his back, her hand looped through the belt of his robe as if to catch him should he become weak and start to fall. After about 15 feet she removes her hand from his belt and links arms with him. (Laura, 22/03/90)

A second example shows Susan helping a newly post-operative patient return to bed after a period of time sitting in an armchair. She says,

> "Just walk to the head of the bed, then turn and face me." The patient does this. "Now, sit on the edge of the bed." The patient does so in a tentative fashion and starts to slip off the bed. "No", says Susan, "sit way back." The patient

> starts to do this then starts to fall on his side in an effort to bring his feet off the floor and on to the bed. Susan tells him not to do it that way but to bring one leg up at a time, blowing out through his mouth as he does so. She explains that this will put less strain on his incision. He does this quite smoothly. (Susan, 21/02/90)

In each of these examples, where a post-operative patient is walking on the first day after surgery, nurses are exquisitely clear about what he patient is to do. The patient appears to have no choice in the matter but to follow the directions of the nurse. These example are instances of teaching practices to accomplish the participation of patients in the work processes of recovery. There is no negotiation between nurse and patient as to what is permitted in the way of activity.

Instructions to physicians are usually couched in more oblique terms, giving the impression that the nurse is making a suggestion. Laura, for example, irrigated the infected wound of a patient and then immediately called the clinical clerk to inform him of the condition of the wound and to tell him that, in her opinion, it would have to be opened up and drained (22/03/90).

Often the sequence of the communication between nurse and patient follows the pattern of question-information-instruction, the nurse responding to the patient on the basis of her response to the nurse's question. The following is an example.

> Jill speaks to a patient who we know has had a very rough night with shortness of breath due to

> her terminal lung cancer. Jill asks her "How are you doing?" The patient replies "Better." Jill continues, "We won't be expecting too much of you today, dear, Just lie back and relax." The patient nods. Jill asks another question, "How's the pain level? The patient again, "Not bad." Jill goes on, "We heard in report that they held your Morphine during the night. You let me know if the pain gets bad." (Jill, 27/11/89)

In summary, instructions, even when combined with other forms of exchange, are directions to work in a particular way. They are transmitted in ways that respect the relation between the nurse and the patient, or physician, but nonetheless they are calls to act in ways judged appropriate or necessary by the nurse, and which will accomplish the care or treatment of the patient.

Setting expectations. Nurses have expectations for the work that patients will do, particularly concerning ambulation post-operatively but also about what constitutes adequate food and fluid intake. They communicate these expectations to the patients. Expectations, however, vary with the condition and long-term outlook for the patient. Patients who are elderly, or dying or are encumbered with various tubes have different expectations set for them than do young and basically healthy patients. Thus Jill, in the example given above, declares to a patient who she knows is terminally ill "We won't be expecting too much of you today." Barb is equally forthright but in the opposite direction, with a patient who has had an elective gallbladder removal. This is how it went.

> Barb and I [FG] are checking that patients have their breakfast trays. We return to Room DDD to see if the patients have received them and if they can manage them. At Bed 4 Barb asks the patient who is sitting in a chair some distance from her tray, "Is that your breakfast?" The patient replies that she wants to return to bed to eat. Barb says, "OK, but I don't want you sleeping all day." (Barb, 24/01/90)

Laura, too, makes it clear, despite various physical complaints of the patient, that she and the patient will walk in the hall.

> Laura crosses the hall to check on the IV of the elderly woman in Room BBB. She picks up a cup of ginger ale and suggests that the patient take a few sips. This she does. She then asks the patient "Are you nauseated?" The patient say she is, and Laura adds "Other than that what else is wrong?" The patient complains of double vision and a sore head. She says that perhaps she will get up in a little while and sit in the chair but doesn't know whether she will take a walk today. Laura says that yesterday she walked to the Nurses' Desk and tells her, "We'll walk at least as far as that today." (Laura, 22/03/90)

Statements such as these declare to patients the behaviours nurses expect to see them display. Like instructions, statements that convey expectations to patients are explicit attempts to secure their participation in work that patents may not want to do but that nurses judge to be necessary to their recovery.

Demonstrating correct performance. As I have shown in several examples in previous pages the correct performance of an activity by a patient is frequently the topic of educative work by nurses. Nurses provide clear instructions to patients to produce correct performance. This is

especially so where post-operative coughing and ambulation are concerned.

Nurses sometimes model the activity they wish patients to attempt. This is particularly the case with deep breathing and coughing where the patient's failure to adequately expand the lungs and clear the bronchial tree of secretions after surgery could lead to pneumonia. A demonstration of deep breathing and coughing was included in several instances of pre-operative teaching that I witnessed. Anna includes a demonstration of correct technique in her pre-operative teaching which she performs after first taking a blood specimen from this patient.

> Anna sits down on the bed beside this patient, a woman who will have a mastectomy the following morning. She first obtains the consent for the operation, making sure that the patient understands that she has the right to specify which surgeons may perform the operation. This the patient did, specifying the attending surgeon, "The others can assist," she says. Anna then proceeds to the teaching, not using the flipchart or any other aid, but covering all the usual points. She stresses two things to this patient, deep breathing and coughing, and the fact that, after the operation, she will have quite large amounts of blood in her Hemovac drain because she is taking an anticoagulant. Anna practices deep breathing with the patient, taking a deep breath and expiring slowly in concert with the patient. She does this three times and afterwards describes the similarity between this breathing and that which the patient may have practised in childbirth with the daughter who sits beside her mother's bed. (Anna, 25/02/90)

In summary, nurses educate patients and inexperienced hospital staff to their work responsibilities through a variety of teaching practices which are embedded in routine

work processes. In this first section of Chapter Three, I have displayed six types of teaching: asking questions; offering explanations; giving information; providing instructions; setting expectations; and demonstrating correct performance. While I have described each separately in order to bring into view the kinds of interactions that constitute teaching, in practice, as has been clear in several excerpts, several types of teaching often go on simultaneously, and often occur in the course of other aspects of nursing work.

As I pointed out in Chapter One, the first disjuncture underpinning this thesis is that much educative work is invisible to nurses. Thus, my first task has been to bring a range of educative work into view. In describing nurses' educative practices I have implemented the first procedure of institutional ethnography, to examine the everyday work world to see what it is that people do and to see how their work is organized by and maintains the institutional process. But the analysis must go beyond this. How is it that the work is invisible? We begin to explore this question by seeing first, how the teaching work is central to getting all sorts of interrelated work processes done in the everyday life of the hospital; I claim that it is teaching work which produces the functioning hospital. Second, we will see how this very routine and necessary character renders the work invisible to those who perform

it. As a final piece of the argument in this chapter, I will explore the character of work that women ordinarily do and point to what analysts have said about what makes women's work invisible.

Producing the Functioning Hospital

With the exception of pre-operative teaching which is a work process in itself, teaching always takes place in the context of other work. A typical example is Nursing Rounds. The nursing rounds that follow the twice daily change-of-shift report are the occasion for considerable teaching by nurses. In what follows I describe nursing rounds and two work processes that intersect with nursing rounds, diagnosis and discharge, to locate nurses' teaching work within all three.

Nursing rounds follow a pattern. A team of 3 or 4 nurses, headed by an RN known as the Team Leader, visits each patient in turn. The Team Leader greets the patient with a "Hi! How are you? How was your night?". This general greeting is quickly followed by specific questions, for example, "How is your pain?", or "Are you nauseated this morning?", or "Have your bowels moved?". Once the answers to these questions are obtained, and, if necessary, responded to ("We'll get you something for the pain."), information and instruction is given to the patient about the day. For example, the Team Leader might tell a patient

"You're going for a gallbladder test at 10 o'clock this morning, so nothing to eat or drink for breakfast, OK?", or "Dr. Smith will be in later to see you. Let us know if he says you can go home". Sometimes instructions are given to the patient: "Please don't raise your arm above your head like that. The IV slows down", or "We need a 24 hour urine specimen. Could you save your pee and put it in the big bottle in the bathroom?".

Each of these utterances of the Team Leader, each question, instruction, or piece of information that she gives a patient is part of a work process concerning, for example, the relief of pain and nausea, or the administration of IV medications. In each instance the work process stretches both backwards and forwards in time from the moment of talk between her and the patient.

For example, the comments of the Team Leader about the gallbladder test are a moment in the work process of diagnosis. The Team Leader knows the patient she instructs will have this test because she has learned of it in the change of shift report; the physician has booked the test with the X-Ray department which has notified the ward of the time (10am) and the state the patient must be in (fasting). This information has been entered by the ward clerk into the patient card file which, in turn, is used by the night nurse to construct the report. The Team Leader, and all other nurses on the team, note this and similar information on

their worksheets as they listen to report. As they make rounds they are able to inform patients of these upcoming events. It is likely that this patient had been told by her doctor at the time of admission "It looks like you might have gallstones so we'll do some tests on your gallbladder". From the Team Leader the patient receives specific information and instruction, "Your gallbladder test is at 10am today. Please don't eat or drink anything for breakfast". This enables the patient to be available to go to the X-Ray department when the porter arrives and to be in the proper physical state for the test to be performed. The talk of the Team Leader during rounds is thus part of the teaching that allows the diagnosis of this woman's gallbladder disease to take place, and in a timely fashion.

The discharge of a patient initiates another work process which again can be taken up in the talk of the Team Leader. She asks to be informed by the patient if her physician decides to discharge her. The Team Leader knows this is a possibility because of information she has been given in report. The night nurse has indicated that this patient is five days post-surgery, her temperature is normal, she is eating and drinking a regular diet and is "up and around". Knowledgeable surgical nurses recognize this information as the description of a patient sufficiently recovered to go home.

The discharge of a patient, however, involves a complex documentary work process that concerns the Team Leader because she must verify that it has been completed. This work process requires that the physician write the discharge order in the chart, complete a brief summary of the patient's progress to be given by the patient to her family doctor, possibly fill out a prescription for medication, and indicate whether he wishes to see the patient for a check-up in his office in a number of weeks. The Team Leader can only "sign-off" the chart when all this documentary work is done. The message from the patient, "Dr. Brown was just in to see me and he says I can go home today", perhaps delivered directly to the Team Leader, or to a nurse encountered in the hall, will set in motion the documentary process that accomplishes the discharge of this patient. If the physician has not done so the Team Leader will telephone him and request that the proper documentation of the patient's discharge be done. But it does not stop there. The Team Leader will speak to the ward clerk to inform her of this impending discharge; she, in turn, will notify the Admitting Office of this event and the consequent availability of an empty bed for a new patient.

These two examples show the contribution of nurses' teaching work to the accomplishment of two common work processes, diagnosis and discharge. Two other work processes in which nurses play a pivotal part are the

admission of patients to hospital, and the preparation of patients for therapeutic procedures which take place either on or off the ward. In displaying how teaching work contributes to the achievement of diagnosis and discharge (and other work processes) I fulfilled the second directive of institutional ethnography: examine the intersection and coordination of work processes to determine in what ways the institutional process is produced. This involves showing, as I have done, how the work of many people, often not known to one another and also distant from one another, produces institutional processes.

Nurses teach patients and health care workers to do the body and organizational work that ensures hospital work processes go forward to completion. Nurses' teaching work is essential to the orderly accomplishment of hospital work. In Lewis Thomas's terms (see page 54), it is the glue that keeps the hospital work organization together and functioning smoothly. This is a key claim of this dissertation - the teaching work that nurses do actually accomplishes hospital work. Thus, to this point, not only have I identified it as educative work, but I have argued that the result of this educative work is the orderly accomplishment of institutional processes in the hospital. Further, this teaching work is skilled work. Nurses' teaching work is skilled work that depends on the knowledge of nurses about the organization of work in the hospital.

Yet as I argued in Chapter One, this work of teaching was not initially visible to me or the nurses as important teaching work. How can work processes central to the organizational process be invisible? How can such skilled and knowledgeable work be invisible? Why do nurses not "see" the teaching work they do? The answer to this question, as Smith (1987) reminds us, is that the social relations organizing our experience are not fully visible in our immediate situation. We must look beyond it to understand what practices and processes organize it. She says, "There are social relations that are not encompassed by the setting .... but they nevertheless enter in and organize it" (p. 155). To begin to reveal the social relations organizing invisibility in nurses' teaching work I turn first to feminist analyses of work.

Feminist Analyses of Work

Within the last fifteen years social anthropologists (Wallman, 1979; Wadel, 1979) and feminist scholars (Armstrong & Armstrong, 1984, 1990; Armstrong, Choiniere, & Day, 1993; Daniels, 1987; DeVault, 1984; Eichler, 1983; Fudge & McDermott, 1991; Gaskell & McLaren, 1991; Jackson, 1991; Luxton, 1980; Margolis, 1979; Smith, 1987; Tilly & Scott, 1978) have produced analyses of work and the work that women ordinarily do. These studies help to reveal two features of nurses' hidden teaching work. The first feature

is that this work is typical of women's unpaid and paid work. It is typical of the unpaid work women do as housewives in families[25] (DeVault, 1984; Eichler, 1983), and as volunteers in political organizations (Margolis, 1979). It is also typical of the paid work of secretaries, technicians, computer operators, etc., whose work makes possible the work of other people. The second feature is that nurses doing teaching work share with women doing political and household work a perception that what they are doing does not really count as work.

Wadel (1979), in a paper called The hidden work of everyday life, points to the narrow idea of work held by economists, and also present in folk concepts of work, that work is an activity that one is paid to do. He argues for a definition of work that takes into account the work of everyday life. He argues also for recognition of the fact that social institutions, such as the family, are produced

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[25] Eichler (1983) describes three separate functions of housework: housekeeping, childcare and personal services. The personal service function most closely resembles the teaching work of nurses. She describes this function as including:

> personal maintenence work such as doing the laundry for an adult who is mentally and physically fit to do so himself or herself; rendering emotional support such as listening to problems, by stroking, etc.; organizational work such as reminding others of dates and duties, making appointments and reservations, entertaining (provided it is done for the sake of the other person rather than for one's own sake), etc. (p. 144).

through the work of persons, and that this work often goes unrecognized as work, even by those who do it. In this regard he says:

> Concretely, we should ask in each case what work (activities and effort) is necessary for the creation/ maintenance/ change of an institution? I think we may find various kinds of work that are overlooked by both layman and economists alike. The importance of the exercise is that it opens the possibility of demonstrating that whereas activities which, when considered in isolation may appear "trivial" (even to the person who carries them out) and not merit the label work, when aggregated and considered in relation to formal work do constitute a prerequisite of effective institutional arrangements. (Wadel, 1979, p. 372)

Daniels (1987) makes the same point as Wadel concerning the work involved in producing social institutions when she says that "the social fabric of life is constructed" (p. 408). She argues that it is women who are expected, or who are assumed to have the ability, to produce the "fabric of life". The reason for this assumption, she contends, is the nature of the work needed to produce everyday life and the belief that women have a natural talent for it. This point is evident in the following quote.

> The closer the work to the activities of nurturing, comforting, encouraging, or facilitating interaction, the more closely associated it is with women's "natural" or "feminine" proclivities. Such activity is not seen as learned, skilled, required, but only the expression of the character or style of women in general. (Daniels, 1987, p. 408)

Another point that Daniels makes through this quote is that the activities of "nurturing, comforting, encouraging, or facilitating interaction" are not understood as learned,

or skilled,[26] and therefore, in some way, acquired, but as intuitive, or inborn, to women.

Like Wadel, Daniels also suggests that the work that people do to construct social life may not be thought of as work. Margolis (1979) and DeVault (1984) note the same thing in their studies of the work of women. Margolis (1979) describes the amount and range of work done by women

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[26] Issues of skill and the work of women have concerned feminist scholars for some time. Barrett (1980) argues that "Women have frequently failed to establish recognition of the skills required by their work, and have consequently been in a weak bargaining position ...." (p. 166). Phillips and Taylor (1980) note that the definition of skilled work is "saturated with sexual bias". They say,

> The classification of women's jobs as unskilled and men's jobs as skilled or semi-skilled frequently bears little relation to the actual amount of training or ability required for them .... The work of women is often deemed inferior simply because it is women who do it. Women workers carry into the workplace their status as subordinate individuals and this comes to define the work they do. (p. 79)

Like these authors Gaskell (1991) argues for the social construction of skill. She says,

> Women's skills have often been considerd part of their femaleness, and therefore not to be counted. Being polite and helpful and 'attractive' in particular ways are learned, but considered personality, not skill. Many of the things that women do at work tend to be taken for granted in this way, and not seen as skills. (p. 142)

Jackson (1991) speaks to the essence of the issue surrounding skill and work when she says, " .... the relevant question to ask is not which workers have skills, but which skills get selected for recognition and reward and which do not" (p. 19). I will have more to say in Chapter Four about the link between the visibility of nurses' educative work and skill definition.

members of a political organization. This includes making schedules, sending out flyers, phoning to urge people to come to meetings, arranging meeting halls, preparing refreshments. She comments on the fact that this work was not seen as important by the women who did it even though it was essential to the success of the political campaign.

DeVault (1984) describes the activities of housewives in feeding their families. Included in these activities were planning, restocking, improvising and adapting to family quirks and demands. She reports that the women she interviewed did not report these activities as work, that the work character was invisible to them. The invisibility of this work seemed to be tied to the fact that much of it was mental work, and therefore hidden from view, but also that it was regarded as being done out of love for family members.

Smith (1987) provides a related analysis of the work that women customarily do. She argues that in many kinds of paid and unpaid work, women do the working-up, shaping-up, background work that makes the work of other persons, especially men, possible. Smith (1987) describes this work as giving concrete form to conceptual activities. She says,

> They do the clerical work, giving material form to the words or thoughts of the boss. They do the routine computer work, the interviewing for the survey, the nursing, the secretarial work. At almost every point women mediate for men the relation between the conceptual mode of action and the actual concrete forms on which it depends. Women's work is interposed between the abstracted

> modes and the local and particular actualities in which they are necessarily anchored. Also, women's work conceals from men acting in the abstract mode just this anchorage. (pp. 83-84)

All of these analyses provide assistance both in characterizing the teaching work of nurses as typical of women's work, and in revealing the invisibility to nurses of teaching work as real work. Wadel and Daniels make the point that the social fabric of institutions is constructed by persons doing things that, individually, often seem unimportant but, when added together, are significant for the overall function of the institution. Nurses' questions or explanations to patients or physicians often appear trivial when considered on their own but, as I have shown in relation to the work of diagnosis and discharge, such practices are important in the achievement of the hospital as a smoothly functioning workplace. They produce the social fabric of the hospital.

The work that Margolis describes women doing in political organizations, and that DeVault describes women doing in their families, resembles the work that nurses do in the hospital. It is the work of maintaining the "institution" (Margolis, 1979, p. 323). Nurses' teaching practices maintain the "hospital", as an institution like the family, or the political party, an organization of social beings acting purposefully together. Nurses' teaching work produces the everyday life of the hospital. Their questions, explanations, instructions and expectations

are essential in continuously making the work processes of diagnosis, treatment and recovery go forward.

Nurses' teaching work is also of the order that Smith describes as background work. It is a part of what brings into being physicians' work of diagnosis and treatment, and in a way that conceals from physicians the practical effort involved therein. Using the gallbladder test once again as an example, one sees that a nurse's teaching practices mediates, in part, the relation between the conceptual work of the physician to determine what is amiss with the patient and the concrete activities that are the diagnostic procedure. The "background" work in this example is the nurse's instruction to the patient to be available at the appointed hour for the test, and to remain fasting.

Margolis and DeVault, while claiming that the work of producing everyday life remains invisible as work to the women who do it, and to others (Daniels, 1987), do not provide an analysis of how or why this is the case, other than to claim it is in the nature of the work. A more useful analysis is to understand these work processes as typical of "family" work processes occurring in the "private" domain of social life. In this regard Margolis (1979) notes the following:

> With only minor transformations, the roles the Fairtown men and women were playing on their Town Committees were the same ones men and women play in households. Men are thought to be the "heads" of their families; and men were the chairpersons of the Town Committees. Men have specific and

> narrow functions in the family-primarily to provide its income and sometimes to act as its public spokesperson. So, too, on the Town Committees they did only what was specifically required of them. Women, on the other hand, handle the day-to-day maintenance of the household, performing a plethora of tasks, some precisely defined such as preparing food, but many amorphous, such as bonding the nuclear family to others through social contacts. Similarly, on the Town Committees all the regular, official maintenance-type functions and also all tasks which could not be specifically defined fell to women. Another role women played in both the family and the Town Committees was that of standby. They were there to step in whenever a man failed to accomplish his appointed task. (p. 322)

Within sociology the family has been viewed as existing in what sociologists term the "private" realm of social life. Until the advent of feminist scholarship the private realm was not thought either important for sociologists to investigate nor a domain of work. It was regarded as the sphere of women and of activity that was the expression of natural instinct rather than skill. The paid work of women, such as nurses' teaching work, as well as the unpaid work that women do, for example volunteer work and the work of managing the household, has the character of work in the private realm of family life. In part, this character accounts for why women do not view this work as work.

Summary

In this chapter I have taken up the first disjuncture in the teaching work of nurses. This is the disjuncture between nurses' reports of the scope and amount of their

teaching work, and the actual teaching work they do. Nurses reported to me at the beginning of the study that they did very little teaching work. They told me that pre-operative teaching was the major teaching work they did. However I observed them doing extensive amounts of teaching in the course of routine work processes. I observed them teaching throughout the day and night, and I saw them teaching both patients and inexperienced health care workers, particularly physicians. In this chapter I have given examples of six different practices that I observed nurses using in their teaching work: asking questions; offering explanations; giving information; providing instructions; setting expectations; and demonstrating correct performance. I have shown that nurses' teaching work accomplishes something central in the hospital; it orients patients and inexperienced physicians to tasks that must be done if the work of the hospital is to go forward. I have supported this claim by showing the place of nurses' teaching work in accomplishing the work processes of diagnosis and discharge.

The teaching work of nurses is fundamental to the ongoing operation of the hospital yet this teaching work is largely invisible to nurses. In the final section of the chapter I have argued that one reason for this invisibility is that teaching work is women's work. Just as in other institutional sites, the work women do in maintaining the ongoing practices of the institution is invisible. As

women's work the things that get done are simple tasks, routine tasks, seen as caring, or as nurturing, seen as so natural to women's character that they are not regarded as work at all. A feminist analysis of teaching work brings into view those features of the work that render it invisible as work, and as skilled work.

Nurses' teaching work is women's work. Applying a feminist analysis to nurses' teaching work helps to reveal how the invisibility of much of this work is constructed. The educative practices that are embedded in routine nursing work, such as encouraging patients to eat or reminding physicians about hospital regulations, are similar to the kinds of women's work other authors have seen as "invisible". Applying a feminist analysis begins but does not complete the full explication of the social organization of this work. Teaching work is women's work but it is also professional work; it is done by workers drawing from a specialized body of knowledge shaped by aspirations of professional status. Furthermore, teaching is managed work; nurses' teaching work is carried out in relation to managerial concerns about the efficiency of nursing work, the quality of nursing care, and patient and institutional safety. And finally teaching is gendered work; nurses teach within a medical division of labour organized along gender lines. Each of these features of nurses' teaching work, its professional character, its managed and gendered character,

require explication if the social organization of this work is to be fully revealed. This is the task of the following three chapters beginning in Chapter Four with an explication of the professional character of nurses' educative work.

Chapter Four

Professional Relations and Teaching

Introduction

Applying a feminist analysis to nurses' educative work reveals those features of the work that make portions of it invisible. The educative work that is embedded in work processes such as surgical dressing changes or rounds appears as simple, routine and unskilled. Applying a feminist analysis, however, is only a beginning; there is more to be discovered about the social organization of educative work and especially the construction of invisibility.

The nurses whose work I studied told me that pre-operative teaching was their major teaching work. This seems at first glance an obvious thing for them to say, and not requiring comment. They were, after all, surgical nurses; one would expect them to report, for example, that showing a pre-surgical patient how to cough properly is teaching work. Yet failing to ask the question, "How do nurses know what is, and what is not, teaching?" is to ignore essential social structures framing teaching work.

One aspect of this social structuring is the discourse of teaching[27] within which nurses learn and practice teaching.

The women whose work I observed were surgical nurses. They were trained in programs preparing professional nurses to understand teaching work through a discourse that defines, in a broad sense, what teaching is about, why it is done, to what ends and by what means. Moreover they worked on a daily basis within this discourse. Metaphorically speaking, it was there waiting for them when they went to work, in the concepts and terms that were available to them to describe and account for their teaching work. Empirically, however, it could be discovered in the texts and articles from periodicals on the theory and practice of teaching composed by nurses over the past twenty-five to thirty years.

In what follows I argue that a substantial amount of teaching remains invisible to nurses because it lies beyond the boundaries of what they are trained to see as teaching. I became aware of those boundaries when I, myself, began to "see" teaching differently. For me this was a matter of

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[27] As I first described in Chapter Two, a discourse is like a conversation among persons on a particular matter. It is about the "concepts, methods, relevances, and topics" (Smith, 1987, p. 61) of the matter and goes forward in and through text; in Smith's words it is a "conversation mediated by texts" (1991, p. 159). The discourse of teaching is about the nature, purposes and methods of teaching in nursing practice, the conditions under which it occurs, the persons involved, impediments and facilitators to teaching.

stepping beyond the margins of what I, as a nurse, "knew" to be teaching. It was also a matter of taking seriously, as teaching work, the talk and actions of nurses to influence patients and physicians to participate in hospital work processes. In this chapter I show how the current discourse of teaching in nursing shapes nurses' views of teaching work. In my analysis I use articles from nursing periodicals and nursing texts, especially the work of B.K. Redman who has been writing on the topic of patient teaching in nursing since 1968. There are two parts to my analysis: the first part is about how nursing discourse portrays the content or subject matter of teaching; the second part is about how discourse portrays the process of teaching.

The Subject Matter of Teaching

When I asked my nurse participants "What is teaching?" their replies revealed an understanding of the purposes of teaching that is consistent with the current discourse. As these nurses view it, teaching is always about some aspect of the patient's illness or recovery, and its purpose is to help the sick person manage, or cope, with whatever confronts them by adding to their knowledge of the problem. Thus Judy said:

> I think teaching basically involves anything that you can tell the person about their condition, anything about their medication, anything about a test being done .... anything about surgery. Just

> something that they are not knowledgeable about already. I think that is what teaching involves. (Judy, 16/12/89)

In this quote Judy implies that teaching is adding to patients' knowledge about their disease and treatment. In the next quote Barb suggests that it is helping patients to learn the skills needed to look after themselves when they leave the hospital. She said:

> The first thing in my mind is helping them deal with their current situation, their current illness, helping them with their ostomy .... learning to manage post-operatively, learning to manage a new tube that some of them go home with, their T-tube. That is the real focus of priority. (Barb, 11/01/90)

The same is evident in the following comment by Jill:

> I think anytime I relay information to them, about their test, or their own condition, it is making them more aware. I consider that teaching. Not that everybody would, but I have just more or less been brought up that way in my own teaching [her own nursing education] to consider it as teaching. (Jill, 11/12/89)

From the earliest days of the profession the purpose of teaching, as expressed in nursing texts that refer to teaching, has been to modify the behaviour of persons so that they may achieve a more healthy state. Over the years there have been subtle shifts in emphasis within the texts with respect to the precise objectives of teaching. These shifts reflect changes in illness patterns within populations from infectious to chronic illness, an ever decreasing length of patient stay in hospital, as well as a shift in emphasis within the nurse-patient relationship away

from authoritarianism (Pohl, 1968; Streeter, 1953) to partnership (Smith, C.E. 1989; Zander, Bower, Foster, Towson, Wermuth, & Woldrum, 1978). Despite these shifts, securing the cooperation and compliance of the patient with the medical plan of care and the assumption of self-care and independence from professional caregivers remain the key purposes for teaching by hospital nurses (Cramer & Spilker, 1991; DiMatteo & DiNicola, 1982; Gerber & Nehemkis, 1986). This is as true in 1994 as it was twenty years ago. For example, in 1973 Pohl, in her book The teaching function of the nursing practitioner, wrote that the subject matter of teaching was content related to the patient's health status including the current illness, convalescence, and the prevention of illness and the promotion of health. She said about recovery,

> The primary task for convalescent patients is to give up their dependency on the nurse and to assume responsibility for themselves .... Teaching directed toward self-care and the prevention of further illness may help the patient to assume increasing responsibility for himself [sic] .... The teaching at this time is primarily concerned with interpreting the doctor's plans for continuing therapy and making it clear to the patient how he may be able to avoid a recurrence of this illness and maintain good health. (p. 63)

Twenty years later in 1993 Redman said much the same thing about the goals of teaching patients:

> Every person who receives health care has some need to learn. Major objectives of teaching are often classified by phases of health care .... During the phase of diagnosis and treatment, patients and their families learn about the disease, the need for care and treatment, and the

> hospital or clinic environment. During the follow-through phase, they need to understand care at home, including medications and diet, activity, continuing rehabilitation, and prevention of recurrence or complications. (p. 5)

Within the last twenty years patient independence from professional help has also become an impetus to teaching. In the early 1970s compliance with the medical treatment plan remained the chief reason for the nurse to teach (Storlie, 1975), but there was a growing awareness that teaching must prepare the patient and family to function independently when they leave the hospital. Palm (1971) wrote,

> The rising incidence of chronic and long-term diseases requires that patients have an understanding of their conditions and treatments. Understanding by patients can lead to increased cooperation with the therapeutic regimen and may enable them to solve problems when meeting new situations outside the hospital, thereby increasing independence. Patient teaching can facilitate the individual's adaptive response to disease. For such teaching to occur, it must be considered important by staff nurses in direct contact with patients. (p. 669)

Redman (1971) also called for nurses to prepare patients for independent functioning through teaching. She wrote, "The complexities of health care today and the necessity of the initiation, participation, and independent functioning of patients over long periods of time require an educational function in nursing" (p. 573).

Teaching for patient and family "independence" has remained the major focus of the teaching discourse for the past two decades. Teaching for independence is inherent in

Louise's ideas of teaching described above when she says "Like, teaching is given to patients so they can help themselves" (Louise, 11/6/90) and in Barb's comment that she teaches so that patients will be able to manage drainage tubes when they leave the hospital (Barb, 11/01/90). As first mentioned above this focus recognizes the fact that most persons now enter hospital not for treatment of an infectious illness, such as tuberculosis, but for a chronic illness, such as diabetes or heart disease. Chronic illnesses are lifelong; patients must be persuaded and educated to the task of looking after themselves after they leave hospital. Teaching for so-called independence is teaching for self-management of chronic illness.[28]

The responses of my nurse participants reflect the conceptualization of the subject matter of teaching found in the discourse: nurses teach about the practical matters of illness management in order to promote self-care and independence. But there are two central gaps, or absences, both in the responses of these nurses about their teaching work, and in the actual discourse itself. Absent from their view of teaching work, and from the discourse, is the work

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[28] Across Canada, in 1994, hospital closures and bed closures within hospitals, suggest that hospitalization of the sick, if it occurs at all, will be brief. Patient self-care following hospitalization, or care by family members or other lay caregivers, is likely to take place earlier within an illness course, and with greater recognition by government of the role such care plays within the total health care system.

of teaching for participation in hospital work processes, and the work of teaching physicians that I described in the preceding chapter.

To consider the first of these absences: nurses don't "see" as teaching the educative practices that maintain the hospital as an institution and that produce the everyday life of the hospital. This work seems trivial to them, and not especially significant when compared to work directly related to the patient's reason for being in hospital. This became evident to me when, during the second round of interviews with my nurse participants, I asked them to examine and identify as teaching work the eight instances of teaching embedded in nursing routines shown in Appendix D. While seven of the eight instances included references to some feature of the patient's illness or treatment, and were variously identified as instances of teaching, one instance was uniformly rejected as an instance of teaching. In this instance the nurse is helping a group of patients to settle for the night in a nursing routine called "Evening Care". The nurse gives a back rub to patients who want it, straightens bed linen and offers a drink to patients. She tells each patient in turn as she leaves them for the next patient, "Be sure to call us if you want anything. We'll [the night-shift nurses] be around every hour through the night." The reply given by Louise (11/6/90) to the question

"Is this teaching?" illustrates my point that nurses do not "see" the teaching work they do.

> Louise: Really, that's not teaching. I consider teaching ... teaching is done for the patients to assist in their own care in the hospital. This is just saying "Look, if there is anything you need just call me." It is not really teaching. It's just information given to the patient as part of the routine of the hospital, to make them more comfortable. But I don't consider it teaching.
>
> FG: So information about the nursing routines, or the hospital routines doesn't qualify for you?
>
> Louise: Not in my opinion of teaching. I think it is part of the nurses' job to make the patient comfortable. But I don't think it is teaching. Like teaching is given to the patient so they can help themselves. This here, to me, is something that is just done whether you are a cashier, or you are a clerk at Zellers, or you are a nurse. But the other stuff is important things, particularly to nursing and medicine, that will help the patient.

Marie (15/6/90) says much the same thing as Louise about this example and about the teaching for participation in hospital routines that nurses do on the morning rounds after change of shift report.

> Marie: No, I wouldn't consider that teaching. That is just easing a patient's mind and settling them, and making them feel comfortable for the night. But I don't consider that teaching.
>
> FG: OK ... now I think the thing that is common about a lot of these examples is that, for me, they tell the patient something about the hospital routine and how the patient can cooperate with the routine .... like if they eat and drink before a test then ....
>
> Marie: They can't go, no
>
> FG: So I put those in there to see whether you would see that by giving patients information about the routines of the

> hospital you are teaching and I am curious .... now that I have told you, how does it strike you?
>
> Marie: Yes .... I suppose it would be .... I don't know. I just think of it as so basic to the patient's needs that .... I just have never really looked at it. I have a lot to think about now! I guess you could consider it unstructured teaching.
>
> FG: OK, informal?
>
> Marie: Informal teaching .... yes.
>
> FG: Because a lot of it goes on Marie.
>
> Marie: Yes, you actually could.
>
> FG: When I go on "rounds" in the morning I see a lot of it happening and I am curious about whether you see it as teaching.
>
> Marie: Yes .... I can see that .... because for some of them [the patients] you do it, and these are the things you do, and you do it without even thinking .... like, it is a natural ...

Until I began to point to some of these activities as a kind of teaching, both Louise and Marie reject as teaching work instructing patients on how to behave in the hospital, whether in matters of securing nursing attention, or in participating in a diagnostic test. Their initial responses to these "instances" of teaching seem to suggest that such work is not teaching because it is the work of helping patients to feel comfortable in unfamiliar circumstances, or of nurturing them, but it is not specifically about their medical problem. Louise seems to imply that such work is not important when compared to the significance of teaching about medical matters. Marie suggests that it is "natural"

to do such work, as if any reasonable person would do the same, that such work does not rely on skill. The replies of these two nurses resonate with the idea that the work of making people feel at home in strange surroundings, of meeting their needs for comfort, work that Daniels (1987) identified as associated with the "talents" of women, is barely work at all.

In opposition to this view, I argue here that when nurses tell patients about the night-time routines of nurses, and how to gain their attention, they are teaching them the behaviour that is expected of patients. This seems trivial but it is not. When patients don't know how to use the call bell, or when they don't know that nurses make hourly visits to check on patients, they may attempt to get out of bed by crawling over the bed rails and fall, they may awaken other patients, they may inadvertantly dislodge a drainage tube or pull out an IV. None of these events are inconsequential for patients, nurses, or the hospital. Patients who know how to be patients maintain the ongoing work processes of the hospital.

It is important to note that teaching patients about hospital routines was once included in the discourse as part of what counted as teaching. In 1953 Virginia Streeter provided these reasons why hospital nurses teach patients, in her paper, The nurse's responsibility for teaching patients. She writes,

> Certain factors regarding health teaching can be assumed. To be most effective it must be regarded as having three equally important parts - prevention of disease, promotion of health, helping people adjust to the limitations imposed by disease. If teaching is effective it will help the patient understand (1) the hospital and its routines, (2) diagnostic examinations and therapeutic treatments, (3) preservation of health and prevention of disease, (4) disease conditions, (5) instructions about his [sic] care when he goes home, and (6) rehabilitation. (p. 819)

While it is not clear what instruction would fall into the category, "the hospital and its routines", the fact of its mention suggests nurses realized that patients needed to know about the organization of work in the hospital, that it was a recognized piece of their teaching, and that furthermore compliance of the patient to these routines was expected. The early discourse thus provides some evidence that work of the character that I claim is educative and necessary to the smooth running of the hospital was recognized as teaching.

This work disappears from the discourse of the late 1960s and 1970s. The reports of the 1960s concerning teaching by hospital nurses reveal that, like the 1950s, informing the patient with a view to securing their cooperation with the medical care plan was a paramount purpose of teaching. However the idea that the nurse orients the patient to the hospital routines has vanished

and does not appear again.[29] But the work itself does not vanish, as I showed in Chapter Three in describing the work processes of diagnosis and discharge.

The disappearance of this work in the discourse is evident in a 1965 survey by Pohl of 1500 American nurses for their views of the teaching function in nursing. She grouped her sample in the categories of private duty, general duty, public health, occupational health, or office nurse. She used as a definition of teaching "any activity by which the nurse helps her clients or co-workers to learn or understand the various aspects of health and illness" (Pohl, 1965, p. 5) and asked her subjects to complete a questionnaire about learners, teaching content and technique based on this definition. Respondents in the category of general duty nurse (today called staff nurse) reported that they taught sick and convalescent adults and their families, as well as RNs, practical nurses and nurse's aides, professional nursing students and clerks or secretaries. They taught about the causes, complications and prevention of illness, objectives of nursing care, treatments and procedures, diet in illness, attitudes toward health and

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[29] Redman indicates (see page 100) in the latest edition of her text, published in 1993, that a goal of teaching is for the patient to learn about the "hospital or clinic environment." This statement might appear to challenge my argument that teaching for participation in hospital work processes is now invisible within the discourse. However, the reference to the "hospital or clinic environment" in this introductory chapter represents one of the few references to such matters in the text.

illness, and maintenance of physical health. Co-workers were oriented to their work, taught "work techniques, how to get along with people, accident prevention, topics related to patients' illness, and the plan of nursing care for patients" (p. 9).

The absence from this lengthy list of the instruction of the patient in "the hospital and its routines", found in the discourse ten to fifteen years earlier, appears to herald a shift in thinking about teaching in nursing. I will have more to say about this shift in later parts of this chapter. Suffice to say at this point that in the mid to late 1960s teaching patients to participate in the everyday work of the hospital falls out of the discourse. A number of points can be made about its disappearance. Firstly, it exemplifies what Smith's critique of discourse reveals, that there is a separation between the work that is actually done by real people and how that work is known in the discourse. Nurses continue to do the work of orienting patients to hospital routines but this work has all but disappeared from view within nursing texts on teaching. Secondly, it speaks to the invisibility of the work that produces everyday life (Wadel, 1979) and that is usually done by women (Daniels, 1987). The invisible work that nurses do to secure the participation of patients and inexperienced health care workers in hospital work processes is work that produces the "fabric of hospital life", the

everyday life of the hospital. Thirdly, it points to the invisibility of this work to the very women who perform it (Devault, 1984; Margolis, 1979). Nurses, such as Marie and Louise, teach but until the educative character of their work is made explicit, they do not "see" this work as teaching.

In respect to the content of teaching, therefore, the first "absence" is the teaching about hospital routines. But implicit in the idea of "content" is who the students are. This leads to the second absence, the invisibility of one key group of "students". Absent in the responses of nurses to my question, "What is teaching?" is their work to teach physicians. The current discourse of teaching is also silent on the nurse as a teacher for the physician and other hospital staff (except see Note 30, below). The discourse of the 1950s and 1960s described the nurse as a teacher for patients, their family members, and co-workers but not physicians or nurse managers.[30] For example, Pohl (1973) is careful to describe who is, and who is not, the student for the nurse. She says,

> The use of this term will be limited to the co-workers for whom the practitioner has a teaching responsibility. This limitation of the

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[30] The literature of this and an earlier time did not differentiate between the teaching of patients and families, and persons whom the nurse supervised, such as nursing assistants and aides. Later work (1970 and beyond) focuses on the nurse as a teacher for patients and families, not other health workers. Yet experienced nurses continue to "teach" the inexperienced co-worker and student.

> term is necessary because many of the nurse's co-workers are professionally educated people who are thoroughly grounded in the principles and practices of good health and therefore have no need for the practitioner's teaching. .... The term will not be used here to mean physicians, professional workers in allied fields, or nurses who administer or supervise nursing services, since, although they are co-workers, the practitioner does not have a teaching responsibility for them. (p. 3)[31]

In the preceding chapter I displayed that nurses teach physicians on matters of patient care and the organization of work within the hospital, yet the teaching discourse says almost nothing of this work. The focus of teaching is the relationship between nurse and patient and the role of education as a mode of nursing intervention. This is evident in the titles of texts as, for example, The teaching function of the nursing practitioner (Pohl, 1973), The process of patient teaching in nursing (Redman, 1972), Patient teaching in nursing practice (Narrow, 1979), Teaching in nursing practice, A professional model (Whitman, Graham, Gleit and Boyd, 1986), Patient education: Issues, principles, practices (Rankin and Stallings, 1990), Patient education: A practical approach (Lorig, 1992). If physicians are discussed at all in such texts it is because they are

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[31] This same author, in the third edition of her book published in 1978, modifies the co-worker category to include those persons excluded ten years earlier, namely physicians and nurse managers. Pohl (1978) is one of very few authors (Leavell, 1955; Wylie, 1988) who recognize, even if in a limited way, a teaching role for nurses with physicians. But neither she, nor others, takes up the contradiction this presents for nurses, nor how they manage it. I will take this up in Chapter Six.

seen to limit in some way nurses' work to teach patients (see Pohl, 1973; Rankin & Stallings, 1990). Within a professional discourse of teaching where the focus is teaching as a therapeutic nursing intervention directed towards patients, there is no way to accommodate teaching physicians.

The historic relationship between medicine and nursing is one of subordination (Freidson, 1970). Nursing's professionalism (the development of a unique body of knowledge applied through the nurse-patient relationship) is, in part, an attempt to overcome this subordination by establishing itself as "separate from, but equal to medicine" (Rispel & Schneider, 1991, p. 111). With respect to teaching work this approach essentially ignores, or fails to recognize, that hospital work processes are entered into jointly by nurses, physicians and patients, and that, at any one time, any one of these workers may be more knowledgeable than others of the matter at hand, and may need to instruct them in order to get work done. The reality of what is actually occurring is obscured by a discourse which trains persons to "see" other than what they see, to see the nurse assisting, but not teaching, the physician. This is not to say that nurses are unaware of the fact that, in certain instances, they are more knowledgeable than physicians and give them information they need to do medical work, but they do not call this teaching work. This work is framed by

nurses as helpfulness or assistance to the physician. In Chapter Six I take up the matter of how nurses' knowledge appears other than what it is in their relationships with physicians.

To this point in the chapter I have argued that the current discourse of teaching contributes to the invisibility of teaching work in two different ways: first, the focus is teaching for health and illness behaviour change, to the exclusion of teaching for the performance of hospital work and participation in hospital routines and second, the focus of the current discourse is teaching patients and their families but not health care workers, especially physicians. Thus, in terms of what teaching is about, invisibility is structured in part through textual materials where nurses learn to name and conceptualize teaching.

But teaching is more than content. It is also conceptualized as process, as particular ways of acting. In the next section I take up the teaching process and show how the current perspective on teaching as a systematic process of health care instruction obscures much of the teaching work that nurses do.

The Process of Teaching

When I first asked nurses to participate in this study several of them told me, as I noted in Chapter One, that

nurses on Study Ward did very little teaching, that the majority of their teaching was pre-operative teaching. Yet, as I have indicated in Chapter Two, it became clear to me after embarking on field observation that the nurses I observed were teaching in the majority of their interactions with patients and inexperienced physicians, and, when I reported this assessment to individual participants, many agreed with me. They could "see" the teaching that they did when I probed in the interviews and reflected on my own observations.[32] As well when I asked participants to describe their teaching they reported an educative practice occurring in the context of their ongoing nursing work, and broader in scope than pre-operative teaching. For example Mary (20/12/89) responded to my question about the nature of her patient teaching practices by saying,

> I've never really thought about patient teaching, only pre-op teaching. But from doing this

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[32] It could be argued that the nurses "began to see" their "invisible" teaching work only because I "showed" it to them. When I sought the participation of these nurses in my study I was a nursing outsider and, as an academic, a member of the ruling elite of nursing. In telling me that the majority of their teaching work was pre-operative teaching these nurses, as surgical nurses, may have been telling me what they thought I expected to hear. As well, as I will show in Chapter Five, pre-operative teaching was an explicit form of teaching expected of them by nursing management. It was visible to them as a work process. In reporting pre-operative teaching as their major teaching work they were telling me of the work they were accountable for. When I became less of an outsider (by spending time with them, by helping them in small ways and by being present during the (undesirable) evening and weekend workshifts) and showed them that I valued their work, they spoke about it more openly.

> [participating in the study], and reading your [FG] notes you find out that you do a lot of teaching. Almost everything you say is for somebody's or someone's benefit. And especially when it comes to the patient, its something as simple as getting them up after surgery. There's a way to do it and there's another way which is the wrong way and it's going to hurt them. So you teach them how to get up, you teach them how to do anything .... if they have drains, if they have IV's .... it's an ongoing process.
>
> FG: So you see instances of you giving information to patients as teaching?
>
> Mary: Yes, yes. But you kind of don't think about it. You just think it is the normal thing you are supposed to say. This is what the patient needs to hear and you don't clue in that you are actually teaching them until you get them all down in the little room and you go through their pre-op teaching with them. Then you know, "Yes, this is patient teaching." .... but all the day long you are teaching the patient different things.

The relevant question seems to be, How is teaching work made visible or invisible for nurses? In the previous section I argued that the narrow focus of the teaching discourse in nursing texts shapes nurses' perspective on this work. In this section I argue that another feature of the textual discourse, the prevailing conceptualization of the teaching process as a planned and systematic process, renders much of nurses' educative work invisible.

In taking up the conceptualization of the teaching process I am also returning to the point I made above concerning a shift in the discourse about the actual practice of teaching. The shift to which I refer parallels a shift in the conceptualization of nursing more generally occurring in the context of professionalization.

Since the mid-1960s there has been a sustained effort by an occupational elite of nurse academics, educators and managers in the United States and Canada to conceptualize, teach and practice nursing as science (Campbell & Jackson, 1992). This work has taken several forms: theoretical models of nursing have been developed (see Marriner-Tomey, 1989 for a description); theory from other fields such as behavioural and social psychology have been imported into nursing to explain patient behaviour and guide nursing action (this is the case with teaching in nursing); a systematic approach to nursing practice, the so-called "Nursing Process", based on the scientific model, has been constructed and widely advocated (see Hargreaves, 1981). In short, since the mid-1960s a process of codification and "scientification" (Elzinga, 1990; Selander, 1990) of nursing knowledge and practice has taken place as part of a process of professionalization. Teaching in nursing has not escaped this process and indeed developments in the scientification of teaching have paralleled those in nursing more generally.

In what follows I first lay out the current conceptualization of the teaching process, and second argue that this conceptualization is at odds with practicing nurses' actual teaching work. Herein lies one source of the invisibility of much of nurses' teaching, or educative, work. The current conceptualization of teaching is both produced and supported by a ruling elite of nurses. It is

what counts as true about teaching. Nurses' actual teaching work, the teaching that is embedded in routine work processes, does not resemble this current conceptualization. It therefore remains outside the boundaries of what is seen to be teaching.

Redman (1993b), in a review of the field of patient education, states that "in the late 1960s and early 1970s, patient education was reborn, especially in nursing" (p. 725). This rebirth is the shift in thinking about teaching in nursing that I noted above. An important feature of this new beginning, not identified by Redman but evident in her early texts (1968, 1972), was the recommendation to nurses to use a "systems approach" (Banathy, 1968) to patient teaching. Prior to Redman, as is evident in the work of Pohl (1968), nurses were urged to teach using established principles of learning (repetition, reinforcement, etc.) but instruction was not described in the discourse as a systematic process. Teaching was essentially effective communication based on established principles of learning. Ideas about teaching changed with the importation into the discourse by Redman of the systems approach to instruction developed in behavioural

psychology.[33] The systems approach now dominates the discourse of teaching in nursing, as is evidenced by a review of texts published in the last fifteen years (Narrow, 1979; Haggard, 1989; Rankin & Duffy, 1983; Rankin & Stallings, 1990; Redman, 1993a; Springhouse Corporation, 1987). To teach, as a nurse, is to engage in a systematic process of needs assessment, learning diagnosis, instruction and evaluation. A particular conceptualization of the teaching process has come to stand for what counts as teaching in nursing.

Redman has remained, through seven editions of her text (1968, 1972, 1976, 1980, 1984, 1988, 1993a), a proponent of the systems approach and a powerful voice in shaping nurses' views of teaching work. Redman's advocacy of the systems approach represents the "scientification" of teaching that began in the 1960s and 1970s, and continues to take place, as part of a larger effort to professionalize nursing. The

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[33] The systems approach is described by Banathy as "a self-correcting, logical process for the planning, development, and implementation of [instruction]. It provides a procedural framework within which the purpose of the system is first specified and then analysed in order to find the best way to achieve it" (1968, pp. 15-16). The systems approach relies on empirical evidence for the design and improvement of instruction. Reiser (1987) traces the roots of this approach back to the 1600s but the major developments in the field have occurred since World War II in concert with the dominance of behavioural psychology in education. These developments include the programmed instruction movement, refinement of the procedure of task analysis, the behavioural objective movement and, in the 1960s, the emergence of criterion referenced testing, and competency-based education (see Jackson, 1991).

process of scientification of teaching through the adoption of a rational model of action mirrors that occurring in the wider nursing arena. Within nursing this same model of rational action is called the Nursing Process. Its documentary representation is the Nursing Care Plan (for an example see Figure 5 on page 148 of Chapter Five). Redman, herself, connects the two processes. She says,

> It is impossible not to use a process in professional practice. The amount of data that must be synthesized to do purposeful intervention requires a categorizing system because people cannot keep any more than seven items in their short-term memories .... The teaching process can be seen as parallel to the nursing process in that each has an assessment, diagnosis, intervention, and evaluation phase. (Redman, 1993a, pp. 12-13)

In the most recent edition of her text Redman acknowledges that her model of teaching in nursing is drawn from the work of Ralph Tyler, a founder of the systems approach to instruction. She says:

> The process model that supplies the organizational framework for this book was derived from the Tyler model in the field of education. It asks the following questions: (1) What are the purposes of patient education?, (2) How can learning experiences be selected to achieve these purposes?, (3) How can the learning experiences be organized for effective instruction?, and (4) How can learning experiences be evaluated? (1993a, p. 10)

While still a force within the teaching discourse in nursing, and thought to be evidence of the scientific character of nurses' educative work, the Tylerian approach has come under strong criticism by contemporary educational theorists working outside nursing. Cherryholmes (1988)

argues that it "gives the appearance of order, organization, rationality and enlightened control, and engineering" but it does not address the crucial questions that educators face. He says, "The rationale is not helpful in making choices .... because there is no discussion of decision making, politics, ethics, social criticism, social responsibility, or critical reflection" (p. 41). The content of recent texts in patient teaching reflects those general characteristics that Cherryholmes criticizes. The texts display a focus on instructional technique and the organization and implementation of hospital-wide programs of instruction. They reveal a pre-occupation with the mechanics of behaviour change. With the exception of two pages in Redman's 1993 text, the ethics of patient education and other issues such as the efficacy or impact on the patient of the change the health care worker is trying to bring about are unexamined.

The systems approach appears to be unrelated to the actual practice of teaching as I have observed it and displayed it in this thesis. Nurses teach but they do not go about it in a manner consistent with the systems approach. They do not specify precise objectives, nor do they conduct explicit learning diagnoses. Rather they teach on the bases of learning needs that arise in the context of their work, needs that they or another, a patient, a physician, may identify. These learning needs are not

limited to health and illness concerns. As I showed in Chapter Three they can be as commonplace as the location of the ward bath tub and as significant as the timing of an operation. In teaching nurses draw upon their own experience-based knowledge of how work proceeds in the hospital and of how patients and physicians must participate in it. Furthermore teaching seldom stands alone as the discourse suggests it does. While pre-operative teaching is an explicit teaching activity on a surgical ward such as Study Ward, most teaching occurs in the middle of, and in relation to other work. Nurses teach in relation to physicians, as Judy (16/12/89) indicates when she tells me that she is happy to inform patients as long as "I am not divulging any medical information that I am not supposed to." Finally, nurses teach through everyday communication practices (asking questions, providing explanations, etc.). The use of instructional material, as I will show in Chapter Five, tends to be limited to educative work that is authorized by management, and for which nurses are held accountable.

In summary, a discordance exists between how teaching processes are known in authoritative texts about teaching, and the actual work of teaching by hospital nurses. On the one hand teaching is shown in texts to be systematic and planful, and on the other hand in nurses' work to be emergent in everyday work processes, arising at the time of

immediate need. Authoritative texts, however, are just that, authoritative. As the authors of established sociology have shaped what is understood to be true about social processes (see discussion in Chapter Two of Smith's critique of sociology), so authors of texts on teaching, like Redman, have shaped the discourse of teaching in ways that are unavailable to the practising nurse. The teaching discourse has been produced not by the rank-and-file nursing practitioner but by nurses with advanced degrees in nursing and other fields, such as educational psychology, and holding positions as nurse educators. These are the persons who have the proper credentials (training in the "science" of instruction) to participate in producing the discourse of teaching in nursing. It is this discourse that nurse managers and policy makers take up in organizing and documenting nurses' work.

The current nursing discourse on the process of teaching has developed in the context of the professionalization of nursing. The mode of professionalization is scientification; the conceptualization of the teaching function has undergone scientification as part of the process of professionalization. Teaching is teaching when it displays the character of science; when it does not it appears to be something else.

Summary

Nurses learn and practice teaching within a professional discourse of teaching that accomplishes particular ways of conceptualizing the content of teaching and the process of teaching. Taken as a whole, this discourse trains nurses to "see" teaching as the systematic instruction of patients in practices to promote health and independence from professional caregivers. In Chapter Three I showed that teaching is much more than what it appears to be. In this chapter I have shown the role played by the professional discourse that obscures for nurses the true range and scope of their teaching practice. While the discourse of thirty-five to forty years ago displayed teaching as embedded within nursing practice, with attention to the instruction of patients in the routines of hospital life, the present discourse no longer does. Furthermore the present discourse no longer reflects the emergent character of nurses' teaching work; its focus is on teaching as a systematic process of behaviour change. These shifts in discourse have taken place, I contend, as part of the professionalization of nursing.

Nursing professionalism now organizes nursing workplaces through mandated documentary practices and process. While the professional discourse I have analysed in this chapter organizes nurses' view of teaching work such that major parts of it remain invisible, documentary

practices in their workplaces build this invisibility in to nursing accounts. The teaching discourse provides the concepts and categories for managerial accounts of teaching. In this way the educative work that remains beyond the boundaries of what nurses are trained to "see" as teaching remains as well outside of managerial accounts of educative work. This is the subject for the following chapter.

Chapter Five

Managerial Relations and Teaching

Introduction

Up to this point in the dissertation I have described nurses' teaching work, shown what it accomplishes in the hospital, and argued that the educative character of much of this work is invisible. In making this argument I took up the first disjuncture I reported in Chapter One: nurses teach, but their teaching work is not fully apparent to them in their everyday talk. The range and scope of their teaching work only becomes apparent to nurses in discussion and reflection, although with some ambivalence around whether it is teaching. The invisibility of much teaching work is linked to the fact that much of it resembles women's household and office work, work which often goes unacknowledged as work. Invisibility is also linked to a discourse of teaching in nursing which establishes boundaries for teaching; teaching that does not follow a systematic approach and is not about illness or self-care practices is not recognized as teaching.

In this chapter I move to the second disjuncture I see in teaching work. This is the disjuncture between the character of the pre-operative teaching that nurses are explictitly authorized to perform and held accountable for

by nursing management, and the character of the teaching that is embedded in other work.

It is generally agreed by analysts of health care in Canada that, in the last twenty-five years, there has been a gradual erosion in professional control over work in hospitals and an increase in managerial,[34] or administrative, control (Coburn, 1988; Sutherland & Fulton, 1988; Wahn, 1987). This shift in control which began in the early 1970s occurred in the context of government concern over the rising costs of health care. New management systems based on corporate management methods that aim to produce efficiency in a labour process (Braverman, 1974; Sloan, 1972) were introduced into hospitals to control labour costs. At the same time, accreditation of hospitals and other health care institutions became an accepted practice in order to assure the quality of service provided to Canadians (Canadian Council on Health Facilities Accreditation, 1992). Another feature of the new managerialism were programs to manage hospital liability arising from the actions of health care workers.

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[34] In a recent report analysing issues in nursing in one Canadian province, Cassin (1993) notes a "general incursion of managerial methods of control, compliance,and audit into nursing work" (p. 66). Hospital nursing services have been a prime target for managerial control because nursing labour costs are the largest portion of a hospital's budget and nursing is a central and highly visible work process.

When hospitals are managed through corporate methods, the managing of nurses' work, including teaching work, is achieved through documents and documentary processes. Historically, documents that relate directly to the care of patients, such as the Nursing Assessment and the Nursing Care Plan, have been the most significant documents for nurses. Since the advent of managerial control over nursing work, however, documents that relate to the organization of nurses' work have become significant for nurses, documents such as the Patient Care Hour Chart, a component of nursing workload measurement. These documents carry information oriented to managerial concerns out of the ward to administrative sites where decisions are taken that shape nurses' work back on the ward.

The purpose of this chapter is to show the organization of teaching work through documentary relations oriented to three managerial concerns: controlling the costs of nursing labour, assuring the quality of nursing care including teaching, and protecting the hospital against liability arising from inadequate or insufficient patient teaching. My analysis will also show that managerial accounts of teaching work build in conceptions of teaching present in the discourse examined in the last chapter.[35] In so doing they contribute to the invisibility of the work I claim is

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[35] My analysis will illustrate Smith's claim that discourses "intersect, interpenetrate, and coordinate the multiple sites of ruling." (1990b, p. 6)

teaching, the work of teaching inexperienced physicians and patients to participate in hospital work processes.

Before moving to an analysis of documents I provide an excerpt from my fieldnotes. In this excerpt Jill admits a new patient to the ward and at the same time carries out pre-operative teaching. This excerpt shows the work of entering certain aspects of what a nurse does into documentary form, producing or constructing an account of one's work. It also provides an entry point into the analysis of the documentary relations of management.

Nurses' Work and the Construction of Accounts

On a busy day on Study Ward up to five or more elective patients might be admitted between mid-morning and late afternoon for operation, usually scheduled for the following day. "Doing an admission" and "doing the pre-op teaching", as nurses called these work processes, were frequently carried out at the same time. Admitting and teaching a patient might be carried out by the nurse as soon as she was notified of the patient's presence on the ward; alternately some time might pass while she completed work at hand. The point is that this work had to be fitted into an ongoing work process. I observed the following admission and pre-operative teaching carried out by Jill (27/11/89).

> 1050hrs. Jill and I return to the ward from coffee and Jill is told there is a new admission in one of her rooms. We go to the patient but don't stay very long. Jill speaks briefly to her. She has

her sign the Valuables sheet and says to her "We'll be giving you the book and everything later. We'll tell you what to expect".

1100hrs. Jill is doing "the glucs" [measuring glucose levels] on the diabetic patients on our end of the ward.[36] She returns to the chart carrier to record them and is interrupted by a porter from x-ray asking for help to get a patient back into bed. The women feels nauseated and Jill spends about ten minutes with her, positioning her on her side, tucking a small basin under her chin, telling her "Just lie on your side. It will be better if you are sick."

1115hrs. Jill goes to the Teaching Room to pick up the flipchart, Before an operation and two pamphlets. We go back to the new admission, a young women of about twenty, who is to have gallbladder surgery the following morning.

Jill starts the admission process, explaining that she will be asking her some questions, " ... about your allergies, your skin. The doctors will be in later for your history and physical. Don't be afraid to ask questions of any of us here. If I can't answer questions someone else will." Jill put the Nursing Assessment,[37] Part I, on the

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[36] This excerpt shows that admitting/teaching a patient must be fitted into an ongoing work process in which work on the body of the patient takes priority over all other forms of work.

[37] In this excerpt from my fieldnotes six separate documents are identified: the Nursing Assessment, Parts I and II, the Nursing Notes, the Nursing Flow Sheet, the Nursing Care Plan and the Patient Education Record. All of these specially formatted documents relate to the care of patients and, with the exception of Part I of the assessment form, are completed by the nurse. The Nursing Assessment is an inventory of the psychological/social (see Part I, Appendix E) and physical (see Part II, Appendix F) needs of the patient. The Nursing Notes (see Appendix G) and the Nursing Flow Sheet (see Appendix H) are records of nursing observations and actions. The Nursing Care Plan (see Figure 5, p. 148) is a systematic description by the admitting nurse of the patient's need for nursing care and intended nursing interventions. Finally, the Patient Education Record (see Figure 8, p. 158) is the record of instruction given to the pre-operative patient.

overbed table in front of the patient. "This is for you to complete. It is just to see if you have any concerns, other than being here in hospital. Concerns related to missing school, or to your boyfriend, or to anything else." Then Jill took the Nursing Assessment, Part II and began asking the patient questions: was she allergic to any drugs? any recent exposure to infectious diseases? was she taking any medications and what were the names? She continued to ask questions that assessed the function of all body systems and obtained information about other medical problems and past surgeries, filling in the assessment form as she did.

Once the assessment form was finished she took the Pre-operative Patient Education Record, and asked again, was the patient allergic to any drugs?, recording her response on the form. Then Jill began to go quickly through the flipchart. At each page she stopped and explained the content briefly, in a shorter and simpler fashion than in the text. The patient occasionally made a statement or asked a question: "How long will I be in? How soon can I have a shower after my surgery?" Jill answered all these questions in a straightforward manner. On at least two occasions as she moved through the flipchart she said; "If you can't remember anything else, or if you are so anxious that it all goes out of your mind, just remember: deep breathing and coughing and leg exercises."

1140hrs. Jill and I return to the Nursing Station where she sits down at the counter and, in her terms, "writes up the admission": filling in the Nursing Notes, the Nursing Flow Sheet, and the Nursing Care Plan form, transferring information from the assessment that she completed on to the cardfile, filling in the Pre-operative Patient Education Record. Jill tells me she will collect the Nursing Assessment she left for the patient to fill in later in the day and place it in the chart with the assessment she completed.

1210hrs. Another nurse comes into the Nursing Station and tells Jill that one of her patients is asking for a needle for pain. Jill leaves to prepare and give the medication.

> 1220hrs. I catch up with Jill. She has given the patient the injection and is now helping another patient to use the bedpan.

Jill starts to "write up" the admission as she gathers information from the patient at the bedside. She fills in Part II of the Assessment Form as she queries the patient, and she begins to complete the Pre-operative Patient Education Record. Once Jill is back at the Nursing Station she fills in the other forms. All of these documents, with the exception of the Nursing Care Plan, will be placed in the patient's medical record, or chart. There they will act as an information resource for other health care workers caring for this patient and as a record of the nursing care that has been rendered to her. The care plan will be placed with the cardfile in a binder, with those of all other patients, on top of the Chart Carrier. This aggregation of care plans and card files enables nurses and other workers (dietitians, physiotherapists) to scan the needs and care plans of an entire ward of patients without the need to examine the chart of each patient.

The documents that Jill completes in admitting this patient to Study Ward, are pieces, or links, in the documentary relations of management of nurses' work. In completing these documents she enters her work into these documentary relations. The character of these documents and the categories and concepts they provide for information about patients are expressions of institutional discourses

of nursing professionalism and managerialism. These documents articulate, or link, to other documents of the same order which have their origins in government departments that fund hospital health care, and professional agencies that regulate nursing practice. In what follows I analyse the documents and forms that are visible in my account of Jill's work, and others that are not visible, and by analysing them display the documentary relations of cost control, quality, and protection against liability.

Controlling the Costs of Nursing Labour

Nursing labour costs are the largest portion of any hospital's budget. As in other hospitals in Canada, nursing management in Study Hospital controls the costs of nursing labour through a document-based workload measurement system which conceptualizes nursing as a set of tasks and controls the amount of time allocated to perform them. Cassin says:

> In contrast to the skilled, committed conception of nursing work formulated within unionism, managerial conceptions of nursing have focused on describing and treating nursing as a set of tasks which can be and have been specified. These tasks then become the subject of cost and managerial accounting. (1993, p. 3)

Jill moves quickly through the admission and pre-operative teaching, not only because other patients need her to attend to their physical needs but because she has a limited amount of time to devote to these two tasks. Extra time that Jill might spend in the admission and

pre-operative teaching is time "borrowed" from other tasks she must do.

Nurses (Runions, 1988) identify a lack of time as one of the chief barriers to teaching patients and my nurse participants did too.[38] Lise (01/03/90) told me that there were many opportunities but no time to teach in the course of the day. She said "Every room you go into there is always an opportunity. But a time factor is there, the time to sit down with patients and do that .... which is very unfortunate but it is there." Jill indicated that attending to the physical care and safety of patients could limit the teaching work that nurses could do. She told me:

> The patients get a minimum level [of teaching]. The majority get what they need. We could probably do a lot more but often on our ward a lot of difficult things arise and we have to insure their safety. (Jill, 11/12/89)

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[38] I observed nurses engaging in several practices that appeared to me to be ways they managed a shortage of time for pre-operative teaching. For example some nurses brought the flipchart to the patient and asked that they read it in advance of their teaching by the nurse. When the nurse returned to teach she might ask if the patient had any questions, and, if there were none, simply reinforce the most important features: the need to breathe deeply and cough frequently in the first few days after surgery. Another practice was to combine the teaching with the admission process (Jill does this), or to spread the teaching between the admission process and a subsequent visit to the patient. A third strategy, used when nurses were especially rushed, was to deliver a lecture. Nurses would bring the flipchart to the patient and speak directly to the content of each page, only stopping if the patient asked a question, only asking if the patient had any questions at the end of the lecture.

It is not obvious in these nurses' comments why there is not more time to teach other than to see the lack of teaching time as the inevitable consequence of overwhelming demands by patients for physical care. In fact, the lack of teaching time is built into the process of workload measurement. The process is a documentary process involving, at the level of the ward, a document called the Patient Care Hour Chart. This document is not visible in the pre-operative teaching that Jill carries out, nor in her construction of accounts of teaching work. Nevertheless it controls the nursing time she has available for this and other teaching work.

Nursing managers at accredited Canadian hospitals such as Study Hospital must use a workload measurement system, or a similar device, as the basis for making decisions about allocating nursing resources (Canadian Council on Health Facilities Accreditation, 1991). Several workload measurement systems are in use in Canadian hospitals, the GRASP system, the MEDICUS system and the PRN system.

Study Hospital used the GRASP system of workload measurement.[39] The GRASP system quantifies the needs of individual patients as the basis for determining the nursing workload for the whole ward. The device used to generate

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[39] GRASP is an acronym for Grace Reynolds Application and Study of PETO. PETO refers to Poland, English, Thornton and Owens who developed a system of nursing workload measurement which became the foundation of the GRASP system (see Poland, English, Thornton and Owens, 1970).

the estimate is the Patient Care Hour (PCH) Chart. A portion of the PCH chart used on Study Ward is shown in Figure 4 (see Appendix I for the entire document). It was used to estimate the nursing workload for the day shift, 7am to 7pm. It displays the needs of patients as a set of fifty-two nursing care tasks grouped in ten categories: assessment, planned teaching, activity, hygiene, elimination, nutrition, vital signs, other nursing, related nursing activities and medications. Beside each task is the time, expressed in tenths of hours, allocated to the meeting of the need represented by the task (for example pre-operative teaching is allocated a time of two-tenths of an hour, or 12 minutes). The time values for each task have been established based on observation of nurses at work and with reference to norms provided by the vendor of the system.[40] The time available for teaching is an estimate derived from decisions about nursing labour time taken when the GRASP system became the basis for allocating nursing resources within Study Hospital, some years before the study. It is a feature of the GRASP system, and touted as an advantage by its designers, that each ward, at the

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[40] The GRASP System is proprietary to FCG Enterprises Inc. which owns the copyrights and trademarks. CHCL Comprehensive Healthcare Consultants Ltd., Ottawa, Ontario, is the sole party licensed by FCG to implement The GRASP System ir Canada.

DATE: ______ 12 HR. DAY UNIT: Day of week predicting for NURSING CARE										
ASSESSMENT (CIRCLE IF APPLICABLE) Initial assessment and care plan	6	6	6	6	6	6	6	6	6	6
Daily assessment, PCU update, and care plan	①	①	①	①	①	①	①	①	①	①
PLANNED TEACHING (CIRCLE IF APPLICABLE) Pre-op teaching	2	2	2	2	2	2	2	2	2	2
ACTIVITY (CIRCLE HIGHEST IF APPLICABLE) Up in chair with nursing assistance	2	2	2	2	2	2	2	2	2	2
Walk with nursing assistance	4	4	4	4	4	4	4	4	4	4
Bed rest with assistance-reposition	1	1	1	1	1	1	1	1	1	1

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OTHER NURSING (CIRCLE AS APPLICABLE) QIH I & O	3	3	3	3	3	3	3	3	3	3
I & O	1	1	1	1	1	1	1	1	1	1
Urine for sugar and acetone	1	1	1	1	1	1	1	1	1	1
Glucometer	3	3	3	3	3	3	3	3	3	3
Simple dsg/wound/decubitus care	1	1	1	1	1	1	1	1	1	1
Complex dsg/wound/decubitus care	4	4	4	4	4	4	4	4	4	4
Preventative skin care	2	2	2	2	2	2	2	2	2	2
Simple/NG/Tube irrigation	1	1	1	1	1	1	1	1	1	1
Routine teaching and emotional support	①	①	①	①	①	①	①	①	①	①

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SUBTOTAL TENTHS										
SUBTOTAL PCU'S										
TOTAL PCU'S										
PCU'S divided by NCU'S x 100% = UTILIZATION										

Increase by 21% for all unlisted activities

*ΛΛΛ indicates a total of 6 sections missing

Figure 4. A portion of the study hospital Patient Care Hour Chart.

time of introducing GRASP, "tailors" the PCH chart to reflect the nursing care needs of its patients. This occurs through a systematic listing and timing, by staff nurses, of nursing care tasks, following rules laid down by the system's designers (Meyer, 1978), and a comparison of these findings with a GRASP database.[41]

On the study ward, at the mid-point of both the day and night shifts, a nurse, or nurses, fills in the PCH chart by circling one time value in each category for each patient on the ward, determining from the cardfile and the report of other nurses the amount of nursing time in each category of care each patient is likely to require in the next 12 hours. Where an elective patient (identified as as "admission" on the PCH chart) is expected to be admitted in the next shift the time value in the category of planned teaching is circled. Within the category "other nursing" each patient is automatically assigned six minutes per twelve hour shift of nursing time to meet the patient's assumed need for "routine teaching and emotional support".

Once the total number of patient care hours is estimated the nurse, or another person, the Ward Clerk, enters the estimated figure into a calculation with the

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[41] The question of the adequacy of the time nurses took to teach, and their use of the time, ie., their teaching practices, appears not to have been examined. Practices in place at the time of implementation appear to have been accepted as the measure of the work. (GRASP© Co-ordinator, 06/08/90)

available nursing hours obtained from the nurse staffing schedule. From this calculation is derived a nursing "utilization" estimate for the ward. This estimate, expressed as a percent, indicates the degree of match, or balance, between the workload estimated on the PCH chart and the nursing time available to do the work. Thus an estimate of 80% indicates nursing time to spare, an estimate of 120% indicates more work than nursing time available to do it. This utilization estimate is compiled every day, at 7am and late in the afternoon, and is sent to the central nursing administrative office for review by senior nursing managers. Depending on the utilization figure, and those from other wards in the hospital, these managers may send additional nurses to the ward to work, or, alternatively, require ward nurses to "float" to another ward in need of extra nursing time. Workload data is used on a day to day basis to balance the allocation of nursing resources within the hospital. Workload data that is accumulated over time is used by senior managers in the nursing department to prepare annual budgets for submission to government.

A notable feature of the PCH chart is the preponderance of tasks arising from patients' physical needs and the decisions of physicians (treatments, such as dressings, and medications require a medical order) and the relative absence of tasks arising from patients' educative or psychological needs. The only explicit educative work

process is pre-operative teaching.[42] With the exception of pre-operative teaching, the teaching needs of patients are described as "routine teaching and emotional support" and fall under the miscellaneous category of "other nursing". The brief amount of time allocated to meeting the teaching needs of patients is noteworthy: twelve minutes for "pre-operative teaching" and six minutes per 12 hour shift for "routine teaching and emotional support". These features of the PCH chart reflect the prevailing conceptualization of teaching, described in Chapter Four, that teaching is about the modification of behaviour directed towards the sick body. They also reflect ideas about the significance of teaching in nursing, that it is peripheral to the main business of nursing which is the physical care of the sick body. Absent from the PCH chart, as it is absent from the discourse of teaching in nursing, is the work of nurses to teach patients for participation in hospital work routines, and their work to teach inexperienced health care workers. Yet, the six minutes

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[42] It is interesting to reflect on the emphasis placed on pre-operative teaching in the PCH chart because surgical patients have other needs for instruction: post-operative instruction, discharge instruction. Surgery, by its very nature, poses risks to patients, and to health care providers in the event that an unprepared patient experiences difficulties during surgery. In addition the orderly flow of work through the operating area of any hospital demands that patients come to the area properly prepared. Patient safety, and institutional safety and efficiency, therefore, depends upon adequate pre-operative instruction.

allotted per 12 hour workshift to "routine teaching and emotional support" do indicate recognition that there is teaching other than pre-operative teaching. The naming of it as "routine" and the joining of it with "emotional support" suggests its non-skilled and perhaps, feminized character. The PCH chart thus embodies, or builds in, the prevailing professional conceptualization of nursing as an activity directed solely towards patients, or their family members. It makes visible teaching work that falls within the professicnal discourse, but it renders invisible, through a failure to account for it, educative work that lies beyond the discourse.

The nurses who participated in this study were critical of the workload measurement system that determined the number of nurses available to care for patients. Their criticisms, however, tended to be limited to comments that the list of tasks on the PCH chart was incomplete. They did not appear to take issue with the conceptualization of their work as task. Thus Lise (01/03/90) commented, " ... there is nowhere on the chart that you could document that stuff [teaching patients about diagnostic tests]. You do it and you don't really get credit for it." Judy (25/11/89) said, "We have a problem with the PCH chart. They don't reflect the work we really do."

Systems of workload measurement in nursing were and continue to be developed by nurses seeking objective

measures of nurses' work and "rational assurances of nursing care needs and nursing care itself" (Cassin, 1993, p. 77). Cassin (1993) however identifies that workload measurement is not about nursing but about managing nursing. She says:

> Workload measurement is not directed to caring for patients, it is directed to managing nursing labour. It has its origins in industrial work design and has been developed for nursing work design in the American private health care system, where institutions are managed for profit. (p. 77)

Nursing workload measurement has developed and goes forward in the context of scientification of nursing as a strategy of professionalization. It is part of the effort to ground the work of nurses in science. Objective measures of nursing work, such as those supplied through workload measurement systems, are supposedly "better" measures than practicing nurses can supply because they are more "scientific". While proponents of workload measurement in nursing admit that the work of teaching and coordinating the work of other health care workers is not well represented (Thibault, 1988) in the systems currently available they view this as a problem to be overcome through more research, that is, better science. They do not see the problem as the conceptualization of nursing as task. But Cassin (1993) does. She says:

> The conception of nursing work as task does not (and cannot) grasp [the] complexity in the work process. Indeed, a task orientation assumes a self-contained set of actions which are coordinated outside the site of executing the task. The task orientation to work and its foundation in [workload measurement systems] means

> that the way in which work gets done, the improvisation, communication, negotiation, coordination, in sum the professional judgements and discretion, are not recognized (and ultimately not valued) ..... What is lost in the process is the context for the work, which in this case is real people, the connections this work puts together, and the cadence of the work as it is conducted. In the main, the work of nursing is lost and what remains is a task list which is not an adequate representation of the character of the work or the time it takes to do it. (1993, p. 81)

This characteristic of the workload measure provides an example of a point I made earlier, that nursing documents express institutional discourses of management and of professionalism. Task, as noted above, is a managerial conceptualization. The PCH chart embeds the managerial idea of task.

I began this analysis of the control of nursing costs (including teaching) through the control of nursing time with a display of admission/pre-operative teaching work set within an ongoing nursing work process marked by unpredictability (patients with nausea, pain) and the requirement to articulate, or connect, with other nurses and other workers (the X-Ray porter, the medication nurse). The PCH chart is one representation of this work, a representation of nursing used by managers. But the actual work of nurses, as displayed above, is something else. The PCH chart is an example of "the standardized and general forms of knowledge" (Smith, 1987, p. 3) through which the actual work of persons is entered into the relations of ruling. It is an example of the textually mediated social

organization of nurses' work. In this instance standardized knowledge of nurses' work is created by nurses themselves, for managers, for the purposes of calculating the resources that will be supplied to perform the work. Workload measurement creates a virtual reality about the work of nurses from which is absent the inherent unpredictability of the work. To paraphrase Smith's words, it is a textual device that speaks about the work of nurses in their absence. The "virtual reality" that workload measurement creates is at variance with the real work of nurses but it is on the basis of this virtual reality that nursing resources are made available for the care of patients.

In summary, control over the costs of nursing labour is exercised through a document-based workload measurement system which conceptualizes nursing as task and controls the amount of time allocated to tasks. This system, which is founded on nurses' own estimations of the time required to teach patients, provides less time than has been shown necessary to carry out effective pre-operative teaching (Devine, 1992). Nurses managed this limited time through a range of strategies that ensured that patients, at the very least, received information they could use to prevent complications after their surgery.

Assuring the Quality of Nursing Care

In the excerpt above (pages 128 to 131) Jill is shown completing the Nursing Assessment, Part II and a Nursing Care Plan, and entering information into Nursing Notes and the Nursing Flow Sheet. With the exception of the Nursing Notes these documents are pre-formatted. The categories of information are already established; Jill fills in these categories with information she has gathered from the patient.

The accounts that nurses create must be of a special character. They must display the needs of patients and the work of nurses in a particular way. The accounts that nurses create are the hospital's evidence that nursing care in the institution is of an acceptable quality, that is, that the care meets the accreditation standards for nursing services of the Canadian Council of Health Facilities Accreditation[43] (1991) and the standards of the professional nursing association for the province in which the institution is located.

The standards for accreditation of nursing services address both the management of nursing services and the provision of nursing care to patients within the institution. Where accreditation standards address the

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[43] Hospital accreditation in Canada is voluntary but it is considered essential to the maintenance of public confidence in an institution and it is a requirement for the conduct of post-graduate medical training programs.

provision of care by nurses they articulate with standards for nursing practice of the professional nursing association.

The accreditation standard describing the direct care of patients given by nurses is Standard VI, Patient Care. This standard states,

> The patient's individual needs for nursing care are assessed and care is planned, provided and evaluated consistent with assessed needs, the patient's desires and preferences, established standards and the goals of the service. (CCHFA, 1991).

The established standards referred to are the standards of the professional nursing association which, too, describes nursing care as a process of assessment, planning, implementation and evaluation.[44]

Accreditation surveyors look for established indicators that accreditation and professional nursing standards are being upheld within the nursing department. There are seven separate indicators of compliance with Standard VI, Patient Care, and each indicator is specified in detail. Two indicators are relevant to the teaching function of nurses. One indicator describes the requirement for documentation of patient care and states that this must include evidence of

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[44] The development of standards of nursing practice are a feature of the process of professionalization described in Chapter Four. The articulation between accreditation standards and professional practice standards, evident in Nursing Standard IV, represent the ways in which relations of ruling form a "complex of extra-local relations that provide in contemporary societies a specialization of organization, control and initiative" (Smith, 1990b, p. 6).

patient and family education. A second indicator describes the requirement for "appropriate activities and current materials to support patient and family education" and states that these must reflect current scientific knowledge and have the approval of the "disciplines providing care" (CCHFA, 1991). I will return to this indicator shortly.

To aid nurses in completing documents correctly the nursing department provides guidelines that nurses may consult. To aid in the construction of satisfactory care plans they provide standard nursing care plans that nurses, such as Jill, can look at to model their own after. Brenda's comment to me, "When you admit a pre-op patient you kind of start filling out your forms. You do your care plan, and the first thing is anxiety, and you try to deal with that by doing patient teaching" (Staff Nurse Member, Patient Education Interest Group, 20/07/90), suggests that she knows how her plan is to appear.[45]

Figure 5 displays a care plan created for a patient such as the one Jill admits and teaches in preparation for her surgery the following day. Figure 6 displays portions

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[45] Not all of the nurses on Study Ward were as adept as Brenda apparently is at writing care plans. The clinical development nurse on Study Ward told me that one of her jobs was to help nurses write acceptable care plans. This reponsibility arose out of a previous hospital accreditation report that found nursing care plans in the hospital to be in need of improvement. This nurse explained to me that nurses had difficulty in knowing what to write and that they found the care plans to be "idealistic" accounts of nursing care. (Clinical Development Nurse, 25/1/90)

Study Hospital Nursing Care Plan

Initials/Signature

1.___ _____ 2.___ _____ 3.___ _____

4.___ _____ 5.___ _____ 6.___ _____

Date	Nursing Diagnosis	Patient Goal	Target Date	Nursing Interventions	Initials	Resolved	
						Date	Initials
Jan 21	Anxiety related to surgery	↓ Anxiety	Jan 22	1. Teaching pre and post op	QQ		
		↑ Knowledge		2. Explain all tests and procedures			
				3. Spend time with patient to all for			
				ventilation of feelings, fears			
Jan 21	Alteration in comfort, pain related to	↑ Comfort	Jan 25	1. Assess type, location and severity	QQ		
	surgery			of pain			
				2. Offer analgesics per MD order			
				3. Assess effectiveness of analgesia			

Figure 5. Study hospital nursing care plan.

STANDARD: Pre-operative Teaching and Care Standard for General Surgery

PRODUCED: APPROVED:

PREPARED BY: Patient Education

DEFINITION:

PROBLEM/NURSING DIAGNOSIS	NURSING INTERVENTION PROCEDURE	OUTCOME GOAL
1. Anxiety related to hospitalization and surgery.	1.- Orientate to nursing unit. - Give pamphlet "Medical Tea . and "Social Work Dept." - Arrange for visit by clergy, if desired. - Ask about patient's feelings regarding surgery. - Allow time for and encourage verbalization of patient's fears. - Explain that anxiety is a normal response. - Avoid use of cliches such as "Don't worry, everything is just fine" and "I know how you feel". - Do not use medical jargon. - Ensure patient has received and read booklet "Helpful Hints About Your Surgery". - Provide opportunity for reading of flipchart "Before and After An Operation". - Arrange viewing of appropriate patient education films, see specific surgical procedure. - Provide opportunity to read flipchart appropriate to specific surgery. - Administer sedation as ordered. - Explain reason for and use of siderails.	1.- Able to use call system and to locate kitchenette, tub room, and day room. - Able to distinguish persons of Medical Team, Head Nurse, and their roles. - Verbalizes questions and concerns about surgery. - Shows relaxed manner by facial expression, eye contact, and no visible signs of agitation. - Sleeps well prior to surgery. - No falls, injuries, or accidents. - No physical complications.
2. Knowledge deficit re: pre-operative procedures.	2. Explain routine procedures and reason for the following: - Diagnostic tests - History and physical - OR clothing - Removal of makeup, fingernail polish, bobby pins, contact lenses, protheses, and other artificial devices - Tub bath or shower - Visitors policy - ICU if appropriate - Smoking policy - Complete pre-op check list before pre-op med	2.- The patient will communicate an understanding of preparation for surgery - Voids prior to administration of pre-operative med - Personal hygiene completed - Prepared for the OR
3. Knowledge deficit re: impending surgical procedure.	3.- Assess patient's knowledge of proposed surgery - Explain surgeon will visit and provide opportunity for questions before signing of operative consent - If patient requests information the nurse is unable to provide, contact the resident or surgeon - Witness patient's signature for consent	3.- Verbalizes knowledge of surgical procedure to be performed - Informed consent signed and witnessed
4. Preparation of surgical area and lower bowel.	4. Skin preparation and bowel preparation as ordered by surgeon (see specific surgical procedure).	4. Clean surgical area and empty lower bowel

Figure 6. Study hospital standard nursing care plan (continued).

PROBLEM/NURSING DIAGNOSIS	NURSING INTERVENTION/PROCEDURE	OUTCOME/GOAL
5. Knowledge deficit re: pre-operative medication and anaesthesia.	5. Explain that: - Anaesthetist will visit prior to surgery, talk with patient and answer any questions - Administer pre-operative medication as ordered (before surgery, patient will receive needle or pill for relaxation. This will cause mouth dryness and drowsiness) - Explain importance of remaining in bed following administration of medication - Ensure siderails are up after medication - Patient will be transported to the operating room via a stretcher to a waiting area - Patient will have to wait in this room until the operating room is ready - The doctors and nurses will be dressed in caps, gowns, and masks - An IV will be started in the OR if the patient does not already have one. Medication will be administered through this to put the patient to sleep - The patient will awaken in the recovery room and the length of time will depend on the type of surgery and the patient's condition - The patient may have a dry mouth, sore throat, and feel sleepy after surgery	5. Verbalizes knowledge about pre-operative medication and anaesthesia
6. Potential loss or damage to valuables during surgery.	6.- Jewellery to be locked in valuables drawer, wedding ring may be taped - Dentures to be cleaned, placed in denture container, labelled and stored in bedside table - Medic Alert bracelet, if worn, is to be taped to patient's arm - Ensure note on chart cover of capped teeth, bridge, etc.	6.- Safe storage of valuables and prostheses - Medic Alert bracelet and wedding ring taped (if present) - Note on chart if teeth are capped or bridge in place
7. Potential delay of surgery related to oral intake pre-operatively, elevated temp, signs symptoms of cold, etc.	7.- Explain reason for NPO - Attach NPO alert sign to bed or wall mount - Remove food and liquids from bedside table - Cancel meals - Notify surgeon if temperature elevated, if patient is symptomatic of cold, etc., or abdominal diagnostic tests, pre-operatively	7.- No oral intake after NPO deadline - No delay in surgery
8. Knowledge deficit re: post-operative procedures.	8. Explain that: - Blood pressure, pulse, respirations, dressings, IV's, and tubes will be monitored every 15 minutes while in recovery room and, on return to the unit, will be monitored by the nursing staff on a regular basis - Pain medication will be administered PRN as ordered by the MD (instruct patient to advise the nurse when having pain) - Patient will return to nursing unit when condition is stable - Personal hygiene, mouth care, back care, and positioning will be administered every four hours until patient can attend to own care (patient may feel drowsy and nap frequently for the first 24 to 48 hours)	8.- Verbalizes knowledge of routine post-operative procedures - Will request analgesia post-operatively

Figure 6. Study hospital standard nursing care plan (continued).

of the standard nursing care plan for surgical patients that nurses could consult to construct their own. The portions of the standard plan shown are those that pertain to the pre-operative phase. It appears that the actual care plan is modelled to some degree on the standard care plan, especially with regard to entry in the category "nursing diagnosis". Under the category "nursing intervention" the nurse creating the actual plan resorts to a kind of shorthand to cover the detail of intervention in the standard plan, but she provides the required evidence that patient education has taken place. The intervention for the anxiety attributed to the patient is education described in the terms that Brenda described it: "Pre and post-op teaching. Explain all procedures". The inclusion, as an intervention, of "spending time with the patient" seems at odds with the allocation of nursing time allocated to pre-operative teaching in the workload measure, and at odds with nurses' experience of patient teaching. It speaks to the need to create a plan that reflects the professional discourse of teaching, and nursing, as opposed to the actual work of nursing on Study Ward. This plan is not a plan that takes into account the actual conditions of nurses' work (twelve minutes is allocated for pre-operative teaching). It is a plan that takes into account the need to display the professional character of nursing work, and therefore its quality.

The format of the care plan, that is the categories into which nurses enter information as well as the information itself, demonstrates the achievement of nursing care of a professional character. Some years before my study the nursing department of the hospital adopted a theoretical model of nursing developed by Gordon (1987) as the organizing framework for nursing care given to patients in the hospital. This move was in accordance with the trend in both nursing education and nursing management (discussed in Chapter Four) to ground nursing practice in theoretical models of nursing as part of the professionalization of the occupation. The Gordon model "provides" both the terms of the process that nurses follow in giving care (diagnosis, goal, intervention) and the names of nursing diagnoses (for example, "Alteration in comfort") which nurses may "fit" to information obtained from their assessment. The pre-formatted Nursing Care Plan form (see Figure 6) uses the terms of the Gordon model. Nurses enter information about their patients into categories using these theoretical terms. The use of these terms in the written care plan constitutes the care as meeting professional nursing standards for quality. This provides evidence to persons such as members of an Accreditation Team that quality is maintained.

The second feature of the Nursing Care Plan is that the work of nursing is displayed as a systematic and logical

process: diagnosis, based on information obtained from the assessment forms, "leads" to goal setting and intervention. The care plan displays nursing care as organized within the framework provided by the nursing process (Hargreaves, 1981). This, too, marks it as professional, and therefore of the desired quality. As noted in Chapter Four, Redman (1993a) identifies that the nursing process and the teaching process share the same systematic form. She says, "The teaching process can be seen as parallel to the nursing process in that each has an assessment, diagnosis, intervention and evaluation phase." (p. 13)

In summary nurses produce documentary accounts of nursing care, including pre-operative teaching, that do not reflect their actual teaching. These accounts, however, display that nursing care is accreditable and meets professional nursing standards because they show nursing care as guided by theory and as a logical and rational process. In relation to the accreditation indicators in Standard VI describing teaching, these documents provide evidence that patient and family education has taken place.

Thus certain teaching is rendered organizationally visible, pre-operative teaching. The work of teaching about hospital routines disappears as necessary even though, as argued in Chapter Three, it is fundamental to the ongoing functioning of the hospital.

To return to the second indicator (see page 146) concerning patient teaching: accreditation of nursing services depended upon evidence of "appropriate activities and current materials to support patient and family education". Furthermore such activities and materials needed to be scientifically current and be approved by the relevant professional groups in the institution. Within the Study Hospital the resources and processes to meet the requirement to educate patients and family members "appropriately" were managed by the Patient Education Coordinator, a senior member of the nursing department. She chaired two committees. The Patient Education Committee, made up of nurse managers and educators, was charged with setting policy for this function; the Patient Education Interest Group, made up of staff nurses, took responsibility for the preparation of teaching materials. On Study Ward teaching materials prepared, or reviewed, by the Patient Education Interest Group were stored in the Teaching Room. These materials included flipcharts, such as the one used by nurses to carry out pre-operative teaching, video tapes and a large number of pamphlets and brochures on common surgical conditions and procedures. A pamphlet, typical of those prepared in the hospital, is shown in Figure 7. It is called <u>After-Abdominal Surgery Discharge Instructions</u>. It was prepared by the nurses on the Patient Education Interest

After-Abdominal Surgery Discharge Instructions

This is a guide to help with your care at home.

CARE OF THE INCISION

A light bandage will cover the incision after the initial bandage has been removed.

You may or may not have stitches. If you do, they will be removed approximately 7 to 10 days after surgery. An appointment with either your family doctor or surgeon will be given to you.

If Steristrips have been applied to the incision, they can be peeled off as they become loose. This is approximately 7 to 10 days after your operation.

You may shower if you apply saran wrap over the bandage so that the incision does not become wet.

You may bathe when the incision is healed. This is usually 10 days after the operation.

SYMPTOMS TO REPORT TO YOUR DOCTOR

Vomiting
Redness, swelling or warmth around the incision
Drainage from the incision
Separation of the edges of the incision
Increasing pain or tenderness around the incision
Fever and chills

Figure 7. A portion of the instructional pamphlet entitled, "After Abdominal Surgery Discharge Instructions".

Group under the direction of the Coordinator. Brenda, the staff nurse representative to the Interest Group from the Study Ward, explained to me the process of getting the pamphlet approved (11/6/90). She said:

> When it [the pamphlet] was completed, totally completed, she [the Coordinator], presented it to Dr. XXX. He read it over and thought it was excellent. So he read it through and everything was OK with him. If there was anything in there he thought should not have been there he would have told us. This can so easily be recopied because she has it on computer. And it was at the end, the very end of this. We didn't get any input from him all along because a lot of these things we, the nurses, deal with. And it's in books and stuff.
>
> FG: Why does Dr. XXX have to see it?
>
> Brenda: Uh .... well, I know, because a lot of it, like a lot of it is our [the nurses] input. He has to see it because it has to be approved by him. We cannot give somebody a handout if it's got wrong information on it according to the way that this patient should go home and have things looked after. He [the physician] may feel that taking stitches out in so many days is not what he usually does. OK?

Brenda seems to recognize that something happens to the knowledge of nurses in the process of getting physician approval for educational material that nurses construct for patients. It appears that nurses' knowledge only becomes authoritative once it has been approved by physicians. This points to the appropriation of nurses' knowledge by physicians that I take up in the next chapter. What is relevant about the approval required for documents such as the one described above is that it leads to the third set of

managerial relations organizing teaching work, the relations around protecting the hospital from liability.

Protecting the Hospital Against Liability

As displayed in the Pre-operative Teaching Standard Care Plan (Figure 6) pre-operative patients were routinely regarded as being anxious and possessing a "knowledge deficit" where the surgical procedure and aftermath were concerned. The nursing intervention to correct these deficits was teaching, using, among other devices, the flipchart that my nurse participants sought out so diligently.

Nurses' pre-operative teaching was recorded on a special form, the Patient Education Record: Pre-operative shown in Figure 8. The contents of this form "matched" the contents of the flipchart, Before an Operation. After teaching a pre-operative patient a nurse would complete this form by placing a check mark in the content boxes and by recording the fact that she had provided the flipchart or that the patient had viewed a video tape on pre-operative preparation. This form was the evidence that nurses had, indeed, taught the pre-operative patient. This form could be useful when the hospital needed to respond to a patient complaint about the nursing care she had received. The Head Nurse reported such an incident to me. She said:

> I had a complaint from one of the patients, saying she was never taught anything. So I pulled her

Patient Education Record: Pre-operative

PROVIDED:

		DATE	INITIALS
BOOKLET(S)			
FLIP CHART(S)			
VIDEO			
OTHER			

INSTRUCTION GIVEN RE:	DATE	INITIALS	INSTRUCTION GIVEN RE:	DATE	INITIALS
Medications			Wound Assessment/Care		
Procedures/Exam			Deep Breathing/Coughing		
Anaesthesia			Incentive Spirometer		
Intravenous			Positioning/Turning		
Type of Surgery			Ambulation		
Control of Pain			Leg/Foot Exercises		
Recovery Room/SICU			Splinting of Abdomen		
Vital Signs			Diet Progression		
Catheter (Bladder)			Lifestyle Changes		
Catheter (Wound)					

COMMENTS RE Patient Comprehension, Lifestyle Changes, Other: _____

INITIALS	SIGNATURE	PRINT	STATUS

Figure 8. Study Hospital Patient Education Record: Preoperative.

> chart. And there was pre-op teaching. It was all done. Even a comment saying she understood, she didn't want anymore. To me .... that satisfied me for the nurses. I can back them up, you know what I mean? And it was neat to see....that's great. I was so glad when I turned and it said it was done. Great. But .... it also covers themselves. It gives the information on the patient. (11/4/90)

This excerpt shows the connection between the teaching material and the protection of the hospital against liability in the care of patients. Patient education is an important part of risk management (Yeaton, 1990). The processes and resources managed by the Patient Coordinator serve not only accreditation and professional nursing practice standards but also the safety of the hospital against action by patients. When patients receive written and medically sanctioned instructions about their post hospital care the hospital has met its obligation to care for patients safely. Nurses who produce adequate documentary accounts of pre-operative teaching protect the hospital from liability.

Summary

This chapter has taken up managerial relations that organize teaching work. Hospital nursing services in the closing decade of the twentieth century are organized to respond to concerns of the public and governments about the costs of nursing care, their quality and safety. Teaching, as a component of the care that nurses render in hospitals,

is organized by these same concerns. Documentary practices and processes that nurses engage in organize the resources that are available to do teaching work. They also create displays of their care, including their teaching, that meet requirments for satisfactory and safe care. The accounts that nurses create of teaching work build in conceptions of teaching found in the professional discourse and thus contribute to the invisibility of much of their teaching work.

In describing the production of teaching materials by the Patient Education Interest Group I pointed to the issue of nurses' knowledge and physicians' knowledge. This leads to a third and last set of relations that organize teaching work, the relations between nurses and physicians. These I take up in the next chapter.

Chapter Six

Gender Relations and Teaching

Introduction

In the preceding chapters I have shown that nurses' teaching work is organized through a complex of relations that arise, firstly, out of a discourse of teaching in an occupation undergoing professionalization, and, secondly, out of the management of nursing. These relations impart a particular character to teaching work, and they accomplish professional and managerial relevancies, but they also render invisible a significant portion of teaching work. In each case invisibility is accomplished through documentary practices and processes that attend to only parts of the work, the parts that are consistent with professional and managerial conceptions of teaching. The work that is left out of the teaching discourse, and is absent from managerial accounts, is the work that nurses do to teach inexperienced health care workers and patients to participate in hospital work processes.

The purpose of this chapter is to explicate a third set of social relations organizing the teaching work of nurses. These relations are implicated in the third disjuncture in the teaching work of nurse. This is the disjuncture between what nurses actually know of medical work and patient problems and what they appear to know and be able to say in

the information and instruction they give to patients and physicians. The social relations organizing this disjuncture are the hierarchical and gendered relations between physicians and nurses. I contend that they, too, organize the character of nurses' teaching work. However it is important to see that hierarchy and gender are not things. They are a set of relations that nurses and physicians actively construct through social practices.

In this chapter I show three things. First, that in teaching patients, nurses both refer and defer to physicians as the authority in matters of patient care. Second, that in teaching inexperienced physicians, nurses "hand over" their knowledge of hospital work processes to physicians in order to get work done. Both of these practices which are characteristic of hierarchical relations render nurses' own knowledge invisible and make problematic a claim to be teaching. Finally I argue that the invisibility of nurses as teachers for physicians arises from the profoundly gendered character of the organization of work in hospitals, a point initially raised in Chapter Three. Before making these three central analytical points, I want to provide a brief description of the health care hierarchy.

The Health Care Hierarchy

The health care hierarchy is a taken-for-granted feature of health care work and arises out of an established

and historically grounded set of relations between physicians and nurses (Gamarnikow, 1978).

At one level the health care hierarchy can be regarded as an ordering of health care workers based upon an occupational and gender division (Willis, 1989) in which physicians are dominant. Thus, Butter, Carpenter, Kay & Simmons (1987) describe health occupations according to their major function in patient care. They note that across health occupations female workers are concentrated in occupations identified as "feminine" in which the work is primarily psychosocial or supportive in nature and of mixed or low autonomy. Male workers are found in large numbers in occupations regarded as "masculine" in which the work is mostly curative or technical with relatively high levels of autonomy. Butter et al. observe " .... male workers are heavily concentrated in high autonomy, elite occupations whose status often entitles them to control subordinates in usually preponderantly female occupations" (p. 140).

At another level the health care hierarchy can be regarded as a hierarchy of knowledge and knowers. It is about what counts as knowledge, about who can know what, and who can act on what they know. Within the health care hierarchy physicians' knowledge and skill is deemed to be superior to the knowledge of other workers and physicians' scope of action is wider with respect to patients' bodies and hospital resources. Physician autonomy and authority to

act in and around the body of the patient is protected by the state through legislative acts that define the practice of medicine. The hierarchical relations that exist between physicians and nurses organize nurses' teaching work with both patients and inexperienced physicians.

Teaching Patients

Control by physicians extends to information giving by nurses, and others, as Freidson (1970) points out. This control shapes the teaching work of nurses since, as we saw in Chapter Three, one aspect of teaching work is providing information and explanations. Freidson says,

> In the medical organization the medical profession is dominant. This means that all the work done by other occupations and related to the service of the patient is subject to the order of the physician. The profession alone is held competent to diagnose illness, treat or direct the treatment of illness, and evaluate the service. Without medical authorization little can be done for the patient by paraprofessional workers. The client's medication, diet, excretion, and recreation are all subject to medical orders. So is the information given to the patient. By and large, without medical authorization paramedical workers are not supposed to communicate anything of significance to the patient about what his [sic] illness is, how it will be treated, and what the chances are for improvement. The physician himself is inclined to be rather jealous of the prerogative and is not inclined to authorize other workers to communicate information to the patient. Consequently, the paraprofessional worker who is asked for information by a patient is inclined to pass the buck like any bureaucrat. "You'll have to ask the doctor," the patient is told. (p. 141)

Within the Study Hospital, and consistent with Freidson's formulation, a proprietary relationship appeared

to exist between attending physician and patient.[46] Patients were always identified in hospital documents, and spoken of by nurses, and other workers, in exchanges of information, as the patient of the attending physician who had arranged admission to hospital. This was especially evident to me in the change-of-shift report where the departing nurse introduced her report on each patient by first stating the name of the attending physician. As well, on the worksheet nurses wrote as they received report, they penned the name of the attending physician opposite their entry for each patient. Nurses had various explanations for these practices. The explanation that Barb and Lise (Joint interview, 2nd round, 05/06/90) gave me for the practice of writing the name of the attending physician against the patient's name was that it helped them do their work and answer patients' questions.

> Barb: Well, it is just if you need them, it's handy. If there is a doctor on the floor and you have a patient that needs something, you know right then and there who the doctor is.
>
> Lise: I find it easy .... too, a lot of times you are doing rounds and the patients will stop and ask you, "Has my doctor been around?" Then you can look at your sheet, find out who the doctor is

---

[46] It is important to understand the difference between the housestaff (resident, intern and clinical clerk) and the attending physicians. The latter directed the work of the former. Decisions about the day-to-day medical management of patients by the housestaff were taken by them in consultation with the attending physician. The attending physician's preferences in medical therapy guided the actions of the housestaff.

> and reply. Same thing with finding out what the surgery is.

No nurse volunteered that her notation was a reminder of the limits of her information-giving to a patient, yet all my participants acknowledged that knowing the identity of the staff physician shaped their talk with patients. For example Marie (19/04/90) said:

> The doctor does really warrant what you can say and can't say. Some of them you can say, some of them you can't.

The limits of nurses' information-giving was evident to me in the verbal exchanges nurses had with patients. In the course of responding to patients' questions, and despite their own knowledge of the matter at hand, nurses either deferred to, or referenced, the physician as the source of their knowledge and action. In so doing they displayed precisely the behaviour that Freidson (1970) says is indicative of the control of physicians over medical information.

Talk by nurses with patients that referenced the physician went on during the routine nursing activities of the day such as making a bed, taking blood pressures, and making rounds. For example, Barb was helping patients to wash and get out of bed first thing in the morning. One patient, a woman who had had an operation in the previous two days, asked her if she was to be given breakfast that day. Barb replied "No dear, We must check with the doctors first" (23/1/90).

A second example involves Susan (22/3/90), a nurse with more nursing experience than Barb, and almost 11 years of employment on this ward. Susan is stopped by a patient as she walks up the hall:

> Patient: How long will it be before I can wash my legs? [This patient had varicose veins removed two days before]
>
> Susan: Have the doctors been in to see you this morning?
>
> Patient: Yes, but they didn't say anything.
>
> Susan: When do you next expect to see your doctor?
>
> Patient: I have a return appointment in six weeks.
>
> Susan: Well, you could soak off the bandages in about ten days, or you could call his office to check if you are not happy waiting that long.
>
> Patient: Ten days, ok.

All twelve of my participants told me that knowing the attending physician and his personal preferences about nurses giving information to patients was key in replying to patients' questions. Some doctors, said these nurses, didn't care what you told the patient, others did, and you could get into trouble if you, in the words of one nurse, "crossed the line" (Marie, 19/04/90). It appears that Susan is able to answer this patient's questions in the detail that she does because, firstly, she knows the answer to the question but, secondly, she knows she is not crossing "the line".

Inexperienced nurses on the Study Ward learned by trial and error, and from their more experienced sisters, which attending physician sanctioned the giving of information to patients by nurses. Nowhere was there a policy for nurses to consult on this matter; the limits of information-giving were simply passed from nurse to nurse as they came to work on the ward, or when they ran afoul of a doctor in the process of talking to a patient. Anna said:

> Anna: Some of them, we know how much they will let us go ahead and say to a patient, and some doctors fully expect that we will be the ones that will be telling them .... sometimes if we don't tell them the patient won't find out.
>
> FG: How does a new nurse on this ward find out what she can say to a patient of any particular doctor?
>
> Anna: Trial and error .... live and learn.
>
> FG: Any other way?
>
> Anna: Working with one another .... and you say to the new nurse, "Look, this is Dr. XXX's patient. Don't feel free to go in there and fully discuss his diagnosis with him, or what he can and cannot do, because he [the doctor] won't appreciate it." Basically it's trial and error and getting to know the doctors and their litt e quirks.
>
> FG: Do you know of any legal reason that you could not talk to a patient about a particular problem, test or diagnosis?
>
> Anna: I don't know that there is any law but it was always my understanding that it wasn't my place to give a patient a diagnosis.
>
> FG: What does that mean when you say it is not your place?

> Anna: I am not the medically qualified person to make the diagnosis. I can make the nursing diagnosis but that is different.

Anna identifies that limits to information giving revolve around who is the rightful knower. In situations where test results or a diagnosis are to be revealed to a patient the attending physician is the rightful knower because the subject matter lies within the domain of medicine. Yet, clearly there is some flexibility in this area because Anna suggests that certain attending physicians expect nurses to do the telling. Furthermore Anna indicates it is up to the nurse to figure out which sort of physician she is dealing with; one who will become angry if nurses tell patients the results of their tests, or one who expects that nurses will give this information. The point here is that it is the personal preferences of attending physicians about sharing information with patents, and not nurses' knowledge about patients' medical problems that appears to shape their talk with patients, and therefore shapes their teaching.

The preferences of attending physicians about information giving were not the only factor shaping nurses' teaching with patients. These physicians differed in the recovery regimens they wished patients to follow and nurses had difficulty in keeping up with these differences. This is evident in a group interview of three participants who

talked about information giving and attending physicians (Joint interview, 2nd round, 4/6/90). This is how it went:

> Laura: As far as post-op care here ... like, our teaching ... we do it on a "generalized" manner. We don't do it ... Dr. JJJ likes it this way, Dr. GGG likes it that way ... because we have no idea what they like done anyway.
>
> Susan: Because they do change their minds.
>
> Laura: Exactly ... and they never tell us what they really want done.
>
> Judy: There is no protocol.

The teaching materials produced by the Patient Education Coordinator with the help of staff nurses appeared to be one way the nursing department helped nurses manage physician differences in giving information to patients. Betty (03/04/90) alluded to this when she said:

> We do have written information, for different surgeries, what patients can do and can't do afterwards. And the doctors themselves should be telling them what they should be able to do. Like, the papers [the written information] are guidelines. I don't know if the doctors are even aware of what is on these papers. They have been approved, I know they have been approved .... probably by Dr. XXX, or whoever was head of surgery at the time.

In addition to physician preferences it seemed that the work routines, and practices, of both nurses and physicians on this ward significantly shaped what nurses knew of diagnoses and treatment plans for specific patents, and therefore the teaching they were able to do. For example nurses worked 12 hour shifts and never more than three in a row; nursing work was divided between two nursing teams and

nurses frequently moved from one team to the other after only two work shifts. Nurses, therefore, were hard pressed to develop a depth of knowledge about their patients' medical problems before they had days off or were assigned to new patients. While nurses had a general level of knowledge about the course of illness and treatment in surgical patients their lack of knowledge about a specific patient was a disadvantage in answering patients' questions and providing explanations. Attending physician practices around visiting patients added to this problem. While the housestaff made rounds in the morning, individual attending physicians often came to the ward in the late afternoon or early evening. At that time nurses might be having their evening meal, or helping patients eat theirs, and therefore be unavailable to speak with these physicians. Even when attending physicians did come during the day it was not their practice, as far as I observed, and as nurses confirmed, to find and ask the nurse caring for their patient to come with them when they went to see the patient. Finally the average length of stay by a patient on this surgical ward was only five days. A combination of factors (nurse and patient "turnover", the routines of physicians) therefore led to a lack of direct communication between nurses and attending physicians. Betty (03/04/90) reflected this when she said:

> Well, its hard to be able to know what to tell the patients because there is no communication between

> the doctors and nurses. You don't know what the doctors have told the patients already. Like, if they have given them a little information or told them the whole story of what has gone on. So it makes it really hard for us to go in and try to talk to the patient. The doctors are hardly around, they spend a minute with them [the patients] and try to explain what is going on with them. So it kind of leaves you that you don't know how much you should tell the patient.

In sum the work and communication practices among attending physicians and nurses, plus the short period of hospitalization for the average patient, seemed to produce a situation where nurses would not have, and could not easily get, detailed knowledge about patients and, in replying to patient enquiries, would need to reference the doctor as the authoritative "knower" in matters of treatment and recovery. In so doing nurses constructed physicians, and their knowledge, as superior to their own. The nurses themselves recognized this. One nurse told me "We just do teaching in a generalized manner, because we have no idea what they [the doctors] want" (Susan, 4/6/90).

In summary, in teaching patients nurses participated in the construction of the hierarchy typical of nurses-physician relations. This is a hierarchy of knowledge and knowers. Nurses' teaching practices with patients reflected their position of subordination in this hierarchy. In answering patients' questions, and despite a general level of knowledge of surgical matters, nurses referred or deferred to attending physicians as the authoritative knower in matters of diagnosis or treatment. The work routines of

both physicians and nurses appeared to support the construction of a knowledge hierarchy. Nurses possessed a general knowledge of the recovery process in surgical patients; the specific knowledge they needed to teach the patients of a particular attending physician (to answer patients' questions and provide explanations) was diificult for them to acquire because of the work routines of both physicians and nurses. They thus appeared in their conversations with patients to be uninformed, and to be dependent on physicians for knowledge to give their patients.

Teaching Physicians

Nurses teach physicians. They use their medical knowledge and their knowledge of how work gets done in the hospital to teach physicians to do medical work and care for patients. However there are a number of ways in which their knowledge is structured or "denied" as knowledge. As I have said in the introduction to the chapter, a nurse's knowledge can be seen to be appropriated by the physician so that it no longer appears as her knowledge.

An example of the appropriation by physicians of nurses' knowledge is found in the ways nurses showed inexperienced physicians how to make use of various forms and requisitions on the ward in order to get work done. Requisitions of all kinds are routinely used in hospitals to

initiate diagnostic work like x-rays or blood tests. On the study ward there were probably twenty-five to thirty different forms. Most of them required some information about the patient, for example, the fact that an IV solution was infusing, or the need for a wheelchair to transport the patient to the X-Ray department. From time to time nurses were called upon by junior physicians to show them which forms to choose for which test, how to complete them, where to find the information in the patient's chart, and where to record it on the form. This work was vital to getting the test done because a department could refuse to carry it out if the information was incomplete or wrong. Nurses however could not sign these forms. I observed Lise (06/02/90) instructing a clinical clerk on how to fill out a requisition for an x-ray, what to write on the form in the way of a brief history of the patient's problem and where to write the history. She showed him where to sign the requisition adding "They won't accept a nurse's signature".

Similar practices took place around the writing of medical orders. Experienced nurses often showed doctors who were "learning the ropes" how to write them, what language or symbols to use so the order was consistent with hospital policy and could be acted upon, and in the case of drugs, which brand was stocked on the ward, and the times of administration most suited to the patient's routines. But the medical order as it finally appeared in the chart

appeared to be the sole work of the physician.[47] An example of this is found in the following exchange between Mary, a nurse, and a junior physician.

> Mary and I [FG] are out "covering the unit" as the next shift of nurses gets report in the small room behind the Nursing Desk. Mary talks to an intern who is sitting at the desk with us. There are two patient problems that are the subject of this conversation. The first is the problem of diarrhea in a patient. Mary suggests Lomotil to stop the diarrhea. The intern goes and gets the CPS, a drug manual, from the room where the night nurses are getting report, and begins to look up the side effects, also the dose. He cautions Mary to check for a distended abdomen in the patient which would indicate an adverse drug reaction. The second problem gets solved after Mary tells him about a patient with a rash. She suggests Calamine Lotion but he suggests a drug, Atarax. He once again starts to look up the dose which Mary tells him is 2.5mg. Shortly thereafter Mary begins to transcribe orders from the Order Sheet to the Medication Cardfile, and mentions to me that the intern has, in fact, ordered the Lomotil. As she begins to transcribe orders the intern asks her how to write the order to direct nurses to maintain a record of bowel movements for the patient with diarrhea. Mary tells him the order should read, "Stool chart at bedside". (14/2/90)

The point of such examples is not that nurses should be writing up requisitions and orders instead of doctors, or even that they should let junior doctors flounder around learning these practices by trial and error. In Chapter Three the point being made about such work was that this is

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[47] This example returns us to the earlier discussion in Chapter Three of "background" work that is characteristic of women's work and that, in the words of Smith (1987), "mediate(s) for men the relation between the conceptual mode of action and the actual concrete forms on which it depends" (p. 83). The conceptual work of diagnosis and treatment of patient's problems depends upon concrete action initiated through the medical order.

teaching work oriented to instructing inexperienced health care workers to participate in hospital work processes. The point being made in this chapter is that documentary, and other, practices that get work done in the hospital are part of the construction of hierarchical relations between nurses and physicians. They subordinate nurses as skilled workers by appropriating their knowledge of clinical and managerial matters. Nurses know about hospital policies and clinical matters, and they use this knowledge to get work done in the hospital, and to teach others how to get work done, but documents, and documentary practices, actively structure the invisibility of this knowledge, as knowledge. Nurses do not appear to be part of the work organization, and they do not appear to have anything to do with actually getting diagnostic or treatment work initiated. Rather it appears as if the work is merely passed down the line for them to do, as if they respond to orders but have nothing to do with their formulation.

Nurses further subordinated their knowledge, and therefore their act of teaching, to the physician's knowledge in the manner in which they engaged in interactions with physicians around the medical care of patients. They did this in the way they presented both the problem and the solution to the inexperienced physician. Nurses would bring to the doctor's attention patient problems that needed action, sometimes suggest what that

action should be, show the physician, if necessary, how to initiate it in the way of writing a "Doctor's order" or manipulating equipment, and then carry it out. For example Anna, a staff nurse with six years of experience on this surgical ward, informed her team leader, a new staff nurse, about the difficulties of a post-operative patient in regaining bladder function. She told her to call the intern and get an order for a medication commonly used to treat post-operative urinary retention. The junior nurse got the physician on the phone, explained the patient's condition, and asked if the patient could be given the medication. The intern appeared to ask her what the dose was he should order, but before the nurse could reply, said simply, "Give her the usual dose". The nurse then wrote the order in the patient's chart as a "verbal order" from Dr. "X", and "co-signed" it with her own name (Anna, 25/02/90).

In summary nurses produce hierarchical relations with inexperienced physicians, as they do with patients, through both talk and documentary practice around the routine matters of patient care. In answering patient questions, in dealing with their problems, in guiding physicians in the mechanics of hospital work, nurses actively participate in the construction of the invisibility of their own knowledge. Teaching is predicated on knowing. To be a teacher is to know and to transmit one's knowledge to another who does not know. If knowledged is masked as it is when nurses make

suggestions to physicians about patients' problems/solutions, or if through documentary practices nurses' knowledge is appropriated, then the basis for a claim to teaching does not exist. There is nothing to "teach" because one does not have anything to teach.

Gender, Invisibility, and the Organization of Health Care Work

I want to conclude my argument by drawing from feminist analyses of organizations, particularly the work of Joan Acker. Health care organizations, such as the Study Hospital, are profoundly gendered. Acker (1990) explains what that means. She says,

> To say that an organization, or any other analytic unit, is gendered means that advantage and disadvantage, exploitation and control, action and emotion, meaning and identity, are patterned through and in terms of a distinction between male and female, masculine and feminine. Gender is not an addition to ongoing processes, conceived as gender neutral. Rather it is an integral part of those processes, which cannot properly be understood without an analysis of gender. (p. 149)

Acker continues by saying that "gendering" is to be found in "at least five interacting processes (cf. Scott 1986) that, although analytically distinct, are, in practice, parts of the same reality" (p. 149). The first two processes are, firstly, constructions of divisions, of all sorts, along the lines of gender, and, secondly, the construction of symbols and images that "explain, express, reinforce, or sometimes oppose those divisions" (p. 149).

The third set are social interactions, such as talk between men and women, that "enact dominance and submission" (p. 150). The fourth set of processes are those that help to produce gendered components of individuals, and the fifth set are those processes that create and conceptualize social structures. Of this fifth set of processes Acker says,

> Gender is obviously a basic constitutive element in family and kinship, but, less obviously, it helps to frame the underlying relations of other structures, including complex organizations. Gender is a constitutive element in organizational logic, or the underlying assumptions and practices that construct most contemporary work organizations (Clegg & Dunkerly, 1980). Organizational logic appears to be gender neutral; gender-neutral theories of bureaucracy and organizations employ and give expression to this logic. However, underlying both academic theories and practical guides for managers is a gendered substructure that is reproduced daily in practical work activities and, somewhat less frequently, in the writings of organizational theorists. (p. 150)

Virtually all the processes that Acker names are at work in health care organizations, such as the study hospital, to produce their gendered character. There is a distinct and very obvious gender division of labour in health care work, which is expressed and buttressed through a host of images and symbols both within health care institutions and in the popular media. For example in the foyer of Study Hospital there was a large composite photograph of all attending physicians admitting patients to the hospital, each physician identified by name. Conversely, many nurses in the hospital wore small,

decorated, ceramic name pins, with their first name spelled out in full.

The patterns of communication between physicians and nurses are gendered.[48] At Study Hospital this was evident in a number of ways, the first being the device that nurses used to enlist the participation of physicians in patient care, the so-called "Problem List" (displayed in Chapter Three). The title, itself, suggests that nurses bring forward problems for solution by physicians. In fact the document was a list of work that nurses needed physicians to do, for example re-order medications, or re-start an IV, that only physicians were authorized to do, in order that patient care could go forward. A second example of gendered communication is the use of question or suggestion by the nurse to initiate work by the physician, rather than a more direct request. The use of gendered modes of communication is evident in this comment by a nurse, Lise, who speaks of getting a junior physician to do work that she knows needs doing but cannot do herself. She says,

> It's a fine line. You have an intern on who doesn't know anything, and you do, you know. So you have to make all these suggestions. And then if you have an intern with an attitude, and he

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[48] Nurse-physician communication has been examined, but seldom is gender part of the analytic frame (Hughes, 1988; Porter, 1990; Stein, 1967, 1990). Thus various authors propose that nurses routinely influence the decision-making of physicians in matters of patient care. However they describe this influence of the nurse as "advice" to the physician. The nature of the influence nurses exert on physicians remains unproblematic in these analyses.

> doesn't like you making suggestions, than you are in an even worse situation. So then you have options ... you can call your supervisor, which, in a lot of times, she is in the same boat as you are. You can't make them do what you want them to do. You can call the resident, and if you have a good resident you are lucky. You can call ... well, the only other option, and I have learned this from experience ... and I don't play around any more, I just call the staff man .... I say to the intern [on the phone] "If you don't do what I want I'll call Dr. ZZZ, I'll get him out of bed at 2am." Then I just hang up on them. That's the sign of a nurse who has been burnt. I don't put up with that stuff on nights any more, but I did when I first started. (1/3/90)

Work processes, especially documentary work processes, in health care institutions are profoundly gendered. The "gendering" that documents accomplish is the invisibility of the nurse as a knowledgeable worker, as a teacher, and as an initiator of work, not merely a receiver, or intermediary.

By virtue of their format and use documents are key elements in producing the gendered work organization of the hospital. They not only do this directly, by informing patients, and others, about hospital workers, and policies, they accomplish it indirectly, by structuring the absence of those persons, nurses, whose knowledge accomplishes patient care.

An example of the direct production of the gendered hospital is the instructional material nurses gave to patients to inform them about medical workers. At the Study Hospital nurses were obliged to give to each new patient a pamphlet, called "Your Medical Team" (see Figure 9). This pamphlet was authorized for use in the nursing admission

YOUR MEDICAL TEAM

We would like to introduce you to some of the staff who will be caring for you while you are in hospital.

Attending Physician - The attending physician is the doctor, primarily responsible for your care. As an attending physician, he/she holds an appointment of the teaching staff of the Faculty of Medicine. The attending physician directs and supervises your care while you are in the hospital. You should discuss with him or her any problems or concerns about your medical care. If you have any questions about your participation in the teaching program, you should discuss them with your attending physician on his first or subsequent visit.

Resident - A resident is a graduate in medicine who is continuing his/her medical education to specialize in a particular field, ie. surgery, medicine, ophthalmology, etc. The resident will carry out your day-to-day care and report your progress to your attending physician. If you have any questions about your care you should discuss them with your resident on his/her visits.

Intern - An intern is an university graduate in medicine who is spending required time on hospital staff to gain practical experience. Many are starting to specialize in a particular field.

Clinical Clerk - A clinical clerk is a student doctor. He/she is a fourth year medical student who is gaining direct practical experience with patients. He/she always works under direct supervision. Other medical students may observe particular aspects of your care. They may discuss your illness with you and conduct a physical examination.

Head Nurse - The head nurse is the senior nurse in charge of your unit. She will visit you frequently as possible but if you have any questions or concerns you should request a visit from her at the earliest possible time.

In summary, "Study Hospital", as a participant in several major teaching programs, offers excellent patient care with a team of keen minds and skilled hands.

Figure 9. Study Hospital pamphlet entitled, "Your Medical Team".

process by hospital management. It appeared to be an innocuous document, designed to inform the patient about hospital workers. Nurses gave it to patients as a matter of course when they admitted them to the ward.

It described the qualifications and responsibilities of each rank of doctor patients might encounter (the Attending Physician, the Resident, the Intern, the Clerk), and the responsibilities, but not the qualifications, of the Head Nurse. The purpose of this pamphlet was to help patients sort through and become familiar with the different categories of physicians involved in their care and the relations between them. This pamphlet described a range of health care workers but nursing staff below the level of the head nurse were not included in it. There was no mention of them, their qualifications or work organization. They did not appear as members of the team, they were not visible as persons with education or responsibility like the physicians.

The significance of this pamphlet, and its use by nurses, lies in the fact that it is in just such documents and routine work practices that gendered and hierarchical relations are produced and maintained. The pamphlet presents physicians as knowledgeable persons, and centrally involved in the work of caring for the patient. They are "the medical team". The one nurse on the team has a supportive, assistive role, ready to take up the work handed

to her by physicians but without special qualifications. The rest of the nursing staff, those who will actually attend to the patient's needs, are absent. This document describes a knowledge hierarchy among workers (attending physicians have more knowledge than residents, and residents more than interns), but nurses are not part of it. They are not present as possessors of knowledge that will be brought to bear on the patient's problem. The use of this pamphlet by nurses is an example of their unwitting subordination to physicians, and hospital management, in the work organization of the hospital.

Other documents produced the gendered organization but indirectly. The medical order sheet is an example of the documentary construction of invisibility. Orders are written on the sheet usually by physicians but sometimes by nurses, who take a "verbal" order from a physician. Whoever the scribe might be, the medical order sheet does not disclose the work behind its writing. As I have displayed, nurses identify patient problems and know the action that is required to solve them but they cannot take action without a medical order. The medical order that they persuade a physician to write, or to give to the nurse to write, "holds" the knowledge of the nurse but appears to be the product of physician knowledge. The knowledge of the nurse is invisible in the medical order, as it is in work requisitions, like the x-ray requisition.

Teaching is predicated on knowing; teachers are knowers who pass on their knowledge to others who do not know. Within the gendered institution of health care, however, nurses represent the "wrong" gender as far as knowing is concerned, the "wrong" gender to be teachers of physicians and about medical work. Their knowledge of how the hospital works, of the documentary processes that get work done, of diagnostic and treatment work, is invisible as knowledge that is taught to physicians but visible as helpfulness, or attentiveness, or "good instincts for what needs to be done". The capacity of nurses to be teachers, to be authoritative knowers, is constrained through gendered social relations.

Summary

In this chapter I have tried to show that nurses' teaching work is organized by their subordinated place in the health care hierarchy. This hierarchy is both a work and a knowledge hierarchy. Nurses' subordinated position in the knowledge hierarchy organizes what they teach patients and how they teach physicians. Where medical treatment and diagnosis is at issue nurses are not "rightful knowers" despite their knowledge of medical matters. Their teaching practices reflect this; on the one hand they defer to physicians' knowledge when teaching patients, on the other they hand over their knowledge of medical work when teaching

physicians. Gendered practices and documentary practices within the institution maintain the invisibility of nurses' knowledge and their teaching work for both patients and physicians.

Chapter Seven

Conclusions and Implications for the Theory and Practice of Educative Work in Nursing

Introduction

This chapter concludes the dissertation. In it I summarize the arguments I have made about nurses' educative work and discuss the significance of the research for both the theory and practice of teaching in nursing. It is worth noting that I conclude this work at a time when the health care system in every province is in a state of foment. I hope that this analysis can contribute to the debate surrounding health care in Canada, especially as it involves the contribution nurses make to health care.

I undertook this study because, as a nurse, I wanted to understand several longstanding difficulties that hospital staff nurses report in teaching patients. These difficulties include insufficient time to teach, physician interference in teaching, a lack of administrative support for teaching and a lack of teaching competence. In the process of doing the study I discovered that teaching as a nursing function is much more than I, myself, had been trained to see as teaching. I also discovered that nurses' teaching work is organized through social relations that are not wholly visible from the location of staff nurses working on a hospital ward but that, nevertheless, reach into the

ward to organize their educative work. My entry point into these social relations were three disjunctures I identified in the course of observing nurses working: the disjuncture between what nurses call teaching and the actual teaching work they do, the disjuncture between the character of nurses' authorized pre-operative teaching work and the character of teaching that is embedded in other work, and finally, the disjuncture between what nurses actually know of medical work and patient problems and what they appear to know and be able to say in their interactions with patients and physicians.

My arguments about nurses' educative work rest on several claims that I make about patients, health care workers and hospital work processes. These claims are that patients as well as health care workers do work in hospitals, that their work is of two different types, body work and organizational work, and that experienced nurses teach patients and inexperienced health care workers how to do this work. In making the first two claims I draw on my observations of patients and health care workers but I also draw upon an existing analysis of the social organization of medical work by Strauss et al. (1985) in which they assert that medical work is performed by patients as well as physicians, nurses and other hospital workers. In making the third claim that nurses teach patients and inexperienced

health care workers I draw upon actual observation and analysis of nurses' verbal interactions with these persons.

I accomplished three things in this study. Firstly, I uncovered and displayed the broad range of educative work that hospital nurses perform in the course of their work. Secondly, I showed how nurses' educative work contributes significantly to the accomplishment of complex and extended hospital work processes. Thirdly, I showed how nurses' educative work is organized, regulated and structured by social relations of professionalism, managerialism and gender. A feature of these social relations is their capacity to make invisible, and therefore unvalued, much of the educative work that nurses perform at the same time as they accomplish hospital relevances of cost control, quality of care and institutional and patient safety.

Nurses' Educative Work

Enlarging the picture. Nurses use a variety of communication practices with patients and health care workers that are educative in nature. These educative practices shape the behaviour of these persons towards the accomplishment of body and organizational work. Nurses ask questions and offer explanations; they give information and provide instructions; they set expectations and they demonstrate the correct performance of behaviour. Nurses teach through the use of these practices in established

educative work processes, such as pre-operative teaching, and also in the course of ordinary work routines that appear on the surface to have no educative purpose, for example measuring patients' vital functions and obtaining patient treatment orders from physicians.

Nurses teach health care workers, such as inexperienced physicians, as well as patients. Their teaching encompasses two broad objectives: seeking patient compliance with medical regimens and encouraging self-care and independence from professional caregivers, and securing the participation of patients and health care workers in hospital work processes. In regard to the second objective, nurses' educative work ensures that patients, especially, but also inexperienced physicians and nurses, participate appropriately and knowledgeably in hospital work processes. When patients and health care workers situated on a ward know how to do their part of a work process, other workers, working in other sites remote from the ward (pharmacy, laboratories) can accomplish their part of the same work process. Nurses' educative work is thus the glue that binds together the work of many persons in the hospital in order that an extended work process, such as patient diagnosis or discharge, may be accomplished.

My analysis of the range and impact of nurses' educative work enlarges significantly the current conception of teaching as a function of professional nursing practice.

It implies the need to re-theorize many aspects of the teaching function in nursing. For example the purposes that nurses ascribe to teaching need to be re-formulated because it is clear that this work involves more than current conceptualizations of teaching allow for. It also implies the need to reclaim within the teaching function the education of inexperienced health care workers, and this function must be seen to include the instruction of inexperienced physicians.

As well my analysis suggests the requirement to rethink the significance of teaching in nursing practice. Currently nurses are trained to view teaching as a highly specific work process, essentially separate from other nursing work. The frequently occurring and ubiquitous character of educative work in nursing needs to be recognized. Finally, educative work, especially the educative work that is embedded in routine nursing work, must be acknowledged for what it is, skilled work. Teaching patients and health care workers to participate in hospital work processes requires nurses to possess a detailed knowledge of both hospital policies and the habits and routines of workers such as physicians and managers. The knowledge of nurses that permits them to be effective educators must be recognized.

In summary, the prevailing conceptualization of teaching in nursing practice must be challenged through analyses such as my own to express and encompass the

totality of nurses' educative work. This implies the need to drastically revise current texts in the field (especially Redman's text), or to write new ones, in order that they encompass the full range of educative work that nurses do. It also implies the need to modify courses that prepare trainee nurses in teaching. Preparation in teaching must be more than preparation in the technology of instruction. It must help new nurses to critically appraise the communications nurses have with patients and physicians, to recognize the educative and skilled character of these communications, to understand the impact such communications have on institutional work processes, and to understand how all three of these features - education, skill and institutional significance - remain obscured.

Seeing and valuing women's work. I began the explication of the social relations organizing nurses' educative work by first looking at the educative work that is embedded in routine procedures such as measuring vital functions. By applying a feminist analyis I saw that this work has certain features that render it invisible as work and as skilled work. In the past twenty years feminist research into women's work has shown that work that women do in families and political organizations is often not regarded as work, even by those women who do it. Nurses' embedded educative work has the character of this domestic work that is often not thought to be work. It looks and

sounds like the reminders of mothers to children or partners about the tasks of everyday life: like getting to school on time, like remembering a family member's birthday, like the many small and often routine tasks that, added together, produce the "fabric" of social institutions such as the family. My analysis of nurses' educative work thus opens the door on another area of invisible work: waged, or paid, health care work. It adds to the literaure on women's work describing the nature and location of invisible work.

Feminist research in the area of women's work has shown that women in the paid labour force have had great difficulty in getting recognition for the skills required by their work. The skills required by work such as clerical work and childcare, work that women ordinarily do, have not been seen as skills at all but as talents, innate abilities that women are born with. The educative work that I claim is hidden has the character of work the capacity for which has been viewed as depending on instinct, not learning. My analysis contributes to the body of feminist work that examines the relations between the work of women, and the concept of skill. It shows once again that, where work is concerned, visibility and skill are linked and are socially constructed.

Nurses, however, have not defended nor defined their domestic-type work as skilled work; yet it clearly is that. My analysis suggests that nurses need to recognize and value

the work that they do as the "housekeepers" of the hospital, and they need to demand that others, in managerial positions, recognize and value their work as skilled. In doing so they would shed light on and assign value to domestic work processes in other venues such as the home.

Nursing unions need to take up the issue of invisible nursing work. This could happen in three ways. Firstly, unions could support investigations into nurses' work to reveal invisible work. Investigations which should be undertaken include the technical work nurses do in intensive care units and other special care units where there is a high concentration and use of complex equipment; the emotional or affectional work nurses do in longterm care units and nursing homes in cases where families don't or are unable to visit a family member; the diagnostic and therapeutic work nurses do in the Emergency Room of rural hospitals in the absence of an on-site physician. Secondly, where invisible work processes are revealed unions must be prepared to establish the value of the work to the institution, to argue that the work is skilled work, and to bargain for wage increases for nurse. Thirdly, unions must negotiate for working conditions that will allow nurses to carry out the work that is the "glue" work. This may imply the need for auxilliary nursing, or other, workers to assist nurses. It may imply additional training for nurses and

changes in hospital policies and procedures. It may imply the purchase of specialized equipment.

Professionalism and visibility. Nursing's professionalism rests, in the present day, on understanding nursing as a set of abstract ideas (health, illness, nursing) and in manipulating those ideas to form theories of nursing. This is evident in texts used in nurse training programs and in the literature in every area of nursing practice including patient teaching. One way to view scientification is as a flight from nursing's roots in domestic labour, and from the association of nursing, as women's work, with natural talent and instinct, to a more lofty plane of theoretical or conceptual knowledge. Indeed the scientification of nursing has been the enterprise of a cadre of nurse educators, managers and theorists, a ruling elite who authorize nursing knowledge (but who do not, for the most part, practice nursing on a daily basis within an institutional setting) and who seek to establish nursing as a fully autonomous profession.

Scientification, as a strategy of professionalization, poses two problems for nursing. It ignores the actual conditions under which practicing nurses must carry out their work, and in fact gets in the way of accomplishing work. This was evident in the nursing care plan for the pre-operative patient (described in Chapter Five) which prescribed a nursing intervention that required considerably

more time than provided for through the workload measure, and in the need for the admitting nurse to prepare a written plan that mirrored the standard plan. It assumes that nurses work in isolation from other workers, and especially from physicians who through the mechanism of the medical order have, in fact, a great deal to do with how nurses are able to use their time. Scientification, as a professionalizing strategy, has tended to split the profession into two groups: those who have, supposedly, theoretical training in nursing obtained at a university, and those who have practical training provided at a community college or technical institute, the first kind of training deemed to be superior to the second.

My analysis suggests the need to enlarge the notion of what counts as professional work. It suggests the need to move away from definitions that rely wholly on academic qualifications to include the experiential knowledge and skill gained through work. Such an acknowledgement has practical implications for post-entry level training programs for nurses, such as the awarding of academic credits for experience. Such a step would go a long way to closing the gap that exists among nurses and to restore a sense of value to the knowledge of "front-line" nurses.

Managerialism and visibility. The cost and the quality of nurses' work as well as the protection of the hospital from liability arising from inadequate nursing work are

managerial concerns that organize nurses' teaching work. Each one of these concerns is met through documentary processes in which nurses participate. Where teaching work is concerned these processes express the conventional conceptualization of this work, a conceptualization I criticize because it is incomplete. Documentary practices and processes for managing teaching work "build in" the invisibility of significant components of teaching work. Neither workload measures, nor nursing care plans, nor audits of teaching work include the teaching that nurses do for participation in hospital work processes. Neither do they include the teaching of inexperienced health care workers. Yet this teaching takes place and, in fact, is of tremendous significance to the organization of hospital work. In relation to the findings of my study, and with a view to making teaching work visible, probably the most important managerial process to re-examine is the process to achieve cost control over nurses' work. Currently in nursing the costs of nurses' labour are controlled through the allocation of nurses' time. The basis for the allocation are systems of workload measurement some of which conceptualize nursing as a set of timed tasks. While one criticism of such systems is that they do not capture the ongoing character of nursing work an equally serious criticism is the way they portray nurses' educative work. In these systems educative work appears to play a very minor

role in the total work that nurses do for patients. In this regard these measures reflect the conventional discourse about teaching that nurses are trained within, that teaching is a limited and separate function of nursing.

Systems of workload measurement, if they are to be used (and many nurses would argue not), should be accurate. They should reflect what it is that nurses actually do. My findings suggest the need to modify these measures to achieve a more realistic reflection of nurses' work, and to make visible the educative work that nurses do. But such a recommendation is easier to make than to do. The educative work that I revealed was, after all, initially invisible to my nurse participants. There is a question, also, of why nursing management would wish to reveal, and therefore recompense, nursing work previously hidden. The process of modifying workload measures, however, could be an opportunity for nursing practitioners and managers to learn about the conditions under which educative work goes forward and the contribution it makes to the organization of work. Such an examination could lead to the improvement in conditions for educative work, especially time allotted for this work, and therefore, overall workload allocation.

Gender and visibility. Health care institutions are profoundly gendered workplaces. There is a clear gender division of labour in hospital work, the patterns of communication between physicians and nurses are gendered,

and work processes are gendered. My analysis shows that nurses' educative work is organized through relations of gender in which nurses' knowledge of medical work is made invisible and their authority to act on this knowledge is constrained. Nurses defer and refer to physicians' knowledge in educating patients about medical matters. Nurses educate physicians about medical work in ways which do not disturb the hierarchy of knowledge which exists between the two professions: nurses ask questions and make suggestions; they appear helpful, not directive. My analysis also shows that documents nurses use to educate patients, and documentary work processes that involve nurses, are active in producing the invisibility of nurses' knowledge. In these instances invisibility is linked to the absence of nurses as the authors of instructional material for patients and as the instigators of therapeutic or diagnostic action in the hospital.

In the closing decade of the twentieth century, in virtually every province in Canada, change in the health care system is taking place. It is a time of uncertainty; questions are being raised by policy makers and the public about the costs of health care; new roles and services are being proposed. A time of change is a time that favours a public discussion of the contribution that nurses make to hospital health care and of the issue (many nurses would say "the problem") of physician dominance of the health care

system in terms of the public's access to health care. Such a discussion could result in practical suggestions about breaking down the hierarchy between the health professions, and between the health professions and the public.

Final Comments

I undertook this study because I wanted to understand my own frustrations around teaching and the frustrations of other nurses, either told to me or reported in the nursing literature. I began this study with the view that I could somehow correct the problems that make teaching difficult for practicing nurses. What I offer in these pages is not a solution to these problems but an explication, an understanding of how teaching work is put together such that nurses experience it as they do. Using a method that starts in nurses' work and not in theoretical ideas of the work I have revealed a work process and shown its value in the accomplishment of patient care. Furthermore I have shown that the invisibility of this work process is neither mysterious nor idiosyncratic. It is built in to conceptions of teaching, ways of accounting for teaching, and into the relations between physicians and nurses. These insights could propel nurses, using this same method, to investigate other areas of nursing. My findings can direct change in the education of nurses, the management of nurses' work and the relations between nurses and physicians.

Appendix A

Nurse Consent Form

Study Title: The Social Relations of Nurses' Educative Work

Principal Investigator: Frances Gregor, RN, MN

INTRODUCTION

I invite you to take part in a study of nurses' educative work. It is important that you read and understand several general principles that apply to all individuals participating in studies in this hospital:

(a) taking part in this study is entirely voluntary. Whether or not you participate will not affect your position as a staff nurse on this unit.

(b) personal benefit may not result from taking part in this study, but knowledge may be gained that will benefit others.

(c) you may withdraw from this study at any time without penalty or loss of benefits to which you are otherwise entitled.

NATURE OF THE STUDY

This study is an examination of the ordinary, day-to-day work of the nurse, the focus being the work of

the nurse to educate patients about their illness. The purpose of this study is to describe this work and its organization. The findings may contribute to knowledge about nurses' work and about the process of hospital patient education.

PROCEDURES

This study will proceed in two, and possibly three, phases. In each phase of the study I will observe you for up to three consecutive workshifts. I will take notes about what you say, who you talk to, and what you do. I will collect and make a copy of each hospital document and patient record that you read, or write in, during the shift. After the observation, I will interview you about your work. The interviews will take place at a time and place convenient to you as soon as possible after the observation. The interviews will be audiotape recorded and transcribed. I will provide you with a copy of each transcribed interview for you to add any comments.

A code known only to me will be used to protect your identity. Your name will never appear on the notes I take nor on the transcriptions of the interviews. Your name will never appear on the documents and patient records I collect and copy. The taped interview will be listened to by me alone, and will be erased once transcribed.

I will never discuss with the hospital administration, nor allow them access to, the notes I take nor the interview transcriptions. All study material will be kept confidential.

The results of this study may be published or presented at a scientific meeting but the identity of those taking part will not be revealed.

PLEASE COMPLETE THIS ITEM

I have read the explanation about this study and have been given the opportunity to discuss it and ask questions. I hereby consent to take part in this study.

_____	_____
Signature of Nurse	Date Signed
_____	_____
Signature of Investigator	Date Signed
_____	_____
Signature of Witness	Date Signed

Appendix B

Patient Consent Form

Autumn, 1989

Dear Patient:

Hello, my name is Frances Gregor. I'm a nurse and a PhD student at Dalhousie University.

Attached to this note is a Consent Form that your nurse will discuss with you. It describes a study I'm doing on this unit. The study is about how nurses' do their work.

I'm asking every patient admitted to this unit to participate in this study. The Consent Form explains what is involved if you participate. I hope that you will read it and decide to be part of the study.

I can't be present on the unit every day, but I am available to answer any questions you have. Just let your nurse know that you would like to speak with me.

Thank you for considering this request.

Sincerely,

Frances Gregor, RN, MN

Study Title: The Social Relations of Nurses' Educative Work

Principal Investigator: Frances Gregor, RN, MN

INTRODUCTION

On behalf of Mrs. Gregor, I invite you to take part in a study of nurses' work. It is important that you read and understand several general principles that apply to all individuals participating in studies in this hospital:

(a) taking part in this study is entirely voluntary. If you are a patient, whether you participate or not will not affect the quality of medical care provided to you.

(b) personal benefit may not result from taking part in this study, but knowledge may be gained that will benefit others.

(c) you may withdraw from this study at any time without penalty or loss of benefits to which you are otherwise entitled.

NATURE OF THE STUDY

This study is an examination of the ordinary, day-to-day work of the nurse, the focus being the nurse's work to educate patients about their illness. The purpose of the study is to describe this work and its organization. The findings may contribute to knowledge about nurses' work and about the process of hospital patient education.

PROCEDURES

In doing this study, Mrs. Gregor, a nurse herself, will be following nurses around as they do their work. She will make notes about what they say, who they talk to, and what they do.

Only half o the nurses on this unit are participating in this study. It is possible that while you are a patient on this unit you will be cared for by a nurse who is a participant. In this case, Mrs. Gregor is asking your permission to remain in your room while the nurse is attending to your needs.

As well, Mrs. Gregor is asking your permission to read your chart, both while you are a patient on this unit and, if necessary, after you leave the hospital, and to make notes about the nursing care recorded in the chart. Her notes will describe the nursing care you received; they will not describe your illness or treatment. Information will never be copied directly from your chart and your name will never be recorded on the notes.

Mrs. Gregor will use the notes to discuss with your nurse the care she gave you. The information that she obtains from your nurse will help her understand the nature of nurses' work, especially their work to teach patients. When Mrs. Gregor is not using the notes, she will keep them in a locked file.

The results of this study may be published or presented at a scientific meeting but the identity of those taking part will not be revealed.

If you have any questions about this study, please contact Mrs. Gregor at Dalhousie University, telephone 494-3724.

I suggest that you keep a copy of this document for your later reference and personal records.

PLEASE COMPLETE THIS ITEM

I have read the explanation about this study and have been given the opportunity to discuss it and ask questions. I hereby consent to take part in this study.

_____	_____
Signature of Patient	Date Signed
_____	_____
Signature of Investigator	Date Signed
_____	_____
Signature of Witness	Date Signed

Appendix C

Nurse Interview Guide

SECTION A: Introduction

1. Preliminary greetings.
2. Review of general plan for interview.
3. Clarification/expansion of specific incidents where details are missing from my fieldnotes.

SECTION B: Good Shifts/Bad Shifts

1. Exploration of a "good" shift.
2. Recollection of the last "good" shift.
3. Exploration of why it was a good shift.
4. Repeat for "bad" shift.

SECTION C: The Work

1. With patients/patient's families, friends/health care workers.
2. With hospital documents, patient records.
3. With equipment/technology.

SECTION D: Intersection with Other Work Processes

1. Receiving the work, passing it on.
2. Breaks and interruptions in the work.
3. The work that keeps other work processes going.

SECTION E: Educative Work

1. Identification of instances of educative work.
2. Exploration of instances.

SECTION F: The Nurse, Herself

1. Age, preparation in nursing, duration of employment in nursing, duration of employment on this unit, continuing education in nursing, other experiences that build skill in educative work.

SECTION G: Closure

1. Review and summarize interview.
2. Review measures to protect confidentiality.
3. Remind that transcription will be available for review and additional comments.
4. Express thanks.

Appendix D

Nurse Questionnaire: Phase Two

PLEASE READ EACH ITEM AND CIRCLE THE RESPONSE THAT MOST CLOSELY CORRESPONDS WITH YOUR OWN OPINION.

1. Melissa helps Mrs. Smith to transfer from the OR trolley to her bed. She tells her "They have given you a new scar". She takes her pulse and blood pressure and says to her "Mrs. Smith, I want you to take deep breaths, in through your nose and out through your mouth. I want you to do that every time you wake up".
   WOULD YOU CALL THIS TEACHING? Yes No
2. Jenny is making rounds after the 7am report with the rest of nursing staff on the south end of the ward. She goes into Room XXX to see the patient, Mr. George. She checks his T-tube for drainage, then she says to him "You're going for a cholangiogram this morning, so nothing to eat or drink until after the test".
   WOULD YOU CALL THIS TEACHING? Yes No
3. Stephanie is doing the 4pm vital signs. She takes the temperature of the patient in Room ZZZ, then says to him "It's up a bit, Mr. MacDonald. It's 38.6. Have you been using your incentive spirometer? Make sure you use it every hour to bring that temp down".
   WOULD YOU CALL THIS TEACHING? Yes No
4. Linda is helping patients to settle for the night. She gives back care to those who want it, straightens bed linen and offers a drink to patients as she works her way around the north end of the ward. She tells each patient "Be sure to call us if you want anything. We'll be around every hour through the night".
   WOULD YOU CALL THIS TEACHING? Yes No

5. Rhonda speaks briefly to the patient in Room WWW who is for the OR tomorrow. She sees the flip chart "Before and after surgery" lying on his table. "Any questions?" she asks him. The patient has no questions about his surgery but asks Rhonda "Can I keep my pyjamas on under the hospital shirt?" Rhonda tells him that he can wear them for now but they must come off before he goes to the OR.
   WOULD YOU CALL THIS TEACHING? Yes No
6. Margo stops at Mr. Rogers bed as the team for the south end of the ward makes morning rounds. She says to him "Hello, Mr. Rogers, how are you? Getting your sugars done? They were really good last night. You are to save your urine until 2pm this afternoon, OK?"
   WOULD YOU CALL THIS TEACHING? Yes No
7. Annette tells Mrs. Daniels that her N/G tube can come out. She pulls on disposable gloves and places a blue pad across Mrs. Daniels lap. She says to her "This isn't going to hurt but it may feel a bit funny. Just take a deep breath and blow out through your mouth".
   WOULD YOU CALL THIS TEACHING? Yes No
8. Sandra is preparing to discharge Mr. Brown from the hospital, two days after a hernia repair. She tells him to call his family doctor if he notices that his incision is red, puffy, or draining pus. She also tells him that for the next couple of weeks he shouldn't lift anything heavy.
   WOULD YOU CALL THIS TEACHING? Yes No

Exchange #1

Mrs. Jones is going home today after a recent vein ligation. She stops Wendy in the hall, outside her room, and asks her how long it will be before she can wash her legs. The conversation goes like this:

Wendy: "Has your doctor been around this morning?"

Mrs. Jones: "Yes, but he didn't say anything."

Wendy: "When do you expect to see him again?"

Mrs. Jones: "I have a return appointment in six weeks."

Wendy: "Well, you could soak off the bandages in about ten days, or you could call his office to check, if you are not happy waiting that long."

Mrs. Jones: "Ten days, OK."

Exchange #2

I think we would like to spend more time with the patients ... and basically when you spend time with them there is usually some kind of a teaching aspect, or something comes out of the conversation rather than just chit chat ... but again its the time factor. During the day there is something to be done every half hour ... glucometers HAVE to be done at 1100 hours, the vitals HAVE to be done at 1000 hours ... you have to feed the patients at a certain time. There is no leeway there at all for you to have an hour and say, "Well, I think I will go and talk to Mrs. Smith about ...". There is just no time.

Appendix E

Study Hospital Nursing Assessment Part I

Dear Patient:

Your nurses will be planning your hospital care. We would appreciate your help in answering the following questions. This information will help us learn about your general health and condition. As nurses, we are concerned about your response to the diagnosis and treatment of your problems. This information is confidential. Thank you.

Instructions For Completing the Form:

1. If you wish, a relative or friend may ask you the questions and/or write your answers for you.
2. Please indicate the correct answer with a check (✔) where appropriate.
3. After you complete the form, your nurse will review your answers and develop a plan of care with you.

1. HEALTH PERCEPTION - HEALTH MANAGEMENT
   (a) How would you describe your general health?
   Good_____ Fair_____ Poor_____
   Describe any long-term health problems_____
   _____

   (b) Have you been hospitalized previously? No_____ Yes_____
   If yes, when, where, and for what reason?_____
   _____

   (c) What is the reason for the present hospitalization?_____
   _____

   (d) What is your understanding of your present condition?_____
   _____

   (e) How would you describe your use of alcoholic beverages?
   None_____ Social_____ Greater_____

   (f) How many cigarettes do you smoke each day?_____

2. NUTRITIONAL - METABOLIC PATTERN
   (a) How would you describe your appetite?
   Good_____ Fair_____ Poor_____

   (b) Do you have any dietary restrictions or special diet?_____
   _____

   (c) Have you noticed any change in your appetite over the past year? Yes_____ No_____
   If yes,_____

   (d) Has your weight changed over the past year?
   Gain_____ Loss_____ How much_____

   (e) Do you experience any difficulty/discomfort eating or swallowing? No_____ Yes(describe)_____
   _____

3. ELIMINATION PATTERN
   (a) What is your usual bowel habit?_____

   (b) Have you experienced any change in bowel habits? No____
   Yes(describe)_____

   (c) Do you use laxatives or other aids for regularity? No_____
   Yes(describe)_____

   (d) Do you experience any difficulty when urinating? No_____
   Yes(describe)_____

4. ACTIVITY-EXERCISE PATTERN
   (a) Has there been any change in your level of activity over the past year? No_____ Yes(describe)_____

   (b) Do you experience any limitations to your activity level, eg. pain, shortness of breath? No_____ Yes(describe)_____
   _____

   (c) Do you require devices when ambulating?
   No_____ Wheelchair_____
   Walker_____ Other(describe)_____
   Cane_____

5. SLEEP - REST PATTERNS
   (a) On average, how many hours of sleep do you receive per night?_____

   (b) Do you usually sleep through the night without interruption?
   Yes_____ No_____

   (c) Do you usually feel rested in the morning? Yes_____ No_____

   (d) Do you have any habits or medications to promote sleep?
   No_____ Yes(describe)_____

6. COGNITIVE - PERCEPTION PATTERN
   (a) Have you experienced any changes in memory lately? No_____
   Yes(describe)_____

7. SELF-PERCEPTION PATTERN
   (a) Has the reason for this admission made you feel differently about yourself? No_____ Yes(describe)_____
   _____

8. ROLE RELATIONSHIP PATTERN
   (a) Do you live alone? Yes_____ No(with whom)_____

   (b) What is(was) your occupation?_____

   (c) What is your native language?_____

   (d) Do you presently receive visiting home support?
   No_____ Community Health Nurse_____
   V.O.N._____ Other(describe)_____
   Meals on Wheels_____

   (e) Are there any problems/concerns at home/work as a result of this hospitalization? No_____ Yes(describe)_____
   _____

9. COPING - STRESS MANAGEMENT
   (a) Has there been a loss or major change in your life in the past year? No_____ Yes(describe)_____
   _____

   (b) What is your greatest concern relating to your health?
   _____

   (c) Being in a hospital is stressful for many people. Is there anything we can do to make it easier for you? No_____ Yes(describe)_____

10. SEXUALITY - SEXUAL FUNCTIONING
   (a) Is there any possibility you are pregnant?
   N/A_____ No_____ Yes_____

   (b) Are there any changes or problems with your sexual activities? No_____ Yes(describe)_____

11. VALUE - BELIEF SYSTEM
   (a) Is there a religious or cultural practice (diet, book, ritual) that you would desire during this hospitalization?
   No_____ Yes(describe)_____

COMMENTS:_____
_____
_____
_____

COMPLETED BY _____
Signature Time Date

Relationship to Patient Self_____ Other_____

REVIEWED BY _____ Time_____ Date_____

Appendix F

Study Hospital Nursing Assessment Part II

Ht;Wt & Vital Signs: See clinical records

Allergy	Allergic Response
_____	_____
_____	_____
_____	_____

NONE KNOWN_____

INFECTIOUS DISEASE
Recent Exposure/Contact_____No _____Yes Comment_____

MEDICATIONS: Stored on Unit_____ Taken Home_____ On No Medicatons____

Medication	Dose Freq.	Last Dose Taken	Medication	Dose Freq.	Last Dose Taken

1. SENSORY PERCEPTION

a) VISION WNL_____

Glasses___No ___Yes With Patient No___ Yes___ Prosthesis___ No___ Yes__
Contacts__No ___Yes With Patient No___ Yes___
Impaired__No ___Yes ___(R) ___(L) Draining __No __Yes __(R) __(L)
Blind_____No ___Yes ___(R) ___(L) Reddened __No __Yes __(R) __(L)
Cataract__No ___Yes ___(R) ___(L) Pain __No __Yes __(R) __(L)
Glaucoma__No ___Yes ___(R) ___(L) Bleeding __No __Yes __(R) __(L)
Foreign body_____Yes ___No Other_____

Comment_____
_____

b) HEARING WNL_____

Impaired_____No ___Yes ___(R) ___(L)
Hearing Aid___No ___Yes ___(R) ___(L) With Patient __No __Yes
Prosthesis____No ___Yes ___(R) ___(L)

Comment_____
_____

c) SPEECH WNL_____

Slurred_____No ___Yes Languages Spoken_____
Garbled_____No ___Yes Language Barrier ____No ____Yes
Expressive Aphasia___No ___Yes Speaking Device ____No ____Yes

Comment_____
_____

2. SKIN

Color ___WNL ___Pale ___Cyanotic ___Ashen Jaundice Other_____
Turgor ___WNL ___Poor
Temperature ___WNL ___Warm ___Cool ___Cold
Edema_____No ___Yes Location/Described_____
Rash_____No ___Yes Location/Described_____
Lesions____No ___Yes Location/Described_____
Bruises____No ___Yes Location/Described_____
Reddened___No ___Yes Location/Described_____
Other_____ Location/Described_____ _____

Comment_____
_____

3. RESPIRATORY WNL_____

Rhythm____WNL ___Irregular
Depth_____WNL ___Shallow ___Deep
Quality___WNL ___Labored ___Wheezing ___Stridorous ___Congested
___Cheyne-stokes
Cough_____No ___Yes ___Productive ___Non-productive
Trach Stoma___No ___Yes

Comment_____
_____

4. CARDIOVASCULAR WNL_____

Pulse Rhythm___WNL ___Irregular ___Thready ___Bounding
Chest Pain___No ___Yes Description_____

Comment_____
_____

5. GASTROINTESTINAL WNL_____

a) ORAL CAVITY WNL_____

Dentures___No Upper (__Full__Partial) Lower (__Full__Partial)
With Patient__No __Yes

Capped Teeth___No ___Yes Location_____
Lesions___No ___Yes Location/Description_____
Gums___WNL ___Reddened ___Bleeding
Stomatitus___No ___Yes Description_____
Dysphagia___No ___Yes Description_____
Appetite___Normal ___Increased ___Decreased Describe_____

Taste Sensation

Comment_____
_____

b) GASTRIC WNL_____

Nausea___No ___Yes Vomiting___No ___Yes
Weight Changes_____Kg/Lost _____Kg/Gained

Comment_____
_____

c) INTESTINAL WNL_____

Bowel Habits____BM's/day _____Date last BM
Constipation__No __Yes Diarrhea__No __Yes
Bowel Sounds__No __Yes
Abdominal Distention__Yes __No

Incontinence___No ___Yes
Pain___No ___Yes Location/Description_____
Colostomy___No ___Yes Ileostomy___No ___Yes

Comment_____
_____

6. GENITOURINARY

a) URINARY WNL_____

Dysuria_____No ___Yes
Urgency_____No ___Yes
Frequency_____No ___Yes
Nocturia_____No ___Yes
Incontinence_____No ___Yes
Hematuria_____No ___Yes
Bladder Distention____No ___Yes
Indwelling Catheter___No ___Yes Date of Insertion_____
Ileoconduit_____No ___Yes Location/Description_____
Pain_____No ___Yes Location/Description_____

Comment_____
_____

b) GENITO WNL_____

Bleeding_____No ___Yes Location/Description_____
Discharge_____No ___Yes Location/Description_____
Pain_____No ___Yes Location/Description_____
Self Examination
of Testicles_____No ___Yes

Comment_____
_____

FOR FEMALES:

Self examination of Breasts___No ___Yes
Gravida____ Para____ Abortion____
Date of last menstrual period_____
Normal___No ___Yes Describe abnormal_____

Birth Control Measure_____

Date of last Pap Smear_____

Comment_____
_____

7. MUSCULOSKELETAL WNL_____

Ambulatory_____No ___Yes Walking Aids Type_____
Pain_____No ___Yes Location/Description_____
Swelling_____No ___Yes Location/Description_____
Deformity_____No ___Yes Location/Description_____

Comment_____
_____

8. NEUROLOGICAL WNL_____

See Clinical Record

Comment_____
_____

KNOWN MEDICAL PROBLEMS_____
_____
_____
_____
_____

PAST SURGERIES LISTED_____
_____
_____
_____

COMMENTS_____
_____

DATE_____ _____
Signature of Registered Nurse

_____MINUTES REQUIRED TO COMPLETE

Appendix G

Study Hospital Nurses' Notes

DATE	TIME	

Appendix H

Study Hospital Nursing Flow Sheet

Date:
Initials Signature Status

			Days		Nights	
			0700-1900		1900-0700	
ACTIVITY	Assessment/Planning	①		①		
	Planned Teaching Pre-op Teaching	2		2		
	Up in Chair with Help	2		1		
	**Walk with Assistance	4				
	Br with Assist, Reposition	1		1		
HYGIENE	Bathes Self	1				
	Partial Bath	3				
	Complete Bath	6				
	PM Care/Post Op Care	1		2		
ELIMINATION	Toilet with Assistance	2		2		
	Toilet with Supervision	8		5		
	**Incontinent	7		8		
	Bowel Movement					
NUTRITION	NPO					
	Feeds Self with Help	2				
	Total Feed	13				
	**Tube Feeding	4		4		

			Days		Nights
			0700-1900		1900-0700
	Vitals				
	Vascular/Doppler Check	.5		.5	
	Medications				
OTHER NURSING CARE	Q1H Intake and Output	3		3	
	Intake and Output	1		2	
	Isolation				
	Urine for S & A	1		1	
	Glucometer	3		3	
	**Simple DSG/Decubitus/Compr.	1		.5	
	**Complex DSG/Decubitus	4		4	
	**Preventative Skin Care	2		1	
	**Simple N/G Tube Irrigation	1		.5	
	**Complex Wound Irrigation	4		8	
	**Initiate IV	3		3	
	**IV/TPN	4		4	
	**IV with Infusion Device	6		6	
	Level TBA				
	**Central Line DSG/Tubing Change	1			
	**Chest/NG Tube Assess/Measure	1		1	
	**Hot/Ice Packs (Jaw Surgery)	3		3	
	**Enemas to Clear	3		3	
	**Ostomy Care by Nurse	4		3	
	Surgery Today	4			
	Specimens Collected/Type				
	Procedure/X-ray				
	**Pain/Type/Location				
	**Constant Nursing	111		114	
	**Teaching and Emotional Support	①		①	
	**Restraint Precautions	5		5	

			Days		Nights
			0700-1900		1900-0700
	**Close Observation	5		5	
	Side Rails Up				
	**Aerosol				
	Venipuncture	2		3	
	Slept Well				
	Awake at Intervals				
	**Awake Most of Time				
	Other Support			.5	
	Related Nursing Activities	7		4	
	TOTAL		TOTAL		

**These items require nursing progress notes.

Appendix I

Study Hospital Patient Care Hour Chart

DATE: _____ 12 HR. DAY UNIT: Day of week predicting for NURSING CARE										
ASSESSMENT (CIRCLE IF APPLICABLE) Initial assessment and care plan	6	6	6	6	6	6	6	6	6	6
Daily assessment, PCU update, and care plan	①	①	①	①	①	①	①	①	①	①
PLANNED TEACHING (CIRCLE IF APPLICABLE) Pre-op teaching	2	2	2	2	2	2	2	2	2	2
ACTIVITY (CIRCLE HIGHEST IF APPLICABLE) Up in chair with nursing assistance	2	2	2	2	2	2	2	2	2	2
Walk with nursing assistance	4	4	4	4	4	4	4	4	4	4
Bed rest with assistance-reposition	1	1	1	1	1	1	1	1	1	1
HYGIENE (CIRCLE IF APPLICABLE) Bathes self	1	1	1	1	1	1	1	1	1	1
Partial bath	3	3	3	3	3	3	3	3	3	3
Complete bath	6	6	6	6	6	6	6	6	6	6
PM/Post-op care	1	1	1	1	1	1	1	1	1	1
HS care										
ELIMINATION (CIRCLE HIGHEST IF APPLICABLE) Commode, bedpan, urinal/BR c assistance	2	2	2	2	2	2	2	2	2	2
Commode/BR c constant supervision	8	8	8	8	8	8	8	8	8	8
Incontinent care	7	7	7	7	7	7	7	7	7	7
NUTRITION (CIRCLE HIGHEST IF APPLICABLE) Feeds self with help	2	2	2	2	2	2	2	2	2	2
Total feed	13	13	13	13	13	13	13	13	13	13
Tube feeding	4	4	4	4	4	4	4	4	4	4
VITAL SIGNS (CIRCLE IF APPLICABLE) TPR 1/shift	.5	.5	.5	.5	.5	.5	.5	.5	.5	.5

DATE: _____ 12 HR. DAY UNIT: Day of week predicting for NURSING CARE										
TPR 2-3/shift	1	1	1	1	1	1	1	1	1	1
BP 1/shift	.5	.5	.5	.5	.5	.5	.5	.5	.5	.5
BP 2-3/shift	1	1	1	1	1	1	1	1	1	1
Vascular/doppler check	.5	.5	.5	.5	.5	.5	.5	.5	.5	.5
OTHER NURSING (CIRCLE AS APPLICABLE) Q1H I & O	3	3	3	3	3	3	3	3	3	3
I & O	1	1	1	1	1	1	1	1	1	1
Urine for sugar and acetone	1	1	1	1	1	1	1	1	1	1
Glucometer	3	3	3	3	3	3	3	3	3	3
Simple dsg/wound/decubitus care	1	1	1	1	1	1	1	1	1	1
Complex dsg/wound/decubitus care	4	4	4	4	4	4	4	4	4	4
Preventative skin care	2	2	2	2	2	2	2	2	2	2
Simple/NG/tube irrigation	1	1	1	1	1	1	1	1	1	1
Complex wound irrigation	8	8	8	8	8	8	8	8	8	8
Initiate IV	3	3	3	3	3	3	3	3	3	3
Continuous IV infusion/TPN	4	4	4	4	4	4	4	4	4	4
Continuous IV with infusion device	6	6	6	6	6	6	6	6	6	6
Central line dressing/tubing change	1	1	1	1	1	1	1	1	1	1
Chest tube/NG tube assess and measure	1	1	1	1	1	1	1	1	1	1
Hot/ice packs (jaw surgery)	3	3	3	3	3	3	3	3	3	3
Enemas to clear	3	3	3	3	3	3	3	3	3	3
Ostomy care by nurse	4	4	4	4	4	4	4	4	4	4
Surgery today	4	4	4	4	4	4	4	4	4	4
Routine teaching and emotional support	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
Constant nursing (1-1)	111	111	111	111	111	111	111	111	111	111
Restraint precautions - check patient	5	5	5	5	5	5	5	5	5	5
Close observation of disoriented patient	5	5	5	5	5	5	5	5	5	5
RELATED NURSING ACTIVITIES	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)
SUBTOTAL TENTHS										
SUBTOTAL PCU'S										

DATE: _____ 12 HR. DAY UNIT: Day of week predicting for NURSING CARE										
MEDICATIONS (CIRCLE AS APPLICABLE) Oral/gtts/ointment 1/shift	1	1	1	1	1	1	1	1	1	1
Oral/gtts/ointment 2-4/shift	2	2	2	2	2	2	2	2	2	2
IM/SC/Heparin flush 1-2/shift	1	1	1	1	1	1	1	1	1	1
IM/SC/Heparin flush 3-4/shift	2	2	2	2	2	2	2	2	2	2
I/V partial fills/soluset 1-3/shift	3	3	3	3	3	3	3	3	3	3
IV antibiotics 1-3/shift	2	2	2	2	2	2	2	2	2	2
IV antibiotics 4-6/shift	5	5	5	5	5	5	5	5	5	5
Q1H Heparin IV	8	8	8	8	8	8	8	8	8	8
SUBTOTAL TENTHS										
SUBTOTAL PCU'S										
TOTAL PCU'S										
PCU'S divided by NCU'S x 100% = UTILIZATION										

Increase by 21% for all
unlisted activities

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