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CONTEXT AND CARE :

NURSES' ACCOUNTS OF STRESS AND SUPPORT ON A CANCER WARD

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SUMMARY

This is a study of all ranks of nurses working on a cancer ward in a London teaching hospital. Other than the sisters, who had specialist oncology training, the nurses were not self-selected, but simply were assigned to this particular ward.

Nursing, as a job, is stressful (Menzies 1959). Nursing cancer patients is believed to be particularly stressful; nurses on cancer wards have been shown to manifest extreme signs of stress which affect their perceptions of their work and the quality of care patients receive as well as their own health.

Using a symbolic interactionist approach, the purpose of this study was to explore the issues of stress and support from the perspective of nurses themselves. An important aspect of the study was the use of repeated interviews which revealed changes in nurses' experiences and ward practices over time.

Nurses did not identify illness category as a cause of stress nor did they view additional psycho-social support as necessary. Their accounts of how they experienced nursing cancer patients provides insights into their ideology of nursing. They spoke repeatedly of this being a "good ward" where they could practice "good nursing." This thesis explores how these nurses made sense of their work and felt enabled to nurse cancer patients without experiencing emotional distress. A theoretical explanation is proposed in terms of the interaction between the context of nurses' work (including the way in which it is structured and managed) and their ideology which was based on the concept of caring.

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CHAPTER ONE

INTRODUCTION TO THE STUDY

The research reported in this thesis started from a premise, widely supported in the literature, that the care of the dying is in itself stressful for nurses (Rothenberg 1967; Kubler-Ross 1969; Klagsbrun 1970; Benoliel 1977). This study sought to explore nurses' views of the premise, and furthermore to establish whether nurses perceived additional psycho-social support as necessary or beneficial. The nurses studied challenged the premise itself - many nurses spoke of nursing the dying as one of the most satisfying types of nursing work, and of the cancer ward studied as a 'good ward'. The question addressed by the thesis is therefore not that which was envisaged originally but rather:- why can nursing the dying be satisfying; and because this was not a consistent view found throughout the study, under what conditions is this possible?

The argument proposed concerns the interaction of two key variables - the nurses' views of 'good nursing' (i.e. the meaning of their work for them) and the existence of a 'good ward'. Where there was congruence between these two factors, stress was minimised or avoided completely and support was 'built in'. When circumstances altered, the ward was no longer perceived as a 'good ward'. The balance was disturbed, nurses experienced their work as stressful and considered the possibility of psycho-social support measures more favourably. The nature of patients' conditions - seen by other authors as a major cause of stress - was found to be of less importance than this balance between nursing ideology and the context in which nurses worked.

This thesis argues that one reason for this finding lies in the nurses' orientation towards 'care', where death itself is not the basis of failure, rather than 'cure', where it is. Failure to care upset nurses, but this arose from disruptions, conflicts or pressure of work on the ward. The management of the ward and nurses' ability to understand the rules of behaviour pertaining to it, were critical for nurses. Although other writers have pointed to the influence of work settings on the ways in which nurses interpret their work, they have overlooked the inter-relationship between the context of nurses' work and their orientation to 'care' rather than 'cure'. One reason may be the dominance of the medical model, in which the structure of the work differs (with responsibilities for individual patients rather than a focus on the ward as a whole) as does the overall ideology. Another reason may be the changes that have taken place in nursing itself.

The research setting and subjects

The setting chosen for this study was a large teaching hospital and school of nursing (referred to as 'Suburban Teaching') in Greater London. 'Suburban Teaching Hospital' is a well-known, established teaching hospital which was relocated in the early seventies and purpose built on the site of an old district general hospital in a residential area of London. By the time this study commenced, Suburban Teaching had been in its new premises for over ten years, and staff can be seen to have acclimatised to new circumstances, especially a more modern ward design - a mixture of different sized rooms including open plan wards as opposed to a dormitory type - Nightingale style.

The site of the study was the oncology (cancer) ward here referred to as Taylor ward, at Suburban Teaching Hospital. This was situated on the tenth floor and was organised differently from other wards in the hospital. Taylor Ward had eight single rooms, one four bedded room and a high dependency area - an "open" ward of eight beds for the most dependent patients. The outside perimeter of the ward consisted of the patients' areas whilst the centre of the ward was divided into corridors off which were situated the sluice room, kitchen and sisters' and doctors' offices. Patients could not be seen from the sisters' office, but the nurses' station, a desk with phones, to which nurses returned regularly, was in full view of the high dependency area.

Taylor ward had a bed allocation of twenty as opposed to twenty eight on other wards in this hospital. The arrangement of beds, with many more patients on an open ward, gave the ward a different appearance from other wards in the hospital. The sisters' office was furnished with easy chairs in a rather stark room dominated by a desk. The doctors' office was similarly arranged.

The rationale for the different appearance of the ward lay in the nature of the patients' conditions. The ward had a full complement of nurses despite the reduced bed allocation. This high staffing level was deliberate hospital policy because of the perceived load on nurses working with cancer patients. This meant that when nurses were absent from the ward, it should not be necessary to second nurses from other wards. This practice (of secondment) operated in the rest of the hospital nursing service but was regarded as inappropriate in a cancer ward.

Taylor Ward treated solid tumours with radiotherapy and/or chemotherapy. Most blood cancers were treated on the haematology ward. Adult men and women were admitted to Taylor Ward; children were wherever possible admitted to the paediatric ward and only occasionally were treated on this ward.

The issue of regulation of information has dominated sociological studies of cancer wards (Glaser and Strauss 1965; McIntosh 1977; Bond 1978). Consultants on Taylor Ward varied in their disclosure practices - neither of the two extremes, blanket disclosure or total denial, were the norm. Great variation existed in the levels of information given to patients and in patients levels of awareness (Glaser and Strauss 1965 - see discussion in Chapter Two). Chapter Five will discuss how this worked in practice.

The data generated in this study came primarily from interviews with all the nurses, including students, who worked on Taylor Ward during the period February - August 1983. In addition to the interview material, an observation period of a fortnight preceded the formal interviews. This was arranged in order to familiarise myself with ward routines, devise interview agenda and meet additional hospital staff who might provide important relevant data as well as facilitate access to nurses should this prove problematic. Information was sought from relevant others who were responsible either for aspects of work on Taylor Ward or for students assigned to this ward during the research period. These additional informants included three medical consultants, four junior doctors, eight nursing tutors, two out-patient sisters, two clinical teachers, one nursing officer, and the director of

the nursing school. The gender of doctors was evenly divided between men and women (all white and British); only one nursing tutor was male, the remaining additional informants were all white women.

Although technically the observation period ended with the commencement of the interviews, I also spent time on Taylor Ward prior to and following interviews attending meetings where relevant and simply observing nurses working. Incidents observed during these informal observation periods, such as routines following the death of a patient in a general ward, provided confirmation of some details provided by nurses in their accounts. The bulk of the data, nevertheless, according to the initial intentions, comes from interviews with nurses working on the ward.

All the nurses who worked on Taylor Ward between February and August, 1983 were interviewed. This included five sisters, nine staff nurses, one auxiliary nurse, six third year students, five second year students and six firstwarders. One trained nurse was a man, the remainder were women. One student nurse was a black woman, the remainder were white women .

In all 52 tape-recorded interviews took place with nurses working on the ward. Daystaff were interviewed at least twice, in a group and individually, at the beginning and at the end of their ward allocations. Night staff were interviewed once only; interviewing night staff in groups was not possible because usually there were only two nurses on a shift.

Terminology

At the outset it is necessary to clarify the terminology that I will be using. In accordance with Smith (1988a) :-

'Student' refers to nurses undertaking the three year Registered General Nursing training leading to a SRN qualification. 'Trained' or 'qualified' nurses refers to sisters and staff nurses all of whom have SRN qualifications. Nurse teachers and tutorial staff refer to registered clinical teachers (RCNT) and registered nurse tutors.

The data chapters use excerpts from interviews to illustrate issues. To differentiate between ranks of nurse, sisters are referred to as Sr, Staff nurses as SN and student nurses as N. The rank of student nurse where appropriate and the time and nature (group, individual) of interview will follow the quote in brackets.

The fields of terminal care and nursing abound with ambiguous terms. This study concerns nursing. As will become apparent, the nature of nursing and of 'caring' are critical issues which will be discussed and analysed.

A. Nursing care

This study explores how nurses on a cancer ward conceptualised their work including how they saw themselves communicating with patients. Armstrong (1983) reviewing recent British nursing textbooks notes that the caring role of the nurse is no longer restricted primarily to the biological functioning of the patient but that nursing rhetoric had begun to ascribe importance to

psychology and nurse/patient interaction. Smith (1988a) notes that as early as 1953 Goddard recognised that nurses' work included 'affective' as well as 'technical' and 'basic' (physical) components. Having incorporated this emphasis on communication as a legitimate feature of nursing, nursing research has generated a number of terms to denote the different components of nursing work. I have found the following terms, often used in the literature, self-explanatory and helpful:- affective/emotional, technical, and physical. I therefore refer to these terms throughout the thesis. It is necessary to point out, however, that the assumption that technical or physical nursing work do not incorporate elements of affective/emotional work is challenged by Strauss and his co-workers (1985). They view health work in terms of phases of illness trajectories and suggest that trajectory work can be separated into a number of categories of work engaged in by both patients and health workers. Those exclusively emotional / affective aspects of nursing work, Strauss et al (1985) term 'sentimental work'.

In discussing their work, nurses in this study referred repeatedly to 'good nursing care'. Depending on what nurses were referring to by the use of the term 'nursing care', it could encompass any one or all of the emotional/affective, technical, physical or practical components of nursing. When using quotations from the data, I shall retain the term 'nursing care'. Where possible, however, I shall avoid using it otherwise. As one of the aims of this thesis is to explain the meaning of good nursing care to these nurses, it is therefore helpful when reviewing the nursing literature to separate out certain components of nursing.

Many researchers have applied the terms coined by Strauss et al. (1985) to describe the healthworker / patient interactions (James 1986, Field 1987, Smith 1988a) and have found them helpful. Further work has been done on developing a conceptual framework to understand the emotional / affective aspects of nursing work. For example, both James (1986) and Smith (1988a) have used the terms "emotional labour" but in different ways. In studying hospice nurses, James (1986) separates nursing work into work, care, and carework and uses emotional labour to describe the affective / emotional components of nursing work. These concepts are discussed in Chapter Six. Smith (1988a) uses Hochschild's (1983) paradigm, emotional labour, derived from a study of airline stewardesses to describe how nurses are taught to interact with patients and how they choose to use 'emotional labour' or withdraw it according to circumstance. The ways in which both James and Smith use 'emotional labour' are helpful for this study but their use of an identical term with discrepant meanings inevitably confuses the reader; hence my decision to adopt different terms. By defining my terms in the following way, I hope to minimise confusion with definitions from other researchers:

1. Nursing will be used to refer to the profession or the job.
2. Nursing service will refer to the technical and physical aspects (This incorporates Glaser and Strauss 1985 terms machine work and some aspects of safety and comfort work).
3. Emotional work refers to the non-technical psycho-social aspects of nursing and will include sentimental and articulation work and some aspects of comfort work (Strauss et al. ibid).
4. Nursing ideology as a term is also used by the

literature to refer to ideologies of different groups of nurses. This term will be used to refer in general to the professional ideology espoused by the nursing profession, whereas the nurses' worldview refers to the ideology of the particular nurses studied in this research.

B. Terminal care

It is sometimes assumed that cancer patients are always terminally ill which is not the case. For the purposes of this study references to cancer patients do not assume any particular stage in the disease trajectory - i.e. cancer patients are not necessarily defined as terminally ill. Where relevant the stages of patients' illness will be clearly stated. In this study, (similar to Field 1987) the terms "dying patients" and "terminally ill" will be used interchangeably. **Terminal care** is used in the literature to mean looking after patients who are terminally ill. Its common usage suggests that in this study it is necessary to retain the word "care".

C. Context

In exploring how nursing dying patients provided nurses with work satisfaction rather than stress, several features regarding the circumstances in which this nursing work took place emerged as critical. Field (1987) in his study of nursing the dying in a number of acute settings as well as in the community pointed to the organisation of work as a critical factor. This study is about the interaction between the nurses' worldview (their concepts of care) and the "good ward" (the context in which they work). By context I refer to the **structure** of nurses' work. A number of factors interact to constitute this structure:- the physical setting, the general environment, the ward atmosphere,

nursing management styles, ward culture and the organisation of nursing work. The organisation includes practical elements such as staffing levels, as well as factors such as rules of behaviour, which incorporate aspects of the ideology.

The research problem

As the study progressed data was collected and analysed in the spirit of grounded theory (Glaser and Strauss 1967). The focus of the study was nurses' accounts of their work and this remained unchanged throughout. Nurses on Taylor Ward, however, presented quite different accounts of their work and their responses to it, from the nurses I had observed before (Chapter Three Section One) whose reactions had been in line with much of the literature. Chapter Three (Section Four) will detail the process whereby I discovered that although nurses understood my concept of stress, and anticipated the responses I expected from them, the criteria upon which they assessed working on hospital wards were unrelated to the medical category of patients. Therefore the fact that patients had cancer or were dying was at most, tangential to their evaluation of their work or of the ward. This finding demanded a refinement of the pre-fieldwork assumptions into the research problem which this study addresses. The final research problem which emerged can be separated into a number of inter-related questions:-

1. How did nurses in this study understand "stress"?
2. Why did nurses in this study not manifest symptoms of stress similar to those documented in previous studies of cancer nurses and which factors contributed to this apparent lack of stress?
3. What aspects of this situation were different from those described in other studies?

Thus the data gathered during fieldwork challenged the original premise upon which this study had been based. Although nurses on Taylor ward understood my assumption that nurses might experience stress as a result of working with cancer/dying patients, their accounts suggested that the nature of patients' conditions did not create stress for them. Their perception of stress related to whether they felt enabled to practise "good nursing" - their **world-view**. "Good nursing" for these nurses was based on a recognition that patients' needs ranged along a continuum from the highly technical (intensive care) and highly dependent (terminally ill) through almost self-caring. The extent to which patients had affective / emotional needs could only be ascertained through individual assessment. Nurses' work satisfaction related to an ability to practise good nursing which incorporated emotional work as an integral part of their job with the same value as carrying out physical and technical tasks.

Nurses' accounts of their experiences tallied with my observations that they did not appear to manifest signs of stress documented in the literature (this is reviewed in Chapter Two) or those manifested during my student observation period (discussed in Chapter Three). The explanation offered in this thesis for the absence of these responses lies in the interaction between nurses' own ideology of nursing (their worldview) and ward organisation and culture.

The advantages / disadvantages of being an insider in studying a particular group are described in the literature (e.g. Burgess 1984a, 1984b). My training in psychiatric social work influenced my approach to nursing the dying insofar as I had observed in

clients and other professionals the apparent advantages of support - talking about issues that caused stress. Therefore my concept of support was derived from a discipline which fosters external and imposed support measures rather than utilising the internal structures of an organisation or group to provide and/or maintain support. In addition much of the literature which explores the question of supporting nurses working with cancer / dying patients also promotes the concept of psycho-social support. Thus I was constrained by my perception of appropriate types of support. The accounts of nurses on Taylor Ward led me to appreciate the solutions which appear to be inherent in **nursing**. In addition, it confirmed my views that the subjects must be allowed to speak for themselves, as their solutions are likely to be more pertinent than those imposed by or from other disciplines.

The organisation of the thesis

The literature which supported the premise upon which this research was initiated, concerning nurses' experiences of stress when nursing dying/cancer patients, is reviewed in Chapter Two. Chapter Three, the methodology chapter, chronicles the process of the study, from initial assumptions through to developing a theoretical framework. Chapter Four presents nurses' accounts both of good nursing care and of factors which caused them to experience stress and distress. The context of their work is assessed in Chapter Five. This demonstrates what constituted the good ward and how nurses defined and perceived the rules of behaviour operating on the ward. In order to gain some understanding of the nurses' worldview and the importance of the context in which nurses work, Chapter Six returns to the

literature to explore issues relating to caring as nursing work, and contexts in caring for cancer / dying patients. Chapter Seven examines the interaction between ideology and context in this study illustrating in particular the circumstances when nurses perceived a lack of compatibility between these two. Chapter Eight concludes the thesis.

CHAPTER TWO

LITERATURE REVIEW ONE : STRESS IN NURSING THE DYING

INTRODUCTION

This chapter examines two aspects of stress in nursing. The first (Sections One and Two) relates to stress arising from caring for the dying, the second (Section Three) to stress inherent in the job of nursing. Section One introduces the topic by looking at historical perspectives of death and dying ; following this, studies are reviewed which suggest that working with cancer and/or dying patients is experienced as stressful (for healthworkers in general, nurses in particular). This literature constituted the basis for the pre-fieldwork assumptions upon which this study was based. Section Two examines individual and structural responses of healthworkers (particularly nurses) to the stress of working with dying patients, and cites strategies used for coping with emotions.

The nature of the patient's condition is clearly not the only cause of stress inherent in the job of nursing; hence it was necessary to supplement the literature focussing on stress in nursing arising exclusively from death or working with cancer / dying patients with studies exploring the general issue of stress in nursing. Section Three addresses this issue.

As indicated in Chapter One, findings from this study indicated that the nurses studied did not experience nursing cancer / dying patients as stressful. Nurses' concepts of care were found to be an explanatory factor. Consequently I decided to include a

further literature chapter which explores nurses concepts of caring (as opposed to stress) especially with relation to dying patients. As this need for a further literature search arose from findings in the data, and relates directly to the findings, this chapter has been placed amongst the data chapters, between those chapters which deal with nurses concepts of stress and support and the chapter which looks at the interaction between care and context.

The conclusion summarises the main issues in this Chapter.

Caring for the dying - the social context

The field of death and dying has burgeoned as an area of study since the mid twentieth century with academics from a wide range of disciplines analysing historical and contemporary practices and attitudes (Feifel et al. 1959, 1977; Choron 1963; Aries 1974, 1981). Aries (1974) and Illich (1975) document the changing attitudes and practices regarding death and dying since the middle ages. The location of death in the home helped the dying person and the observers of his death come to terms with their impending loss. With industrialisation and consequent changes in social patterns and values, attitudes towards life and death have changed.

In any earlier epoch, death had seized the hour-glass, now the middle-class seized the clock and employed doctors to tell death when to strike (Illich 1975 p 139).

This historical sequence removed the right of presiding over his demise from the dying man and shifted the responsibility for his care and death to his family, who in turn invested it in the medical profession.

By the mid - nineteenth century death was seen as dirty; attempts to cleanse death implied the removal of the dying patient from the bosom of the family to hospital, and consequently the loss of open acknowledgement and acceptance of death. All the actors in the death scenario, whether doctor, patient, relative or clergyman manifested the denial of death attitude pretending that 'nothing had changed,' 'life goes on as usual' and 'anything is still possible' (Aries 1981 p 562). Dissimulation became the rule:-

This dissimulation has the practical effect of removing or delaying all the signs that warned the sick person, especially the staging of the public act that once was death, beginning with the presence of the priest. Even in the most religious and churchgoing families, it became customary in the early twentieth century not to call the priest until his appearance at the bedside of the patient could no longer come as a surprise, either because the patient had lost consciousness or because he was unmistakably dead. Extreme Unction was no longer the sacrament of the dying but the sacrament of the dead (Aries 1981 p 562).

Armstrong (1987) challenges Aries' assumption that dissembling as if death were not imminent was interpreted by 1850-1950 contemporary society as a "lie". Armstrong suggests that for this period, dissimulation should be seen as a secret which could not be spoken. He contends, however, that by the 1950's or 1960's the secret had evolved into what we now understand to be a lie. With the change to the "regime of truth", the secret became the "most dreadful question of all. Then it was exposed as a lie" (Armstrong 1987 p653). Death could be seen as a "conspiracy of silence", where encounters between doctors and patients were characterised by secrets.

It is necessary to mention in passing at this point, that changes in societal patterns of behaviour towards the dying should be seen as accompanied by the rise of bio-medicine over the last one hundred and fifty years. Until the eighteenth century there was little distinction between curative, preventative and curative medicine (Stacey 1988). Thereafter the progressively increasing importance both of hospitals as venues for treating the sick, and the medical profession as principal healers contributed (along with other factors, for example market forces) to the birth of modern clinical medicine (Stacey 1988, p57). Foucault (quoted in Stacey 1988; Armstrong 1983) identified changes in approach to

medical problems and places them in socio-economic and historical context. Stacey (1988) adds gender and class issues to Foucault's analysis. The implications of the rise of bio-medicine for nursing the dying will be developed in Chapter Six.

When it was still customary for death to occur at home (i.e before the turn of this century), the management of death and of dying patients seems to have been less problematic for the carers. One can postulate a number of reasons for this. Emotional withdrawal from a family member dying at home (usually in cramped conditions) was not feasible, hence the reality had to be faced. In addition, before 'cure' could be viewed as a realistic possibility, death was not seen as preventable, but inevitable, and hence accepted without question.

Concepts of death and conceptualisations of caring for the dying in addition to changing over time, vary within and amongst ethnic groups, societies and health care systems (Choron 1963; Illich 1975). The ways in which relatives, the unpaid carers, (Stacey 1981) conceptualise appropriate care for dying patients is not addressed in this study. This issue has begun to be addressed, however, by the recent, post world war two, emergence of the hospice movement. This movement developed, according to James (1986) as an alternative to the euthanasia movement and has acknowledged the views and needs of the relatives.

The hospice movement was founded to try to eliminate the undignified and painful aspects of death which abounded in traditional medical institutions. In Britain, this movement was popularised primarily through the efforts of Dame Cecily Saunders

who campaigned to improve conditions for dying patients. In addition personalised accounts such as that of Victor and Rosemary Zorza (1980) have made the lay public aware of the needs of the dying and how hospice can meet these. The assumption that people should die in hospital has begun to be questioned; with more acknowledgement being made of the limitations of modern medicine gradually patients are being enabled to exercise some choice regarding how and where they wish to die. This can be seen as indicative of the adoption of a more death-integrative attitude of society (Pattison 1977).

The dual components of hospice philosophy, symptom control and psycho-social care (Murray Parkes 1985) have influenced the care of the dying in many settings. Two of the off-shoots of the hospice movement are home care and symptom-control teams, (supported by psycho-social services) which operate out of hospices and numerous general hospitals to enable patients in areas served by these teams to die pain-free at home.

Changes in expectations regarding how people should die have had a number of implications for professionals caring for them. Nursing is part of a wide network of health care and is influenced by lay attitudes as well as those of other healthworkers regarding the entire range of health issues. This study explores the ways in which nurses make sense of nursing cancer and/or dying patients. It is therefore relevant to look at how healthworkers traditionally have conceptualised cancer/terminal care and seek to understand the implications for nursing.

a) Traditional perceptions of cancer amongst healthworkers

Sontag (1978) looked at the meanings associated with certain types of illness and how these have changed concurrently with societal transformations. Certain diseases and types of illness are viewed as more devastating than others. Society's attitudes affect the resources allocated both to the "conquering" of the disease, i.e. research and the treatment thereof. Cancer is one disease which has attracted a great deal of media attention and resources.

Healthworkers are believed to share similar perceptions of cancer to lay persons (Lasagna 1970; Castles and Murray 1979). The stereotypical cancer patient is depicted as experiencing excruciating pain, mutilation, and suffering. Cancer is associated with fears of physical degeneration and anxieties relating to losses of both bodily control and normal social interaction. In short : "in the popular imagination cancer equals death" (Sontag 1978 p 7).

Professionals and lay people share similar fears of cancer. Women, in particular, tend to regard cancer as the most worrying medical condition (Elkind 1982). Bond (1979 quoted in Bond 1982) found that nurses feared cancer as much as their patients. Elkind (1982) explored the perceptions of cancer held by nurses in a British hospital. She endeavoured to establish whether nurses believed that cancer was curable or treatable and the extent to which they regarded the disease as alarming. Older more experienced nurses with information about survival rates had a better appreciation of the curability of cancer. Positive personal experience of cancer was more important than professional

experience of cancer nursing, implying that the nature of the experience was crucial. Young learners had a very poor understanding of the curability of cancer. From early on in their training most nurses felt that treatment could be more harmful than beneficial; only just over half of the trained nurses acknowledged the benefits of palliative treatment. Elkind (1982) also found that a substantial minority of nurses would find it hard to convey anything other than a depressing view of cancer to their social network.

The assertions above may explain the apparent logic of the view (which I challenge in this thesis) that the nature of the patient's condition is necessarily a major cause of stress for nurses.

b) The condition of the patient as a cause of stress for healthworkers

Partly for reasons cited above, healthworkers are believed to experience caring for cancer / terminally ill patients as stressful (Quint 1967). In addition other types of medical conditions have been identified as causing stress to healthworkers (Marshall 1980). These include high-tech, high risk healthcare, such as coronary and intensive care where mortality risks are raised.

There has been found to be a relationship between medical category of patient and morbidity within the nursing profession. Nurses working with cancer/dying patients have high rates of physical illness, absenteeism, and report late for work (Menzies 1959; Baider and Porath 1981; Mandel 1981). There are high turnover

rates of nurses working with the terminally ill; there is a higher proportion of cancer nurses who leave the profession than nurses working with other medical categories (McElroy 1982).

Since the mid 'fifties physicians and social scientists have explored issues relating to the medical management of dying patients and their families (Glaser and Strauss 1965; Kubler Ross 1969; Sudnow 1969; Saunders 1978). Doctors and nurses are believed to experience difficulties in coping with death, and therefore facing dying or incurable patients (Duff and Hollingshead 1958; Glaser and Strauss 1965; Rothenberg 1967; Sudnow 1969; Kubler Ross 1969; Aries 1974).

In exploring the structural arrangements under which dying patients are nursed, sociology has been able to contribute to an understanding of historical and cross-cultural patterns in the care of the dying. Sociology has primarily tackled institutional type death and dying, especially traditional acute hospital settings. This research has recognised that the approach of healthworkers towards dying patients contrasts with their approach towards transiently ill patients. Attitudes towards patients are socially constructed; the patient is located in a variety of social structures, such as the family, age group, occupation and the value placed upon it by society, and how s/he fits into the hospital setting (Sudnow 1967).

Quality of care for cancer patients and the terminally ill has been found in a number of studies to be unsatisfactory. Sudnow (1969) and Glaser and Strauss (1965) demonstrated how care of the dying can vary amongst different institutions. Despite variations

arising from the type of setting (public as opposed to private, with different values placed on prolonging life) Sudnow (1967) found a relationship between the age, social backgrounds and perceived moral character of patients and the amount of effort healthworkers put into reviving patients. Many categories of dying patients treated in hospitals were found to be socially devalued (compared to patients predicted to survive) and receive poor medical, nursing and psycho-social care (ibid.). These studies suggested that the care of the dying should be re-evaluated and upgraded.

Many elaborate theories have been offered to explain why caring for dying/cancer patients *creates stress for healthworkers* (Feifel 1959; Weisman 1972). Many of these are based on psycho-analytic theories, such as those of Melanie Klein who relates fear of death to early infantile experiences. A few pertinent to this study are mentioned here briefly.

Atchley (1974) suggests that stress in healthworkers arises from having to deal with emotions in patients and relatives as well as having to control their own emotions. Rothenberg (1967) in a study of healthworkers treating children with cancer found that the primary motive for becoming a healthworker was to make people better. This is consistent with Parson's (1951) sick role model which specifies that the patient should strive to attain the same goal as his physician - to get well. Consequently acknowledging failure of treatment or the imminence of death is an admission of failure for the healthworker. Healthworkers are believed to experience stress as a result of the discrepancy between their aim to cure people and the projected reality (death) in certain

disease types. Stress is believed to be exacerbated when the patient is regarded as of high social value by the healthworker (e.g. a child)(Hall 1979). Nurses, in settings where they share medical ideology, are believed to experience similar feelings of failure (and hence stress) to that of their medical colleagues (Benoliel 1974 - Issues related to ideologies are discussed further in Chapter Six).

Sociology has contributed to this field by examining the function of communication in the care of cancer/dying patients and specifically, of uncertainty. Having to cope with uncertainty (real and functional uncertainty - Davis 1960), has been identified as a cause of stress for healthworkers, particularly nurses (Davis 1960; Plumb and Holland 1974; McIntosh 1977). Uncertainty occupies an interesting position, in that it is both a cause of stress, yet can be used as a strategy to control communication between healthworkers and patients and hence as a way to limit stress.

The subject of communication between doctors, nurses and cancer/dying patients was studied in a variety of settings on both sides of the Atlantic (Glaser and Strauss 1965, McIntosh 1977, Bond 1978). Communicating with dying patients was found to be a major cause of stress for healthworkers (Quint 1967; McIntosh 1977; Bond 1978 etc). This was seen to be most acute for nurses who by the nature of their work are less able than doctors to regulate (limit) contact with patients (Conboy-Hill 1986).

Like uncertainty, communication occupies the dual position of being a cause of stress for healthworkers as well as being used in

a routinised way as a strategy to limit interactions with patients. The way communication is used as a structural and individual response to stress is developed in Section Two.

SECTION TWO : INDIVIDUAL AND STRUCTURAL RESPONSES TO STRESS

How healthworkers perceive and experience working with cancer / dying patients

Sociological work has looked at the strategies employed by individuals to "make sense of" and cope with caring for dying patients and at the way in which such strategies are incorporated into organisational structures and customs, including how this may vary in different types of organisation. Much of this research has taken place in acute hospitals. As complex organisations (Hall 1979) hospitals are engaged in diverse activities and work must be clearly demarcated for staff to be co-ordinated and controlled (Field 1987). Rules and regulations, routines and rituals, both formal and informal, written and unspoken, are believed to facilitate systematic control of information and co-ordination of work in hospitals (as organisations) (Menzies 1959; Chapman 1983; Field 1987). This does not preclude individual or group staff members from negotiating conditions of work with other disciplines (Strauss et al 1964).

Communication with cancer/dying patients has already been identified as potentially creating stress for healthworkers. Glaser and Strauss (1965, 1968) studied communication practices between healthworkers and dying patients in general hospital settings in the USA. Similar studies focussing on different groups of healthworkers, particularly nurses (Benoliel 1977; Bond 1978) followed in acute settings in both the USA and UK (McIntosh 1977; Bond 1979) as well as in alternative settings such as a hospice (James 1986).

Healthworkers have developed strategies to limit ~~communication~~ as a means of dealing with this stress. Communication practices have been characterised primarily by non-disclosure of terminality to patients. The implications for all parties of non-disclosure have been analysed, suggesting that physicians use different kinds of uncertainty (Davis 1960) to postpone (sometimes indefinitely) revealing distressing news to patients and/or families (Glaser and Strauss 1965, 1967; Waitzkin and Stoeckle 1972; McIntosh 1977; Hall 1979). Nurses are believed to collude with the practices of their medical colleagues; this strategy for coping with emotions helps them avoid unpleasant or emotional encounters with patients (Bond 1978 quoted in Bond 1983).

Non-disclosure of terminality to patients is still practised in many settings in the UK and is justified by the philosophy that hope should be retained at all costs (McIntosh 1977). Pilsbury (1985) explored disclosure practices of several British consultants and summarises the prevalent approach:-

I feel you cannot take hope away from a patient, I am a great believer that the truth of a terminal illness reduces hope. When a patient asks, "Am I dying?" is he or she really saying, "I'm not dying, am I?" I do not think that anybody really knows that right answer, but I would hate to think that I had destroyed my patient's last days by being too honest (Pilsbury 1985 p 15)

In contrast, Field (1987) notes the impact on nurses of changing societal expectations relating to conditions of dying. He found a shifting attitude towards the care of the dying amongst nurses and attributes these changes partially to changes in the practical care of the dying, epitomised by improved medication, and to the more open attitudes towards death and dying in contemporary

society. He suggests that questions relating to **whether** to disclose terminality have been replaced by **how** to disclose.

Studies aimed at understanding how healthworkers interacted with each other and with dying patients were pioneered by Glaser and Strauss (1965, 1968). They base their analyses on a symbolic interactionist approach drawing particularly on the work of Goffman and George Mead. Their major contributions to this field are their analyses of how healthworkers devise strategies for interacting with patients. These are :- a) healthworkers' definitions of patients' "awareness contexts" and b) their temporal predictions of dying trajectories - these two contributions will be discussed in turn.

Healthworkers ascertain patients' levels of knowledge about their condition and interact with patients accordingly. Glaser and Strauss (1964) term these levels of knowledge "awareness contexts" which they define as a :-

total combination of what each interactant in a situation knows about the identity of the other and his own identity in the eyes of the other (p670)

Glaser and Strauss (1965) identify four types of awareness - open awareness when both patient and healthworker know what ails the patient and acknowledge this to one another; pretense awareness, when both know, but neither acknowledges this; suspicion awareness when the patient suspects what is wrong but does not verbalise his suspicion ; closed awareness when the patient does not know what is wrong with him.

The second contribution of Glaser and Strauss (1968) concerns

healthworkers' predictions regarding the timing and type of death. They noted that healthworkers assess the medical condition of patients on admission to hospital and forecast various aspects of their illness trajectories. Although differing disciplines might predict different patterns of dying, the doctor was seen as providing the legitimate definition:

Defining the dying trajectory is an open-ended process which continually explains to the staff what they must do now, next and in the future in caring for the dying patient. Changes in definition cause them to revise their ideas of hospital organization to help in this care, and reformulate their feelings about the patient as he proceeds towards death. Defining and redefining the dying trajectory is, in effect, a process by which the staff maps the care of the hospitalized dying patient over long and short periods of time (Glaser and Strauss 1968 reprinted in Shneidman 1976 p 211)

Following Glaser and Strauss (1965, 1968) McIntosh (1977) used a symbolic interactionist approach when exploring communication patterns of British healthworkers with cancer / dying patients in a Scottish hospital in the mid-70's. Focussing on the disclosure issue he explored how hospital staff used routines and uncertainty in interactions. He found that nurses adhered to the predominating medical ideology that doctors should give patients as much information about their conditions as necessary to ensure their co-operation with treatment and consistent with the retention of hope. Bond (1978) also employing an interactionist perspective had similar findings. She analysed nurse/patient interactions and found that nurses emphasised physical care avoiding discussions with patients about their illness or how they felt about it. She suggests that the need to preserve the social order of the ward implied that nurses could not become "involved" with patients unless they were able to provide the emotional support patients would then require (discussed in Bond 1983).

Bond's observations that nurses limited interactions with patients to physical tasks is corroborated in other studies of health workers caring for cancer/dying patients (Rosenthal et al. 1980; Gow 1982). This distancing (sometimes called avoidance or withdrawal) from patients has been documented in numerous studies with both psychological and sociological orientations in a number of settings and societies.

The distancing strategy

Distancing entails withdrawing emotionally from patients. Instead of planning nursing work around the needs of an individual patient, nurses using the distancing strategy are reported to maintain emotional distance from patients by concentrating on carrying out physical and technical tasks for patients or performing ritual procedures on the ward (McIntosh 1977; Bond 1983; Carlisle 1985). Nurses restrict conversations relating to issues of diagnosis, prognosis and patients' emotional states. Nurses are observed to practice "detached concern" (Carlisle 1985) by referring to patients by bed number or disease category and hence depersonalising them (Jacobs 1979).

Distancing as a strategy is most viable where task allocation (as a method of nursing) is practised. Jacobs (1979) looked at organisational characteristics of hospital and treatment. Like Freidson (1970) she noted that the professionalisation of disease and illness has affected the ways in which these processes are understood and handled (Jacobs 1979 p 84). Jacobs asserts that the neglect of the feeling dimension (for patients and healthworkers alike) is consistent with the fragmentation of

care. She suggests that this orientation would be less feasible if patients were viewed as a whole, rather than seen as categories (See discussion Chapter Six).

The strategy of distancing has been analysed also using psycho-analytic or psycho-social concepts. These view distancing as a coping mechanism for dealing with nurses' anxieties related to death and dying by protecting nurses from becoming emotionally involved with patients. Menzies (1959) describes the social defense system which facilitates the distancing strategy as

helping the individual avoid the experience of anxiety, guilt, doubt, and uncertainty....little attempt is made positively to help the individual confront the anxiety-evoking experiences and, by so doing, to develop her capacity to tolerate and deal more effectively with the anxiety (Menzies 1959 p 109).

Rothenberg (1967) using a psychodynamic approach interprets nurses' distancing strategies as a response to a conflict between their personal and professional persona. He suggests that withdrawal is a response to conscious or unconscious feelings of guilt. He maintains that healthworkers suffer from a core conflict where on the one hand they wish to respond compassionately with every type of aid and comfort to the dying (child) and on the other hand are consumed with the need for self-preservation.

Conboy-Hill (1986) studied British nurses to ascertain whether they used similar distancing strategies to their American counterparts. Her study was divided into two sections. The first was a behavioural observation of nurses interacting with terminal and non-terminal patients of equal dependency; the second was a questionnaire which gauged demographic information and measured

death anxiety. The behavioural study found that nurses engaged in less social behaviour with terminal than non-terminal patients. Conboy Hill (1986), like Bond (1983) noted that extremely little social interaction between nurses and patients occurred on the wards. Terminal patients were found to be less popular and had to make considerable effort to ensure any social contact with nurses. Conboy-Hill hypothesises that because nurses believe that task directed behaviour is more highly valued, nurses (aware that she was watching them) may have deliberately reduced social contact with patients during the study. She emphasises that nurses, unlike doctors, are captive on the ward and cannot withdraw with ease. Hence they have to develop certain structural limitations to their job to protect themselves emotionally (i.e. adopt a distancing type strategy):-

What they can do is ensure that they have as little social contact as possible with the patient in order to minimise discussion of the patient's progress. This is done by increasing the number of people dealing with the patient or controlling conversation to cover only task directed topics (Conboy-Hill 1986 p 19)

Distancing strategies are acquired through experience (Baider and Porath 1981, Smith 1988) and imitation. Using a psychological approach, Baider and Porath (1981) compared new recruits with more established nurses on a cancer ward. Nurses who had worked on the ward longer used distancing type strategies, whereas new recruits to the ward started off with an ideological approach and

maintained that in the absence of cure, technical efficiency as a criterion for good performance was out of place and felt that the emphasis ought to be on seeking expressive modes for relating to the dying patient, though such an open and vulnerable position involved real psychological hardship. At the same time, all the nurses accompanied this clear-cut distinction with a common expression of anger and isolation, and felt that they

were unable to share their highly emotional but frustrating experiences with one another (Baider and Porath 1981 p 49).

The newer recruits to the ward attributed their difficulties to insecurity and lack of experience and felt ashamed to acknowledge this to colleagues. Other studies corroborate these findings that nurses work in relative emotional isolation from one another (Bond 1982). In Baider and Porath's study (1981) both the longer staying nurses and new recruits felt inhibited at work, expressed their feelings at home, and looked for external targets towards which they could direct their anger. These included members of staff, types of patients, and rules and regulations.

Nurses who adopt the distancing strategy are believed to feel overwhelmed, fearful, depressed, guilty, anxious and express feelings of dislike and loss of control. In settings where these feelings are suppressed because expression is seen as inappropriate, the establishment of a trusting, empathetic environment may be jeopardised. This has obvious implications for patient care.

Attempts to change distancing behaviour

Chapter One described how this study initially assumed that contemporary interactions between nurses and cancer/dying patients had negative implications for nurses and the quality of patient care. Several studies have described efforts to change this pattern of behaviour, mostly based on psychological (dynamic or behavioural) techniques.

Training - courses were devised to inform nurses working with cancer patients that all cancers are not hopeless and invariably painful (Elkind 1982). Others courses (entitled death and dying workshops etc.) have aimed at developing nurses self-awareness and enabling nurses to acknowledge and express their fears of death and dying. Ross (1978) developed a fantasy technique which he felt should be integrated into training courses to change nurses' defenses (repression and sensitization-avoidance) to enable them to be aware of their own feelings about death and dying. Similarly Miles (1980) using a semantic differential technique measured the effects of a course on death and grief on attitudes towards death and dying patients in nurses who worked on high death wards. He found that after the course nurses had a more positive attitude to death, dying patients and their families. Robinson (1974) devised a course which focussed on developing relationships between nurses and dying patients. The aims of this course were:-

- To be aware of one's own feelings about dying
 - To be aware of the influence of one's feelings on nursing practice
 - To alter practices if they were maladaptive for the nurse or unsupportive for the patient
 - To identify and describe the highest level at which the student can practice vis a vis the dying patient
- (Robinson 1974 p 651)

Students in Robinson's study learned not to fear talking to dying patients.

Acknowledging that nurses work in relative emotional isolation, other efforts have been made to encourage nurses to express their feelings. These have ranged from multidisciplinary consultative or support groups to individual counselling for members of teams working with cancer/dying patients. Baider and Porath (1981) set up group meetings to facilitate communication amongst nurses and

share experiences about working with cancer patients. The authors suggest that these group sessions helped nurses to consult one another, express their anger and aggression, work as a team and socialise together.

Klagsbrun (1970) set up a psychiatric consultative group in a cancer research unit. His goal was to alter ward culture rather than deal with individual patient's management problems. Nurses began by defining their roles vis a vis the emotional well-being of patients. They began to recognise and accept the doctors' need to maintain a distance. Having clarified their own role, nurses started to assess patients critically. Nurses gradually felt able to talk to patients about anxiety or depression but continued to feel uncomfortable discussing issues relating to diagnosis, treatment or prognosis. Once the nurses felt more comfortable with their own feelings, an attempt was made to change the ward culture by encouraging patients to become more self-caring and participate in the care of other patients. Nurses were instrumental in sustaining this changed ward culture despite changes in patient population. Klagsbrun's (1970) experiment was intended to persuade nurses that patients' needs were more important than ward management. This experiment affected medical staff as well, who now acknowledged that they too could contribute to patients' emotional well-being. Klagsbrun (1970) maintains that the opportunity for nurses to share their anxieties at group meetings explains why they were enabled to talk to patients about cancer and death without distancing themselves:-

We all realised that our ability to talk about death and cancer with the patients and to bear their needs without closing ourselves off from them grew in direct proportion to our ability to share our own anxieties at our group meetings. The more we talked together, the more easily we could listen to our patients. (Klagsbrun 1970 p 76)

Many analyses of the distancing strategy focus on the way in which it protects nurses from experiencing distress. For this strategy to have worked it must have been aided and abetted by structural arrangements of nursing in the ward in which it occurred. The status of nurses, vis a vis other health workers, particularly doctors, is one factor which relates to this (see discussion in Chapter Six). Ward ideology (or culture) is another factor which contributes to interaction patterns. Klagsbrun (1970 see above) nearly twenty years ago endeavoured to change interaction patterns through altering ward culture. This attempt resembles Menzies' (reported in Menzies Lyth 1988) Stanmore study where she used action research to improve quality of care for child orthopaedic patients through involving their mothers in their care.

Most attempts to change nurse behaviour however, have focussed on implementing psychological techniques with limited value. Jacobs (1979) argues that even where characteristics of the patient population (e.g. children) might encourage a personalised affective orientation by the staff,

certain organisational features obstructed and prevented the development of such a value system (Jacobs 1979 p86).

Attempts to alter the context of nurses' work, like ward culture above, might facilitate more personalised care of patients. With the introduction of the nursing process, and more individualised care, more frequent interaction between nurses and patients has been encouraged and noted (See discussion in Chapter Six). It is possible that this factor may, ironically, contribute to the increasing incidence of burnout in nurses.

Burnout

Whereas distancing describes a coping mechanism for dealing with stressful situations, the term "burnout" is usually used to describe the end result of progressive and severe occupational stress (Lombardi 1987) arising out of 'people-work' type jobs (Firth 1986). Signs of burnout have been noted in a number of professions, working in both institutional and community settings; these include nurses, social workers, mental healthworkers, teachers and lawyers (Firth 1986).

Symptoms of burnout in nurses have been correlated to the severity of the patients' illness (Pines and Maslach 1978 quoted in McElroy 1982) and in instances where patients die or are predicted to die, nurse are assumed to experience loss. Consequently nurses working with cancer patients are most vulnerable to experience symptoms of burnout. This literature will be reviewed after exploring how burnout is conceptualised.

Burnout in nurses is characterised by high rates of absenteeism, and low resistance to disease - the common complaints are recurrent colds, headache, stomach ache, stiff neck, insomnia and backache, exhaustion and fatigue (Lombardi 1987; McElroy 1982; Jenkins and Ostchega 1986). Burnout can also result in drug and alcohol abuse (Jenkins and Ostchega 1986). Nurses experiencing burnout are believed to quarrel with colleagues and have difficulties in problem solving and decision making. Possible consequences may include deteriorating quality of care, a decrease in morale and eventually a decision to leave the job. Burnout is

cumulative and progressive and can be viewed in stages, starting with somatic symptoms resulting with gradual disintegration of relationships.

Analyses of burnout are still unsatisfactory and lack theoretical bases. Burnout is usually described as follows:-

The term has been used to describe a complex of psychological responses (strain) to the very particular stress of constant interaction with people in need (Firth et al 1986 p 633)

it can be viewed as a disease of overcommitment in which there is a psychological withdrawal from work and which may encompass many different feelings and behaviours. These include resistance to going to work, ineffective work patterns and clock-watching (Lombardi 1987 p9)

Tools for measuring burnout have been developed by Maslach (1982) and Cherniss (1980). Maslach (1982 quoted in McElroy 1982, Firth et al 1986) sees burnout as the combination of three processes, emotional exhaustion, depersonalisation and perceived lack of personal accomplishment. Changes in both perception of clients and self-perception (of the worker) are seen as manifestations of physical and emotional exhaustion, and involve the development of a negative self-concept, negative attitudes towards work and a loss of concern and feelings for clients. Cherniss (1980 quoted in Firth 1986) defines burnout more generally:-

increasing discouragement, pessimism and fatalism about one's work; decline in motivation, effort and involvement in work; apathy; negativism; frequent irritability and anger with clients and colleagues; pre-occupation with one's own comfort and welfare on the job; a tendency to rationalise failure by blaming clients or the system; resistance to change, growing rigidity and loss of creativity (Firth 1986).

Cherniss distinguishes burn-out from temporary fatigue or strain, responses to socialisation or staff turnover (Firth 1986; McElroy 1982). His view of burnout is more pertinent to this study than that of Maslach, because it has equal emphasis on the importance of attitudinal, motivational, behavioural and affective changes as a result of job stress (Firth 1986).

Firth et al (1986, 1987) investigated the similarities between the above descriptions of burnout (from the USA), individual depression and the concept of professional depression developed by Oswin (1978 quoted in Firth 1987) in a study of British nurses working in long stay mental hospitals. Oswin describes staff experiencing a lack of accomplishment at work, becoming overtired, feeling ineffectual and suffering feelings of futile anger (Firth 1986).

Adapting the Maslach Burnout Inventory (which assesses emotional exhaustion, depersonalisation, and the presence or lack of personal accomplishment), the Beck Depression Inventory, and Kahn's role ambiguity questionnaire, Firth et al. (1986, 1987) identified factors which they related to personality dimensions. They found that nurses with a tendency to extro-punitiveness (the tendency to project hostility or blame onto others) were likely to employ avoidance (distancing) strategies, whereas nurses with a tendency to intro-punitiveness (the tendency to project hostility or blame onto oneself) were more likely to avoid both problems and decision-making. Their conclusion that certain personality characteristics predispose nurses to utilise depersonalisation strategies, and also to symptoms of burnout, is similar to that of

Freudenberger (quoted in McElroy 1982) who suggests that those nurses predisposed to burnout are :- the dedicated and over-committed who take on too much for too long, the professional who overidentifies with clients and the overcommitted who substitute work for social life. Nursing may attract individuals with strong dependency and achievement needs, both of which may predispose them to burnout (McElroy 1982).

Conversely, certain personality attributes may protect individuals from burnout. McElroy (1982) quotes Vachon who suggests that nurses at low risk from burnout

- 1) tend to believe that individuals control their own destiny
- 2) have a flexible approach
- 3) have extroverted personalities, in particular can express disagreement, frustration or make suggestions
- 4) have a supportive social network away from work
- 5) choose work settings accidentally or because of convenience. (Vachon 1978 cited in McElroy 1982)

Vachon's reference to personal ideology as a protective factor has a useful application in this study. Brown and Harris (1978) identified protective factors (personal and social) in their study of depression. Although these models were based on a psycho-social, rather than sociological approach, it is possible that these personal and professional ideological factors play a part in reducing both experience and symptoms of stress, in particular burnout, in groups as well.

As indicated in the above discussion, causes of burnout (and protective factors) can be seen as rooted in personality and social characteristics. Unlike other forms of depression, burnout has been identified as related to work conditions, yet most

attempts to relieve burnout in nurses have focussed on individuals rather than on organisations. Burnout is believed to stem from conflicts that nurses face in their jobs. Conflicts relate to discrepancies in personal, educational and institutional goals and resemble general causes of stress in nursing discussed in the next section. For example conflicts may arise relating to discrepancies in approach to treatment between nurses and the medical profession. The nature of the setting can be a source of burnout. On the cancer ward, stress has been related to the emotional and physical status of the patients:-

Dying patients and mourning relatives do not provide much gratification. The oncology nurse is more constantly and persistently exposed to the labile emotions and turmoil of the cancer patient. (McElroy 1982 p 213)

During their training nurses are socialised to adopt a certain worldview which might be challenged as they change hospital wards or nurse in different work settings. Aspects of the setting contribute to symptoms of burnout. These include lack of clear leadership, inadequate communication, and poor supervision (McElroy 1982) . Nurses can experience conflict between their professional ideals and the demands of the institution.

a) Can burnout be prevented?

Efforts to reduce the vulnerability of nurses to burnout primarily adopt individual or group psycho-social support strategies. Measures aimed at supporting junior nurses have also been recommended because a relationship has been identified between high burnout scores and lack of psychological support at work (Yasko 1983, Jenkins and Ostchega 1986).

Benoliel (1985) adopts a structural approach to burnout and suggests burnout may be reduced by adopting a "facilitating" nursing model, which she calls "transition-oriented" nursing care:-

Transition-oriented nursing care that assists patients and families in identifying and solving problems and in normalising their lives in the face of adversity depends having on communication strategies that promote a sense of mastery, facilitate communication and provide support in a context of stress and strain (Benoliel 1985 p 447)

Benoliel's proposal supports my argument that contextual, professional and ideological factors may serve both as causes of and protection against burnout type symptoms.

b) A note of caution

Burnout symptoms have been reported in nurses working in particularly in high activity and high death settings. A number of studies have suggested that oncology nurses, by nature of their work, are prone to burnout symptoms (Review by McElroy 1982). Yet several studies using the same tools have demonstrated that in other groups of oncology nurses burnout scores are moderate and no higher than other hospital based nurses (Jenkins and Ostchega 1986). This is consistent with the contention that burnout should not be viewed as simply related to a type of nursing job, but is an accumulation of a number of "stressful" factors which result in burnout symptoms.

Most tools investigating burnout use psychological testing or other social scientific quantitative methods. The drawbacks of using these kinds of measures are discussed in Chapter Six.

Conclusion

Nurses working with cancer/dying patients have been found to experience little job satisfaction and adopt distancing strategies and/or burn out. Where distancing strategies are used the relationship with the patient is believed to be remote, whereas in burnout, a number of factors contribute to nurses losing self-confidence and self-control.

There are similarities between distancing and burnout, distancing being one of many symptoms of burnout. Use of the distancing strategy does not necessarily imply that burnout may result, but has implications for patient care.

In most of the studies reviewed above, there is an implicit (or in some, explicit) assumption that health workers, especially nurses, experience stress as a result of working with cancer / dying patients. This stress is usually related to communication with patients; when interactions are limited, nurses experience less stress, but provide patients with inferior care through neglecting the emotional component of nursing. When nurses take on the emotional aspect, they become incapacitated, burn out, hence they themselves suffer and so does their work. Nurses in this study did not share the assumption that working with dying patients per se caused them stress. They saw other aspects of nursing as stressful. These factors have been studied in the general "stress in nursing" literature and will now be reviewed.

SECTION THREE : STRESS IN NURSING

Nursing as a profession has been described as stressful (review in Marshall 1980). Stress in nursing has most frequently been attributed to specific types of nursing especially those associated with life-threatening conditions, for example emergency services, intensive care, coronary care units, cancer and terminal wards (Menzies 1959). It has also been suggested that the **nature of nursing itself** is stressful.

Menzies (1959) based her seminal work, "The functioning of social systems as a defence against anxiety" on a study of nurses during the 1950's. She suggested that nurses, more than lay people, are confronted with the threat and reality of suffering and death. Nurses' work involves

carrying out tasks which, by ordinary standards, are distasteful, disgusting and frightening. Intimate physical contact with patients arouses strong libidinal and erotic wishes and impulses that may be difficult to control (Menzies 1959 p98).

Menzies' (1959) suggested that nurses could be overwhelmed by unmanageable or intense anxiety, and depression. She attributed the high rates of sickness / absence and voluntary withdrawal from training to psychological distress associated with the nature of nursing work and organisational strains inherent in the hospital system. Several more recent studies confirm Menzies observations regarding nurses' absence / sickness rates especially in high death areas. Katharine Parkes (1980) corroborates Menzies' findings; she reviews studies which demonstrated the high psychiatric consultation rate of nurses, and nurses' high rates of suicide, self-poisoning and smoking. Recent changes in the organisation of nursing work and in nursing ideology (see Chapter

Six), however, lead one to question whether causes of, or responses to stress have diversified.

Causes of stress

What aspects of nursing have been demonstrated as causes of stress? A review of the literature reveals that many factors have been identified as stressors in nursing. The most pertinent are reviewed briefly:-

a) Patient attributes

Sudnow (1967) and others (Hall 1979; Kelly and May 1982; Murcott 1981) have explored patients' attributes and behaviour to identify whether these influence nurse/patient interaction. Sudnow (1967) found that socio-economic status, class, age and marital status influenced nurses' perceptions of patients. Roth (1972), Murcott (1981) and Kelly and May (1982) demonstrated that nurses expect patients to behave in a compliant, co-operative way. Patients are expected to contain their distress and to facilitate care. Strauss et al (1970) demonstrated how the combination of personality factors and nurses' perceptions of a patient's terminality contributed to nurses' withdrawal from anything other than essential contact with the patient studied.

b) Nurse attributes

Personal factors might aggravate or precipitate stress (Lombardi 1987). These might be related to the nurses' previous experience, or her stage of life. Yasko (1983) found significant correlations between nurses' ages and the amount of stress experienced.

Carlisle (1982) suggests that Yasko's findings supports the theory that young professionals suffer stress because of their idealism and commitment.

Katharine Parkes (1980) looked at personality factors and how this might predispose nurses to stress. Her findings suggest that nurses were typical of the normal female population in personality characteristics, with, however, some bias towards "stable extrovert" personality. Parkes (ibid) refutes the theory which proposes that those women who choose nursing as a profession might be more subject to stress than the general population. (See previous discussion in Section Two about personality predisposition to burnout).

c) Aspects of the interaction

The nurse's relationship with the patient is obviously a crucial element of her working life and thus in the latter's potential to cause stress (Marshall 1980 p 27).

There are a number of factors which militate against developing straight-forward relationships with patients. For example, over-identification with patients who resemble the nurse's self-image or that of her relatives; at the opposite end of the spectrum the nurse's inability to comprehend the patient's frame of reference (Davitz 1969 quoted in Marshall 1980).

Based on their studies of interaction between healthworkers and dying patients, Glaser and Strauss (1965, 1968) looked at how healthworkers structured their work to enable them to predict patients trajectories and understand patients' awareness contexts (Section Two). More recently, looking at hospital work in

general, Strauss et al (1985) have explored interaction patterns between participants in health care and termed these patterns, trajectory work (see Chapter One). Trajectory work can be divided into a number of components, comfort work, clinical safety work, machine work, composure and biographical work, and other types of psychological work, one of which they refer to as sentimental work. They explain:-

sentimental work as an ingredient in any kind of work where the object being worked on is alive, sentient and reacting - present either because it is deemed necessary to get the work done efficiently or because of humanistic consideration.(Strauss et al 1985 p 129)

Sentimental work can be a source of stress for both the recipients and the providers of care (see discussion in Chapter Six). Interactional aspects of the other components of trajectory work can also be sources of stress.

d) Aspects of structure

Stress might be related to the structures in which nursing take place. Staff shortages (Parkes 1980a) have been identified as a cause of stress in nursing both in the UK and in the USA. Absenteeism, sickness and maternity leave have been demonstrated to lead to excessive work overload (Nicklin 1987).

The relationship between stress and absenteeism is both pernicious and cyclical, stress promoting absenteeism, absenteeism promoting stress (Nicklin 1987 p10).

French et al (1973 quoted in Nicklin 1987) suggest that work overload can be divided into two categories, qualitative (too difficult) and quantitative (too much). Data from this study confirms both these points, that stress may be related to staff

shortages and work overload - see discussion of nurses' concepts of stress in Chapter Four.

Frequency of organisational changes creates stress (Nicklin 1987). At the micro-level findings in this study confirm this. At the macro-level the NHS has been re-organised and restructured a number of times over the past fifteen years and is still in flux. The dual concepts of managerial and professional accountability requires directors of nursing to be concurrently accountable to different senior managers. There is considerable potential for conflict between the management concerned with efficiency and cost - effectiveness and professional practices, standards and quality of care (Nicklin *ibid*). This applies primarily to the higher echelons of nursing management rather than to wardstaff who are usually managed by other nurses, though it can have implications for wardstaff through congruence of ideology, for example.

e) Role ambiguity

Nurses can be viewed as caught in a dilemma, they wield some power and authority over patients, yet are subject to doctor's orders and constrained by the institution in which they work as well as by patients themselves and patients' relatives (Rosenthal 1980). In nursing school, nurses learn that patients needs should be their priority, yet on the wards they observe that career prospects are related to fostering the goals of the organisation and fitting in (Rosenthal *ibid.*; Melia 1987).

Nurses are believed to experience uncertainty and concerns about responsibility (Marshall 1980). Role-ambiguity can also be seen to relate to the position of nursing in the health care hierarchy

as well as to the nature of nursing itself. The non-static nature of nursing in itself, which implies a lack of role clarity can be seen as stressful for nurses (Nicklin 1982). Margolis and Kroes (quoted in Nicklin 1982) found a positive correlation between role ambiguity and high job-related tension. Where regular appraisal and constructive feedback are not built into the system, nurses have difficulty in assessing their own work performance objectively.

Contemporary nurse education exacerbates rather than reduces the sense of role ambiguity. Pugh (1986) argues that nurse education based on the nursing process with its holistic approach presupposes that nurses can meet patients' physical, social and spiritual needs. He suggests that nurses' inability to meet these expectations causes stress which may explain why nurses exhibit the same levels of anxiety as patients. The nursing process is discussed in Chapter Six. It is important to mention here, however, that inherent in the nursing process are ambiguities related to nurses' roles which may not apply to care of the dying in settings where dying is acknowledged to be inevitable and certain aspects of the nurses' role (e.g. technical) are subsumed by emphasis on the affective/ emotional.

Other aspects of inadequate nurse education, for example, supervision of students, (Parkes 1980; Fretwell 1982; Melia 1987) have also been shown to cause nurses stress. Many nurses found that their training had equipped them for the physical and emotional strains at work, but saw stress as related to the disparity between their hopes and expectations and the realities of their jobs. Findings in this study (See Chapters Four, Five

and Seven) support the contention that stress is not experienced where nurses' ideology is congruent with nursing reality.

f) Aspects of the job

Certain medical as opposed to social types of patient and/or aspects of nursing work have been identified as causes of stress. Parkes (1980) investigated the effects of medical and surgical ward allocation on measures of psychological stress, work satisfaction and short term sickness over a six month period. Students showed higher levels of anxiety and depression and lower levels of work satisfaction in the medical compared to surgical wards, but no difference in sickness rates or absenteeism. Parkes suggests that the "instrumental role" in surgical wards, where nurses could participate in patients' recovery to the extent that patients might achieve a healthy discharge, provides nurses with satisfaction which they might not derive from nursing patients for a longer period in medical wards and then seeing death as the outcome. Parkes suggests that there are two possible explanations:-

- a) affective role of the nurse, which is particularly important in medical nursing, is likely to impose more difficult emotional demands on the student nurse and provide less tangible sources of satisfaction. The nature of the work in medical wards would be expected to give rise to a greater degree of depression than that in surgical wards
- b) more general aspects of the ward environment, as assessed by the social climate profiles of the two types of wards, may influence well-being among student nurses. The important social climate variables of involvement, staff support and task orientation were significantly higher in surgical wards, with other variables showing differences in the same direction.

Organisational aspects of the work environment, and relationships between students, qualified staff and patients, which are reflected in the social climate

profiles, are influenced by factors such as staffing levels, the particular style of the ward sister or charge nurse, and the nature of the nursing care involved. (Parkes 1980 p 116).

Citing similar factors to those I shall identify, Parkes thus suggests that the **attribution** of the ward (i.e. medical or surgical) is only one factor which contributes to job stress in nurses. (See previous discussion on the relationship between stress and nursing cancer patients in Section One).

Can stress be defined?

At least three types of stress are differentiated in the literature - physiological (Selye 1956), psychological (Monat and Lazarus 1977) and sociological (Mechanic 1970). Consequently constructing a definition of stress, in particular addressing the possibility of measuring occupational stress, is problematic. McGrath (1970) suggests that the criteria chosen to define "stress" should be examined as they involve value judgements regarding important dimensions of behaviour. He cautions investigators to be aware that their value systems influence their interpretations and findings.

Most conceptualisations of stress, irrespective of discipline, imply an underlying assumption that stress is undesirable and noxious (McGrath 1970). In particular, work stress has been identified as dangerous to health. In the '60s physicians identified "Type A" behaviour patterns. Prototype workaholic males were particularly at risk from work related stress. This could be relieved by a complete turnabout in life style incorporating exercise, diet and emotional control.

Marshall (1980), in a very useful and comprehensive review concerning stress in nursing notes that the assumption that stress and/or anxiety are de facto pathogenic is also implicit in studies of stress in nursing. Nurses' jobs cause them high levels of anxiety which leads to poor performance and consequently poor patient care. She points out that stress has been seen as negative and as affecting the individual rather than the organisation, hence most attempts at alleviating this stress have been directed at the psychological individual level. Marshall (1980) suggests that future studies should explore which facets of their jobs nurses themselves experience as stressful. She suspects that

Certain apparent stressors may well be revealed as acceptable parts of the job, ones which can ordinarily be contained, stabilised, reduced or prevented, even sources of satisfaction, once the job holders themselves are consulted. (Marshall 1980 p 29).

Antonovsky (1987) also challenges the view that all those who experience stress perceive it alike. Whether something is a cause of stress depends on the meaning of the stimulus to the person. The individual's own perception of a situation determines whether it is seen as a threat or a challenge (Carlisle 1985). What might be a stressor for one person causing physical and emotional symptoms, might be a stimulus towards constructive and creative action for someone else. This approach therefore does not see stress solely in terms of external events with the individual as a passive object receiving disturbing stimuli (Carlisle *ibid*).

This study addresses the questions posed by Marshall(1980) and Antonovsky (1987). It is based on the assumption that causes of stress may not be the same for all individuals (or groups) and

that the **meaning** of particular events may also differ. In studying nurses' own accounts of stress we therefore need to see if these tally with the received wisdom that the job of nursing is stressful. In particular this study questions whether nurses conceptualise death and dying as stressful. Is it possible that nurses might view nursing dying patients as a positive or challenging experience (Antonovsky 1987) yet conceptualise other aspects of their work as stressful?

CONCLUSION

With the advent of the hospice movement and changing societal views about how and where people should die, patients are no longer assumed to have to die in pain and isolation in general hospitals in Britain. Interactions between health workers and cancer / dying patients have also altered having implications for both parties.

The mid-twentieth century was characterised by nurses neglecting the emotional needs of dying patients by limiting contact with patients to physical or technical tasks (distancing). This scenario has been replaced by increased affective / emotional contact between nurses and patients. (This can partly be explained by changes in nursing discussed more fully in Chapter Six). More intensive communication with dying patients, however, has placed nurses at greater risk from burnout.

This study commenced with the assumption, based on previous research, that the medical diagnosis of their patients contributes substantially to whether nurses experience stress. Specifically, it was assumed that caring for cancer/dying patients was a source of stress for nurses. This job entails unpleasant work and difficult encounters with patients who may have uncertain prognoses. These create a number of anxieties in nurses (Menzie's 1959) to which they respond by adopting distancing strategies to protect themselves emotionally or alternatively become involved with patients and lose their professional demeanour.

Attempts to reduce stress in nurses have centred around psycho-social measures, assuming that nurses in certain settings experience stress and would benefit from talking about it (Parkes 1982). Marshall (1980) and Firth (1986) have questioned these assumptions wondering whether nurses perceive group meetings or individual counselling as alleviating stress.

Many of the studies reviewed in this Chapter, purporting to reduce nurses' anxiety and hence improve quality of care, were experimental in nature and not built in to training programmes. There are few studies which describe success of sustained support measures for nurses on cancer wards.

Strategies to change nurse behaviour, having focussed on individual nurses rather than the organisation of nursing, have not taken into account the structure of nursing work, nor the structure of nurse education. Measures which acknowledge structural aspects might have a more sustained impact than those aimed at current workers. Hence structuring nursing work on a cancer ward to accommodate the needs of the patient population might be a more effective measure to reduce nurse stress.

The assumptions that nurses do experience stress from cancer nursing and / or would benefit from psychological support are questioned in this thesis. Both Marshall (1980) and Firth (1986) wonder whether nurses find sharing their emotions actually helpful. Firth (1987) has pointed out that there has been little enquiry regarding what kinds of behaviour nurses view as supportive, nor what particular kinds of support are associated with lower levels of burnout or professional depression (p228).

Firth et al. suggest that

Prevention is likely to be better than cure, and consequently more thought may need to be given to defining and supporting what nurses might be expected to accomplish in their jobs (Firth et al 1987 p 228).

The next chapter, the methodology chapter, will indicate how this study set out to understand nurses' definitions of stress with a view to suggesting support measures to alleviate stress. Data generated in the field, however, suggested that the nurses studied did not conceptualise cancer nursing *per se* as stressful and hence questioned the assumption that nurses working in a cancer ward required additional support. In order to understand this apparent discrepancy between previous research and the findings, the literature needed to be widened to incorporate contemporary concepts of nursing ideology and practice. Chapter Six addresses these issues - the need for this will become apparent in the following three chapters.

CHAPTER THREE

METHODOLOGY

INTRODUCTION

This chapter presents the background to and the process of the study and is organised around events in a chronological order. Analyses of processes are possible with "hindsight" - despite this, the chronological account will be preserved as far as possible. As in most field research (Burgess 1984a) the purpose of the research, the methodology, and the gathering and organisation of data all interacted with one another.

Two chronological aspects of this study were particularly important. Firstly, the study, methodologically, can be divided into two research phases (see Section Two). Secondly, nursing management on the ward can be divided into three distinct periods. Phase One (methodology) coincides with the first management period, and Phase Two encompasses the second and third management periods.

The chapter division is designed to make best sense of the research process. Section One explains how I became interested in this subject, and the development of the research questions which led to formally negotiating access to a fieldwork site. Issues relating to fieldwork methods, especially ethics, are raised.

Section Two will introduce the concept of two methodological phases, and discuss issues which arose in Phase One, including

fieldwork plans, the negotiation of access, access interviews, observation periods and the first six weeks of the study.

Section Three will describe Phase Two, in particular the process whereby the methodology evolved, and changes in my approach responding to methodological, theoretical and practical issues. The nature of the fieldwork is discussed at some length. Thus Section Two corresponds to Phase One and Management Period One; Section Three corresponds to Phase Two and Management Periods Two and Three.

Section Four analyses the process of data to theory concentrating on theoretical issues arising from the analysis and writing up of the study. Problems confronted in writing up fieldwork studies e.g. writing oneself into the study (Bell and Roberts 1984 p. 3), will be addressed.

The Conclusion summarises the chapter.

The theoretical approach

As the Abstract stated, this study was specifically concerned to discover the meaning of stress and support for nurses working with cancer/dying patients. The initial plan was based on a number of premises relating to stress experienced by healthworkers caring for dying patients. The intention was to further an understanding of what this kind of work means to nurses. The research questions were formulated using a symbolic interactionist approach (Goffman 1959; Becker et al. 1961; Glaser and Strauss 1965) to understanding society - in particular looking at the meanings of

experiences for the subjects studied. The methodology, like the theoretical approach, was therefore in line with this tradition. Empirical or survey type research would clearly have been inappropriate means by which to gather the data.

Blumer (1969) explains this interpretation of social action within symbolic interactionism:-

Under the perspective of symbolic interaction, social action is lodged in acting individuals who fit their respective lines of action to one another through a process of interpretation: group action is the collective action of such individuals (Blumer p 645).

This contrasts with a structuralist-functionalist approach which adopts a more static approach towards society. Symbolic interactionism recognises the extent to which society is a temporary phenomenon, involving constant change. Structures are socially generated, transmitted, maintained and changed from interaction.

Symbolic interactionists see structures as mobile and perpetually developing (Worsley 1988) as opposed to rigid, clear and stable. Stable social arrangements are compatible, however, with a symbolic interactionist interpretation and can be seen to incorporate a variety of processes (Worsley 1987). These arrangements can be seen to be fluid and changeable even within a "stable" and hierarchical structure such as a hospital. Many references are made throughout this thesis to the concept of 'negotiated order' (Strauss et al 1963) which illustrates how people in a particular social setting (in this thesis, the nurses in an oncology ward) negotiate how the work is to be done. Other actors in the social setting also influence outcome; this has been well illustrated in the case of patients by Davis (1963) and

Roth (1963). Although fieldwork for this thesis did not incorporate soliciting the views of the patients directly, nurses' accounts provided evidence that patients maintained and were encouraged to maintain some control over their dying or treatment trajectories.

Symbolic interactionism seeks to understand the meaning of situations for actors as well as their perspectives. This thesis is in this tradition, in that it explores the meaning for nurses of caring for cancer/ dying patients.

The methodological approach

Previous experience in similar settings permitted a number of predictions regarding my research role as well as the findings. In common with several other recent nursing research projects (Melia 1982; James 1986; Field 1987; Smith 1988) the approach adopted was in the spirit of Grounded Theory (Glaser and Strauss 1967) which is an offshoot of symbolic interactionism. Grounded theory is underpinned by the belief that data emerging from fieldwork can generate theory; this emerging theory can then be useful in making methodological decisions. Therefore the Grounded Theory (1967) approach provides reassurance that fieldwork is possible, and can in fact be more meaningful, without preconceived notions about the nature of the data.

SECTION ONE : METHODOLOGICAL OBSERVATIONS FROM PREVIOUS

FIELDWORK EXPERIENCE

Background to methodology

Prior to embarking on a M.Sc. course at London University in Sociology as applied to Medicine, my exposure to social research, nursing and dying/cancer patients had been minimal. My academic background consisted of a degree in Political Science from an American university and a social work degree from a university in Israel; the latter included a research project on amputees.

My social work studies were interrupted by a war in the Middle East, during which I observed great distress which related to survival both of individuals and of a society. My practical placements were altered to accommodate the crisis. I came into contact with soldiers about to die, or lose limbs, and with distressed and grief-stricken families. I observed that the emotional component of care often lost the boundaries emphasised on the Social Work course; at the same time I observed some healthworkers demonstrate a type of demeanour that reflected a need for self-preservation and manifested itself in emotional withdrawal from patients. This behaviour seemed difficult to understand and I attributed it to the enormous strain borne by healthworkers both in their personal lives (the Israel Defence Forces being a civilian army composed of the entire population) and in their professional lives with normal functioning suspended to deal with war injured.

Having moved to London, I worked for four years as a social worker in a multi-disciplinary cardiac rehabilitation programme in a

district general hospital in London. Healthworker / patient interaction patterns seemed different from those I had observed in Israel, both during war and peace. I attributed these differences to British cultural patterns. Nevertheless the apparent docility of the British patient bothered me considerably and led me to investigate possibilities of further study in medical sociology. Domestic considerations played some role in my decision making and in 1979 I left my job to commence a M.Sc. at the University of London.

Previous fieldwork experience

An observation period in a health organisation was obligatory for M.Sc. students. Despite increased awareness of other health settings, I remained fascinated by interactions between disciplines in hospital. To broaden my outlook to encompass other facets of health service functioning, I chose to observe a charity funded medical oncology unit which operated on two sites, one a famous teaching hospital, the other a district general hospital.

My approach to negotiating access was at best naive. My Professor at Bedford College wrote to the Professor of Medical Oncology requesting that I be allowed to observe for a fortnight. A positive reply was immediately forthcoming. It later became apparent that he was flattered that an eminent sociologist had requested a student placement in his unit.

The professor suggested that I meet with him on the first day. During this meeting he made psycho-social observations of work with cancer patients. He described the interpersonal difficulties

of health workers in cancer units, in particular, manifestations of emotional distress amongst his colleagues and junior staff. He attributed frequent marital breakdown amongst oncologists to job stress. He expressed regret that his junior staff, for fear of repercussions on their careers, did not discuss their distress with him.

The research experience was salutary and directly relates to this thesis. Years in medical social work and considerable reading on the hazards of observation had not prepared me for having nowhere to hang my coat, no chair to sit upon, no bolt hole. I found myself standing against the wall in the secretary's office near the entrance to the unit. (This entrance was about five hundred yards from the ward, where there were no facilities for lab or desk space for health workers). This turned out to be a good spot for a wallflower because most discussions about *patient management* and unit functioning took place here. Standing here enabled me to introduce myself to members of staff, be they laboratory scientists, technicians, doctors or nurses. Deciding when and how to introduce myself was very difficult and made me extremely uncomfortable. For example, conversations between workers and colleagues or with the secretary did not necessarily identify the workers' role and it was therefore difficult to pitch the introduction. With certain members of staff introducing myself might have been complicated because in a previous job my husband had worked closely with this unit; in fact most workers did not know him or connect us. Only in two instances did this connection evoke responses, one to some advantage. A scientist who knew my husband, saw how I appeared to be pinned to the wall and offered me the use of a spare desk in an office adjoining his. This

provided a legitimate space for note taking yet disadvantageously removed me from the scene of the action.

Like McIntosh (1977) I discovered that very few staff members were expecting me. Only the senior medical staff (i.e. the consultants) had been notified; they were welcoming and helpful except for one consultant who was positively antagonistic. None of the junior medical, research and paramedical staff had advance warning of my presence. Despite this, they were fascinated by the prospect of sociological observation and were keen to contribute to my findings. In answer to questions about the purpose of my observation, I developed a stock answer because it seemed to evoke a helpful response. This was, "I'm here to see how this unit functions". The response was inevitably, "That means you assume it does function", which immediately cemented contact. The junior medical staff suggested that I should attend their clinics, and introduced me to non-medical key workers. They seemed concerned that I should gain a balanced view. Thus, despite having been imposed upon them from above, I was able to negotiate individual access with junior doctors. At the same time, the scientific model of the unit informed their expectations of feedback from me, and nothing less than instant feedback was expected!! Their insistence on knowing 'my results' reflected their own pre-occupation with results which after all was their *raison d'etre*. The junior doctors offered what they saw to be sociological insights suggesting that the unit was "sociologically interesting", by which they meant that the power structure was other than it appeared superficially.

Other than one consultant who questioned the ethics of observing cancer patients, the staff were most co-operative and keen to share their experiences with me. Even the laboratory workers, engaged on the blood and drug trials for the soft tumour cancers, had direct contact with patients, because they took blood, undertook bone marrow procedures and transfusions.

The group that began to interest me most were the nurses, partly because of the contrast in behaviour between those in the teaching hospital and those in the district general hospital (d.g.h.). Nurses, like the doctors, in the d.g.h. appeared to be more contained about their experience, supported by ancillary psycho-social services (Parkes 1982), and invited me to attend their weekly session with the psychiatrist who enabled them to give expression to their feelings.

In both hospitals the consultants introduced me to the trained nursing staff. In the teaching hospital the sisters expressed a keen interest to talk to me in private. Discussions with all three sisters generated similar material. They felt that caring for acutely ill cancer patients and dying patients *took its toll on* nursing staff. They described the typical trajectory of leukaemia patients. When a patient is diagnosed with leukemia s/he is admitted immediately to hospital and often demonstrates signs of grief (Parkes 1983) including expressing intense feelings of anger. As this hospital was a centre of excellence for the treatment of leukaemia, patients often came from far afield. The intensity of the life change often caused considerable friction within patients' families and nurses remarked on the high incidence of marital breakdown. The sisters in the teaching

hospital commented that the nurses carried the entire emotional burden because they were unsupported by the psycho-social services in the hospital.

All three sisters wondered how working on this ward affected student nurses. One sister remarked that the nature of the sister/student nurse interaction did not facilitate honest expression of feelings. Without consulting me she arranged that I meet with the students on her ward. As all participants in this session were unprepared and it took place in an uncomfortable side room off the ward, I elicited little data from the nurses. This encounter warned me that nurses might be suspicious of my motives and question my relationship with their superiors (i.e. would I report back). This spontaneous session also impressed upon me the importance of careful planning of group discussions with nurses; the location needed to be comfortable and nurses would require repeated assurance that their contributions were of value and would be handled in confidence.

Undoubtedly, two of the three sisters used me for therapeutic purposes. Initially this was a problem for me, but I soon felt comfortable in the role, as it enabled me to feel that I was giving back something in return for my guest status. (See discussion later). At the same time, the boundaries that had been set, and my imminent departure, seemed to facilitate the generation of an enormous amount of data, far more than was to emerge in many more sessions during the study with which this thesis deals. On my last day, I returned to the wards to say goodbye and thank you to the sisters. One sister was extremely distressed as a "favourite" patient had just died. The family had

reacted by threatening the lives of the wardstaff. On entering sister's office I was unaware of the drama that had been taking place. She tearfully brought me up to date, and asked me to accompany her to check the laying out of the patient before our final chat (which I had not planned, but she clearly had). I acceded to her request despite the fact that hitherto I had never seen a corpse, nor was prepared for the sight of a body which had suffered convulsions at death.

Several issues arise out of the above account of my first social research experiences which had implications for the design of the main study reported in this thesis.

a) Access

In retrospect, negotiating access through the professorial connection could have created insuperable problems. My initial interests were related to power and control (how the charity defined the workings of the unit, how patients were allocated etc.) and I simply did not question the advisability of the access route. As soon as I was on the unit, it became apparent that the decision to grant me access had been taken in a unilateral manner without consultation with other workers. Hence I could have been confronted with a number of potential informants who resented my presence and co-operated to a minimum to placate the boss. I realised quite quickly that to understand how this group of people functioned as a cohesive unit, I would have to shadow key individuals throughout their interactions with each other and with patients. Although "official access" was negotiated only once, I was constantly negotiating and re-negotiating access with

different workers (Burgess 1984a). My familiarity with hospital settings (see Burgess 1984a) enabled me to adopt a self-confident facade. The way in which I introduced myself was crucial. At the same time, had workers not wished to unburden themselves, however I introduced myself, they might not have wanted to share their experiences with me. Most workers felt a tension in the unit and welcomed an opportunity to discuss it. None expressed anxieties about confidentiality or repercussions on their jobs. They were desperate to talk, and I was the catalyst in that situation.

b) Social research ethics

When cancer patients are not cured, healthworkers are believed to experience feelings of loss relating to their professional competence (Benoliel 1974). Hence healthworkers' *reviews of causes* of death are carefully constructed to minimise blows to professional worth (Arluke 1977). As an outsider (like McIntosh 1977) I was not supported by these rituals and therefore experienced raw feelings. Hence objections (on ethical grounds) made by one consultant to my wish to observe interactions between healthworkers and patients on the ward hit home hard.

One cannot deny the ethical problems implicit in such research. Contrasting ethical views regarding covert social research are raised in Bulmer (1982). He points out that unlike other professionals, such as clergymen and doctors, sociologists do not adhere to a consistent code of practice. Some contributors in his volume support Erikson's position (Bulmer 1982 p9) that disguising one's true position compromises both the researcher and the researched. Erikson described four kinds of relationships. In the first he describes the sociologist's responsibilities to the

subjects suggesting that the nature of the research can sometimes harm the subjects in unpredictable ways. To study them secretly is comparable to carrying out human experimentation without the subject's permission. The second relationship relates to responsibilities the sociologist has to his colleagues. Covert observation might damage the profession's reputation and close off future channels of research. The third relationship relates to the fact that most covert observers are graduate students who should be protected from the stress involved, by those responsible for them in academe. Fourthly, covert research is bad science. There is no convincing evidence that those who use covert roles really become accepted as full participants in the field of study.

The rationale of the method therefore falls away, and the quality of the data collected by its use is liable to bias, distortion and error (Bulmer 1982 p10).

The opposite point of view is held by Douglas (quoted in Bulmer 1982) who suggests sociology should aim at searching for truth. The nature of society is best described by a conflict model and therefore the social researcher is not only entitled but compelled to adopt covert methods in pursuit of scientific truth.

A number of brilliant social studies have been carried out in the past using questionable social ethics, most notably in my view, Whyte's Street Corner Society (1943). On the other hand, studies of women using in-depth interview techniques have revealed that honest input from the researcher about their own identity clearly improved the experience for all concerned (Finch 1984).

There are dilemmas about how much to reveal, however. Finch (1984) maintains that the fact that she was a clergyman's wife justified her motives to her subjects, the wives of clergy. As a graduate student in medical sociology fulfilling part of the course requirements, my motives were likewise accepted.

Two aspects of my background raised dilemmas regarding what to reveal. The first related to my professional training and experience. My familiarity with hospitals as organisations and different disciplines therein meant that I was able to gauge the attitudes of different professionals towards psycho-social services. I soon discovered that several doctors on this unit viewed social workers with suspicion and therefore decided that, unless asked directly, (under which circumstances I would provide any information requested) it would be counterproductive to reveal my professional background. Towards the end of the placement, however, I volunteered this information to the sisters for two reasons. Firstly they had exposed themselves as rather vulnerable in discussing issues regarding relationships with medical staff and with patients and I felt reciprocity was fair. Secondly, following Finch (1984) it seemed important in establishing mutual trust to reveal my identity as a woman who had also worked in a predominantly female occupation in medical settings. This implied shared experiences and similar conflicts with patronising physicians who trivialised psycho-dynamic disciplines.

The second aspect of my background related to my husband's former connections with this unit (see page 64). Only because my husband had been a former colleague did the consultant who questioned the

ethics of my observation, (grudgingly) grant me access to the wards. To my knowledge, none of the more junior staff knew my husband, nor the connection and it seemed unnecessary to draw attention to this.

c) The social research role

The emotional effect of this fortnight on me was unexpected (Hammersley 1984). I became totally involved with what was happening on the ward and the research unit. Like McIntosh (1977) I began to believe that the role of the sociologist was insignificant compared to those devoting themselves to developing a cure for cancer. Everyone working in the unit was somehow engaged in the fight to cure the patient, or at least palliate. Like McIntosh (1977) I felt an intruder and that I had no useful task to perform :

Everyone but me seems to be part of a team, a cohesive unit, each member of which has a clearly defined role and is working towards a specific end, namely the treatment and care of patients. I am neither a member of that team nor are our goals the same I felt wholly parasitic ... After some contact with the disease, I also came to feel that my work was less important, and the rewards less immediate, than that of the staff. (McIntosh 1977 p23)

My feelings of inadequacy relating to the skills I could offer in a cancer ward were recorded in my observation report (1980) . In addition, I noted the contrast between a clearly defined role as social worker and the wooliness of social researching.

Stephenson and Greer (1981 cited in Burgess 1984a p22) question the extent to which familiarity with the culture helps to translate observations into data. Although my childhood was spent in South Africa and I am Jewish, other aspects of my

identity e.g. my colour, age, educational and class status (derived from my husband's profession) tallied with that of the senior nursing and junior medical staff. Like the nurses, and two junior doctors, I am a woman. Burgess discusses ethnicity (1984) only with reference to whites and blacks. He quotes Liebow (1967) who indicated that colour had enabled him to be seen as an outsider which removed the threat of competition and facilitated observational work. My colonial accent and my foreign sounding surname might be seen to have afforded me the same status. Most workers were exceedingly friendly and forthcoming with material, yet the only person to invite me to join her for a meal (in the doctors dining room) and to subsequently maintain contact with me after the placement, was a woman doctor, exactly my age, who could identify with me on cultural and *religious grounds*. The data she provided, however, was much more guarded than the rest.

Most of my previous professional experience had been concerned with the psycho-social adjustment to illness or handicap in hospital patients. Therefore, although at the time my choice of research topic seemed accidental, it is not surprising that I became interested in staff interaction patterns on the unit.

In conclusion, fieldwork can be a painful experience. I felt uncomfortable at first and distressed by what I observed, but by the end of the placement acknowledged that my role as listener had contributed to the workings of the unit. None of the informants seemed to hold back and I felt burdened by trust displayed in me; I wondered whether the staff who befriended me realised that I was an observer at all times.

The present study

The development of the specific research area

The profound effects working with cancer patients can have on healthworkers had struck me during the placement (above). I wondered whether this experience was common and whether in other contexts (social, cultural, institutional) healthworkers had devised strategies for managing this stress or containing their feelings. In my M.Sc. dissertation I reviewed the field (Katz 1980) and found that published research corroborated these impressions suggesting that cancer care is stressful for healthworkers (particularly for nurses who have the closest contact with patients) and that a number of experimental stress-reducing programmes had been piloted (primarily in the USA) with some success. Few studies on the effect of caring for cancer patients or the terminally ill had been published in the UK at the time (1980), although subsequently Bond (1982, 1983), James (1986) and Field (1987) have done so.

In planning a research proposal for a Ph.D., I decided to study the experiences of nurses caring for dying patients - firstly because the structure of nursing practice implies that of all healthworkers, nurses have the most contact with patients, and secondly because during my placement the **nurses** themselves had suggested that working with cancer patients was problematic for them.

Many researchers undertaking sociological studies of nursing (Fretwell 1982, James 1986, Melia 1987, Smith 1988a) have nursing

backgrounds ; some continue to work in nursing jobs at the same time as conducting nursing research. There are advantages and drawbacks to both insiders and outsiders studying nursing - being a nurse assumes some sympathy with problems faced, but at the same time this implies that the nurses studied expect that the researcher shares underlying assumptions which therefore are not explicitly verbalised. Studying nurses as a non - nurse entitles one to ask about the "obvious" and reach past the assumptive level.

In Chapter One I explained that my professional background was as a hospital based psychiatric social worker. The orientation of my training was casework - a psycho-social treatment aimed at enabling individuals to function more adequately in social relationships. (Hollis 1972). In my last social work job I liaised between different professions in both teaching and district general hospitals. This meant that problems relating to interactions between disciplines in a hierarchical power structure was something with which I was familiar both personally and through the literature (Freidson 1970).

Although my professional background implied certain assumptions about the value of expressing feelings as a way of dealing with stress, at the same time, I was committed to elicit nurses' accounts rather than accumulate data from observational material. In retrospect I realise that my professional background did influence my perspective (see Page 12).

James (1986) lists the advantages of studying an area which hitherto had been given low priority. The media had focussed

attention on dying patients suggesting that dying in hospices was preferable to dying in hospitals. This implied that interest might be shown in the results of this research in this field. The ways in which nurses worked with cancer patients and the terminally ill might inform nursing research, whilst the broader ramifications of such a study might influence other professions working with similar patient groups. Like James (1986) I was aware of the differences in content and approach of research problems in the disciplines of medicine and sociology, and was particularly concerned that a research design would enable me to negotiate access without having to compromise sociological scruples.

The initial research questions with which I approached potential post-graduate supervisors were:-

- 1) Do nurses in Britain find working with dying patients stressful?
- 2) If so, have they adopted strategies to reduce this stress?
- 3) What types of stress-reducing measures would nurses themselves find most helpful?

Having registered as a post-graduate student at the University of Warwick I updated my literature review to refine the research question having chosen an "ideal type" fieldwork location and sample. Burgess (1984a) discusses problems of selection and control. When a research problem is identified, field researchers are faced with making choices about locations, time periods, events and respondents. Inevitably, certain aspects of the field to be studied will be written out of the study, these include groups of people and elements of the situation (Burgess 1984a). The events, situations and people that the researcher chooses to

study depend on the researcher's substantive interests and the theoretical perspectives which in turn determine the use of different sampling strategies (Burgess 1984a *ibid*).

The general substantive area was clear (the study would focus around nurses caring for patients with cancer and/or the terminally ill) whereas the theoretical perspective relied on Glaser and Strauss' (1967) theoretical sampling which they define as:-

the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges. This process of data connection is controlled by the emerging theory, whether substantive or formal. The initial decisions for theoretical collection of data are based only on a general sociological perspective and on a general subject or problem area (such as.... what happens to students in medical school that turns them into doctors) (Glaser and Strauss 1967 p45)

My M.Sc. placement had provided "pilot" data for the research questions (see above). With regard to a sampling strategy, this same experience indicated that all grades of nurses, qualified, untrained, or student should be incorporated into the research design.

But what kind of ward? The ward I observed during the placement specialised in leukaemia treatment and admitted patients from a wide geographical area. Could the nature of nurse/patient interaction therefore be explained partly by the fact that nurses fulfilled patients' social support needs normally provided by visiting relatives? I therefore decided to look for a hospital which offered both medical and nursing teaching, had a local

catchment area and a separate cancer / terminal ward through which student nurses rotated.

It seemed important that the ward studied should handle general malignant conditions without an idiosyncratic emphasis (e.g. cure or heroic interventions). Although I had no illusions of generalisability, I felt the setting should be replicable. Most British nurses who care for the dying do so in hospital settings, and are workers / learners. These nurses are simply allocated to wards without exercising choice. The question of access also influenced choice of sample (see discussion in Section Two) and it seemed appropriate to include all the nurses on a particular ward in the research project. This would also generate data on differences in perspective between different ranks of nurses.

Tentative inquiries regarding cancer and/or terminal care produced information that my "local" teaching hospital fulfilled the exact criteria : general oncology patients, with most types of cancer (other than blood cancers) were admitted to a separate cancer ward where they were treated without being entered into a research programme. As Section Two will demonstrate, access negotiations , far from being tortuous and lengthy were remarkably straight forward, and my fears about having to change the emphasis of the study to fit in with a fieldwork location proved to be unfounded.

SECTION TWO : THE RESEARCH PROCESS 1 :

DEFINITION, ENTRY AND PHASE ONE

Access negotiations

a) Informal access negotiations - the first contacts

Gaining access is a key determinant of the research process (Burgess 1984a). It influences the reliability and validity of the data.

The points of contact the researcher has with an institution, organisation or group will influence the collection of data and the subsequent perspective that can be portrayed..... the activities that occur during this key phase of the research process will influence the ways in which those who are to be researched define the research and the activities of the researcher. (Burgess 1984a p 45)

The process of negotiating access can provide data relevant to developing and understanding research methodology, but also insights into how different individuals view organisations (Burgess 1984). Minocha (quoted in Burgess 1984) found that although his access was very complicated and time-consuming, this gave him

an idea of the medical and administrative hierarchies, the complicated linkages between different departments of the hospital and their relative autonomy, and the status and authority enjoyed by the incumbents of various offices. (Minocha, 1979, pp 202-203 in Burgess 1984a p 49)

Received wisdom suggested that access negotiations would be time-consuming and difficult. Notions of ethical committees, repeated interviews with gatekeepers were expected (See Burgess 1984a). Anticipating long delays, it seemed sensible to proceed with enquiries many months before I anticipated being "ready" to embark

on fieldwork. Having established that the local teaching hospital, had a general cancer ward through which student nurses rotated, I contacted the sociology lecturer there and described the proposed study and the planned route of access. As nurses were to be the focus of the study, it was important to negotiate entry to the ward through them. Obviously access cannot be negotiated through each respondent but I, like James (1986) felt very strongly that the traditional route of negotiating access through the "head" of the department (the senior consultant) was inappropriate. My sociologist friend, herself an ex-nurse, was sceptical about my intention to contact nurses directly, expressing notions of power relationships and hierarchy as explanations why ward sisters would feel uncomfortable with a direct approach. Nevertheless she put me in contact with a nurse tutor at the same hospital who was familiar with the ward and the nursing staff.

The nurse tutor described Taylor Ward as a happy place managed by two pleasant sympathetic sisters. Her response to my research proposal was:-

we all know that nurses suffer distress, what we need to know is how to help them (Fieldnotes January, 1983)

The implication was two pronged - would my study solve the problem and was it not her prerogative to undertake this work. Explanations regarding the need for published documentation on how nurses themselves conceptualise their distress and whether their needs for support are met, appeared to allay her fears as she furnished me with the names of the wardsisters on Taylor Ward and suggested I arrange an informal meeting. She mentioned that one

of the sisters on was about to go on maternity leave. Responding to my question about formal access, she supplied information about the nursing hierarchy in the hospital.

The next step was to telephone the sisters. I spoke to the senior sister, briefly explained my interest in nurses working with the terminally ill, asked if I could come and discuss this with her as I was looking for a fieldwork location. She suggested a time two days later.

I hurriedly completed an abstract of the research proposal to take along (See Appendix). This abstract was not a theoretical treatise nor a research design (See Burgess 1984a) but stated my motives clearly - I wished to study nurses working with dying patients. The abstract identified potential benefits of the study for the participants (Burgess 1984a) i.e. that an effort would be made to gauge which types of support would be appropriate for nurses caring for dying patients in British general and/or teaching hospitals.

The first meeting

I arrived at the nurses' station on Taylor Ward to be met by the non-pregnant sister (Joan). She welcomed me, and directed me to the sisters office whilst she located Anne, the senior sister. Nurses were making themselves coffee in the office. They ignored me and left when Anne arrived.

Both sisters were married, oncology trained and in their late twenties. We sat down on the comfortable seats, away from the desk which was pushed against the wall in their rather stark

office. I asked them for details about the structure of the ward, the nature of conditions treated, the patients and the nurses.

We then discussed the purpose of my visit. I explained the dearth of material about the experiences of British nurses' working with dying patients. I summarised the American literature, with which they were familiar, which demonstrated that some nurses found working with dying patients stressful, distressing and depressing. Research had suggested that this experience had ramifications for nurses' inter-personal relationships, and general functioning both at work and in their personal lives. The sisters' responded by recounting some of their own encounters with dying patients and observations about how their staff coped. They referred to a comment made the previous day by one of the consultants who wondered whether the junior doctors required more support. They felt this also applied to them; Anne herself attended a weekly group arranged by the hospital chaplain and was aware that the other nurses on the ward did not have this opportunity.

Assuming that the study would take place, we then discussed how Anne's imminent maternity leave would affect it. Apparently fertility and pregnancy featured high on the sisters' personal agenda and Anne cited recent data which suggested that administering chemotherapy could cause sterility (Similar data is provided by Selevan 1985). Nurses on Taylor were now using gloves when administering these drugs. In addition nurses were exposed to radiation hazards, with caesium patients, who were admitted for the insertion of radioactive rods into their uterus. Although there was a strict code of conduct relating to the time they could spend with these patients, nurses remained anxious about exposure

to radiation.

Returning to the purpose of the study, I emphasised my preference for interviewing nurses rather than collecting data solely through observation like some other sociologists. Both sisters agreed with this, volunteering that they could contribute to this research and felt that other nurses could do likewise. Throughout the discussion they implied that they might fall short of optimal supervision of their junior staff and I felt that I needed to respond to this by assuring them that I was not undertaking a study to make judgements about ward management per se. Both sisters responded very positively and began to cite the advantages of using Taylor Ward for fieldwork (as if I had numerous offers!). They suggested I start immediately.

We discussed the practicalities. I suggested that prior to interviewing I should like to familiarise myself with ward routines and practices. Joan suggested that I wear a white coat, Anne said, yes, I should go on wardrounds and help. I requested to interview nurses of the same rank both individually and in groups. Anne commented that it would be interesting to compare what was said in groups of peers with what was said in private (See Section Three). Together we looked at the roster of nurses' duties and they explained that the nursing school assigned first, second and third year nurses to Taylor ward for medical placements. Regarding location of interview, Anne suggested this office; I rejected this, saying that a) this would make her homeless and b) the interviews would be disturbed when the phone rang or people came to the door. We resolved that issue by postponing the decision, Joan having suggested the diningroom as

an alternative or supplementary location.

The sisters then commented on the abstract and proposed additional fieldwork locations. Neither felt it was necessary to apply for official permission and told me that they had already secured permission from their immediate superior, the nursing officer. This indicated the impact on access of the brief telephone conversation. I persuaded the sisters that to protect us all, official permission should be obtained and together we planned the strategy. We agreed that I write identical letters, enclosing the abstract, requesting formal permission to undertake a field study on the ward to each of the following:- the Senior Consultant, the Director of Nurse Education, the Director of Nursing Services and to their immediate superior, the nursing officer, Miss A.. We parted with the sisters promising to facilitate positive responses rapidly as Anne was keen that I should be established well before she left on maternity leave.

My entire agenda was covered ; we agreed that the problem of nursing cancer patients should be addressed. The sisters, without private consultation, apparently felt I would fit in to the ward. Their sponsorship rendered a potentially difficult process almost problem free.

b) Formal access negotiations

The letters requesting formal permission indicated the approval and sponsorship of the wardsisters. Each letter was modified to a form suitable for the recipient. Replies came by return of post. In summary, the nursing officer suggested that I start the

fortnight's observation period the following week, before the new set of second year students started their allocation. The Director of Nursing Service replied affirmatively both on her own behalf and that of the Director of Nurse Education and conveyed a message from the latter suggesting that I meet her before starting interviews to familiarise myself with the "small bias" in the allocation of nurses to the ward. The senior consultant's reply suggested abandoning thoughts of an observation period :-

Quite honestly I think you will find this far too long and that you will wish to get down to business rather sooner.

He also stated that he had given instructions to the sisters to "guide my actions" and that he did not want routine ward duties to be interrupted by my presence.

Having anticipated a tortuous process of 'selling' my research proposals to numerous institutions and possibly compromising my aims, I found the whole access question resolved in ten days. This meant the erosion of considerable time during which I intended to plan the observation period and prepare interview schedules. The lack of preparation time haunted me throughout the study; I was constantly trying to keep up, let alone get ahead of myself, and this partly accounts for what in retrospect I feel was insufficient concurrent analysis of the research process. In particular, the implications for the research of the departure of the senior sister were not addressed in depth (see discussion about research phases one and two below). In addition, I had not anticipated the impact of staff changes: that these would considerably alter the interpersonal dynamics on the ward and necessitate constant renegotiations of access.

The observation period

My placement experience (See Section One) had pointed to a period of acclimatisation before embarking on the study; therefore this was written in to the abstract. The purpose of the observation period was three fold :- to familiarise myself with ward routines in order to plan interviews which would be minimally disruptive to the ward; to ascertain key issues to raise during interviews and to select relevant additional informants who did not work as nurses on the ward but would provide critical certain insights.

In addition to familiarising myself with ward practices and routines, I hoped to consolidate access to students during the observation period through talking to nurse managers in the hospital and tutors in the nursing school. The directive to meet the Director of Nurse Education unveiled the tutorial system, about which I knew little, but was the access route to nurse teachers.

Meetings with relevant additional informants provided valuable insights into nurse ideology the importance of which I did not grasp at the time of data collection and only appreciated during analysis. It was advantageous using informants drawn from different status levels in the organisation (Strauss 1964 quoted in Burgess 1984a). Burgess maintains that:-

in field research informants are selected for their knowledge of a particular setting which may complement the researcher's observations and point towards further investigation that needs to be done in order to understand social settings, social structures and social processes (Burgess 1984a p75)

Meeting key others also revealed discrepant views about Taylor ward from different professionals with sometimes conflicting priorities. Had the importance of these views been appreciated an attempt to re-interview these informants during the second research phase might have provided additionally useful information.

Phase One of Fieldwork

Before commencing fieldwork, I anticipated that there would be two distinct research phases i.e.:-

- a) **The observation period:** This would take place during the first fortnight; the primary tasks would be familiarising myself with the ward, interviewing key nurses off the ward (nurse tutors, nursing officers, clinical teachers etc) and making arrangements for interviews on the ward.
- b) **The interviews** Thereafter the interviews would be the primary focus, although some observational material might emerge .

Although the research can be divided into two distinct methodological phases which influenced the nature of data generated and my role as fieldworker, Phase Two did not begin at the end of the observation fortnight with the interviews. Phase One can be seen as beginning with my first approaches for access and ended eight weeks into fieldwork when Anne, the senior sister, left the ward on maternity leave not intending to return. The first phase therefore includes the "observation" and contact making fortnight and the first six weeks of interviewing. Phase Two will be discussed in Section Three. This differentiation into two research phases will be further discussed in both this section and in the next.

The remainder of this section will give an account of additional information and early impressions which affected my approach.

a) The allocation of student nurses to this ward.

The nursing school assessed certain medical wards as suitable for students to acquire the principles of medical nursing. First warders (i.e. first year students on their first ward allocation), second and third year students were allocated to the ward for the purpose of acquiring specified skills appropriate to rank. Student nurses moved from ward to ward in groups of two or three, along a set line of progression throughout all the specialities. The groupings remained the same throughout their training barring attrition or unusual circumstances.

The meeting with the Director of Nurse Education took place on my first day in the hospital, the first appointment of the observation period. Before I embarked on interviewing nurses on the ward she wanted to notify me of the nursing school's policy of carefully selecting first warders for allocation to Taylor ward. This policy was adopted because tutors believed that the nature of patients' illnesses could have a deleterious effect on the nurses.

My fieldwork notes record her views:-

Student nurses are handpicked on the basis of their previous nursing experience (ophthalmic, orthopaedic, etc.) or on the basis of whether their tutors judge them to be mature settled people. The reason for the selection is that the oncology ward is assumed to be more stressful than other wards. However, the selection of students does not ensure that they will be able to cope with the ward necessarily, but they are more likely to have their "Professional armour" (the D.N.E.'s words) as protection..

Miss B. then proceeded to give me the names of the students on the line to the ward and the names of their

tutors so that I could meet them and discuss suitable interviewing schedules. On perusing the names of the students I was immediately struck by the fact that nurses of the same set about to come onto the ward all had names that followed one another alphabetically... the next group of firstwarders all had surnames beginning with H. (Fieldnotes February, 1983)

The reality of allocation practices in contrast to policy became a critical point in the research, particularly as I had chosen a setting where nurses were not selected specifically for cancer nursing. Following Geer (1964) I set about enquiring whether this policy of assigning certain firstwarders to Taylor ward was operationalised or whether it was a myth. I established that senior nursing school tutors were indeed aware of the bias, but those responsible for assigning students were junior tutors who were not.

b) Nursing ideology as perceived in the nursing school

Through the Director of Nurse Education I now had access to all the tutors. My first meeting was with two recently recruited staff - a junior tutor and a student clinical teacher. They were critical of what they saw to be the orientation of the nursing school:-

I spoke today with the junior tutor on Mrs G's team. A clinical teacher student was in her office at the time and participated in the discussion. They expressed their views on the philosophy practiced in the school and the hospital. I find these difficult to disentangle but feel that they are worth pursuing in my fieldwork. They suggested that "cure not care" policy was predominant in the nursing school, with the concept of medical dominance fully accepted by the nurse tutors. The junior tutor expanded her views of the ways in which nurses are expected to behave - "empathy, not sympathy, efficiency is everything" and asserted that nurses must complete their assigned tasks or face sanction; talking to patients is not regarded as legitimate work, regardless of the nature of that talk. They spoke of nurses being a pair of hands on the ward, like factory hands.

Fieldnotes 23rd February, 1983

This view was to contrast markedly with the views both of nurses on Taylor Ward and the more established tutors in the nursing school. The other tutors were concerned primarily with the wellbeing of students in their tutor groups. They regretted that only rarely did student nurses use them as counsellors. Several suggested that they would like to provide emotional support but that the system militated against this. This made sense in view of the educational/service divide and spurred me on to observe and also enquire where nurses put their emotions.

c) The expression of grief on the ward

During the access meeting with the sisters, I was struck by the atmosphere on the ward - the ward appeared to be calm and the staff relaxed - not what I had expected from a cancer ward. Nurses came in and out of the sisters' office freely and appeared unaffected by my presence. I had assumed that nurses would be inhibited by a stranger. This impression was reinforced on the first day of the observation period, when I was seated in the sister's office waiting for the "social round" (see below) to begin. The nurses, making themselves coffee, spoke about their responses to the deaths of patients - the precise focus of my study! Staff nurses reporting for work asked colleagues about the weekend's events and were informed that five patients had died, this included one favourite patient. Tears flowed and amid enquiring who I was, and what I was doing there, which I answered as concisely as possible in order not to lose the momentum of the feeling, one of the staff nurses explained the significance of the death of the special patient - a Cockney lady who they claimed was never visited (despite evidence collected later to the contrary),

whose main wish was to die on the ward, a feat accomplished by the nurses despite the consultant's wishes to move her to a terminal home.

This was the first indication that nurses on Taylor Ward expressed their feelings about patients to peers who identified and shared their grief. This incident illustrates a central assertion of this thesis - that nurses gain satisfaction from achieving goals which are different to and may conflict with those of their medical colleagues.

d) Ward ideology - the psycho-social management of patients

The sisters had suggested that I would find it helpful to start the observation period on a Monday so that I could attend the social round. This was "managed" by a social work team leader, who acted as the liaison person between medical and nursing staff on Taylor and the social work department. The meeting was attended by junior doctors and senior nurses (both in and out patient sisters). My presence seemed to unsettle the social worker who rather aggressively explained to me the "team system" in social work.

Interaction during this meeting provided my first clues about the management of patients' psycho-social welfare particularly in relation to disclosure. Issues such as the level of patients' knowledge were discussed, with the doctors explaining their perceptions of patients' knowledge, and nurses augmenting this information. Different policies of the consultants were hinted at, one referring to disclosure policy, the other to the

occupation of beds by terminal patients. The social worker enquired about the fate of those patients whose names were no longer on the current list.

Methodological issues

Two methodological issues dominated Phase One:-

- a) The issue of sponsorship
- b) My role as fieldworker

a) The issue of sponsorship

The social meeting presented the first opportunity for the sponsoring sisters (Anne and Joan) to introduce me to their medical, nursing and social work colleagues by a title coined by them -"research sociologist". The social worker's reaction to me was the first indication that other workers might resent my presence but were constrained from objecting because of my perceived sponsors.

i) **Sponsorship of wardsisters**

The qualified staff had been informed by the wardsisters that I was going to carry out a research project concerning nurses on Taylor Ward.

By offering me their office as a venue for interviewing, by inviting me to attend any meeting that interested me, and even suggesting that some meetings would be of specific interest to me, Anne and Joan clearly demonstrated their backing of the study.

During the fortnight's observation and for the first few weeks thereafter, I availed myself of these facilities and spent a great deal of time in the sister's office. It was the focus for many encounters amongst nurses, as it was the first port of call when reporting for duty (nurses hung up their coats in the office). In addition most discussions between junior doctors and trained nurses both formal and spontaneous took place in the office and often nurses retreated there for private discussions.

After a fortnight's observation period I commenced interviewing nurses on the ward. By this time I realised that unless nursing tutors had informed student nurses of the purpose of my presence, they were unlikely to expect me. In the same way as nurses are expected to learn on the job (James 1986) students were simply expected by their superiors to find out about the research when the need arose, and to comply with its aims because it was seen as part of the experience of working on Taylor during this period.

It therefore worried me that if I was seen to spend most of my time with trained staff in the office, student nurses might perceive me as a spy for the sisters (the gatekeepers - Burgess 1984a). This was confirmed by data generated in first interviews which indicated that student nurses fantasised about activities in the office whilst they were worked to the bone (See Chapter Seven). In addition, sitting in the middle of the ward at the nurses' station would present an opportunity for observing ward activities. I began to withdraw from the sister's office, where I had based myself hitherto, claiming that I had observed sufficient meetings and now needed to observe nurses working with patients on the ward.

ii) Sponsorship of doctors

The surprise of the house doctors at my presence indicated that the senior consultant had not consulted his colleagues before granting me formal permission nor informed the junior doctors thereafter. Nevertheless all the consultants and junior doctors were welcoming. The consultants invited me to accompany them on wardrounds; and the junior medical staff suggested I attend their out-patient clinics (to get a balanced view of the patient population) and interview them whenever I liked.

The wardrounds (see discussion in Chapter Seven) were an elitist affair and once I realised that only senior nurses and other privileged people (visitors, like myself,) were permitted to attend, I decided that one wardround per consultant would suffice to get a feel for the doctor/patient style. I thought that a high profile attendance at the wardrounds would indicate to nurses a hierarchical imbalance between them and me (Oakley 1981) which I wanted to avoid and in addition nurses might perceive that I was privy to information about their patients which they were not.

The junior doctors were disappointed that they were not interviewed in the same way as nurses, and in retrospect more in - depth discussions with them might have generated some interesting data. I was determined, however, that nurses should see it as their study, their opportunity to express themselves, and therefore I tended to talk to doctors in an unstructured social setting, when I was sitting alone in the sister's office and they came to make tea or to seek me out.

iii) Sponsorship by the Director of Nursing

Working hypotheses are formed just listening to informants or drifting along with a group to see what will happen. (Geer 1964)

Some of these are so simple they can be tested immediately by having a look at a group or asking questions of informants. Others, usually based on an accumulation of data, predict an event or state that people will behave in specified ways under certain conditionsThere is no finality about them. They must be refined, expanded and developed. (Geer 1964 p152)

The wardsisters had intimated that tensions existed between the Nursing School and the Nursing service. This seemed contradicted by the joint reply to my separate requests for access from the two directors, which had suggested that lines of communication between the Nursing School and Nursing Service were open and friendly. Hence the need to investigate.

At my meeting with the DNE she suggested that I meet all the nurse tutors; the sisters comments made me concerned to avoid appearing to be her protege. I assumed, again incorrectly, that she would have shown my research proposal to the nurse tutors, and that possibly, like the first tutor to whom I had spoken on the phone, they would feel that the assumption that nurses caring for dying patients required support contained implicit criticism of them.

Other than two nurse tutors who were clearly not keen to meet with me, the other seven were welcoming and candidly expressed their criticisms of the system. It began to emerge that tutors differed in their approach towards cancer and terminal care which influenced the preparation of their tutees. For example some sets received introductory lectures in the nursing school about the

ward before two or three of their number began their allocation; others received no preparation. I decided to explore whether this affected students' experience of the allocation (see page 100).

b) My role as fieldworker

During the observation period I had intended to prepare myself emotionally for interviews, to acquaint myself with other workers on the ward, and to make the necessary practical arrangements for interviews. In addition I expected that fortnight to provide with a flavour of how nurses felt about their work, which would enable me to direct the interviews most purposefully. The observation fortnight indeed familiarised me with the routines, the ward organisation and enabled me to acquaint myself with the range of people who worked on the ward. Like James, (1986) I became aware of the influence of other people working on the ward, on the organisation and management. These people included ancillary workers such as domestics who clearly were part of the social scene.

Like most other fieldworkers I carried around a notebook and minimised recording observations in the company of nurses. Recording data presented a particular problem on Taylor ward because nurses were not permitted to make notes or carry around notebooks on the ward for fear that patients might discover details about diagnosis or prognosis that were deliberately withheld from them. This created enormous difficulties for nurses, particularly student nurses, who were accustomed to recording details relevant to their day's work. (This is discussed in Chapter Five). This was primarily an issue for newly

allocated student nurses; however data generated by interviews suggested that the issue of having to seek out information remained problematic throughout their allocation. Hence it seemed tactless for me to make notes on the ward unnecessarily; where I did so, these notes related to information which was substantively different from information that nurses were not allowed to record. Observations were thus recorded off the ward, usually at home.

I was anxious to establish rapport with nurses. On my first day when a staff nurse shared her grief I became immediately integrated into the role of listener on the ward, and I wondered whether all the staff nurses present (the full complement) would follow her lead. This indeed happened and these staff nurses took it upon themselves to volunteer information about patients and their attitudes towards them. Thus part of one of my main concerns had been resolved - that access through the sisters might inhibit other nurses. Here, I thought was evidence that I had passed the test.

Starting a fieldwork placement on a ward, is not unlike beginning a new job on a ward (James 1986) with numerous people to meet and a vast number of facts to remember. So in many ways, my first few days could be viewed as a routine event on a ward where new nurses start every fortnight, and consequently questions constantly have to be answered about where things are kept, or how things are done. As James (1986) puts it

Despite previous experience, this base knowledge has to be relearned with each new nursing post, and while the new nurse learns to work to full capacity, the other nurses are in a role of supportive teachers doing extra work (p22)

My position was substantively different from that of James' in that, as a non-nurse, I was not able to participate as she could. Shortly after I began, it became clear that Anne's initial suggestion that I "join in" was part of her enthusiasm for the project. Joining in for me meant making tea, occasionally answering the phone, or locating wardstaff. My concern with presentation of self (Geer 1964) meant monitoring my reactions, being aware of how others acted towards me, at the same time as trying to absorb the ward culture as a whole.

My role as a fieldworker in Phase One, was therefore fairly straightforward; issues arose which could be resolved and which did not threaten my position as researcher on the ward. I shall now discuss the interviews which took place during Phase One.

The nature of initial interviews

Methods for studying nurses in hospitals have varied considerably. Smith (1988a) used triangulation, bringing together a number of methods to assess quality of nursing and the learning environment. Melia (1987) and Field (1987) used interviews in their studies of nurses. Other researchers have found interviewing particularly useful when ascertaining change in opinion following certain kinds of experiences. Studies of nurses caring for dying patients have used a variety of methodologies - McIntosh (1977), Glaser and Strauss (1965) and Quint (1967) used observation as their primary methodology whilst James (1986) used what she terms "participating observation". Whitfield (1979) used survey methods when studying the effects of religiosity of nurses on their experiences of

working with dying patients. My preference for interviewing nurses has already been stated - I believed that interview methods, particularly those which do not incorporate fixed questioning, were more likely to elicit nurses' concepts than survey or observational methods.

When writing the research proposal, the optimal plan was to request access to nurses both individually and in groups of peers. Student nurses in first interviews might find a group less threatening; this could facilitate discussion of different perceptions of ward events. Like Burgess (1984a) I thought that in a group nurses would feel enabled to redefine the topics discussed. At the same time I was concerned that possible tensions between peers might lead to unwillingness to voice unpopular opinions or expose vulnerabilities. The study was specifically designed as study over time to ascertain whether over time and as a result of working on this ward nurses' views changed regarding cancer care. By suggesting that the individual interview be the third and last, I hoped that by then nurses would be sufficiently familiar with me to acknowledge modification of their views (if appropriate) and not be overawed by the research procedure nor the tape recorder.

The initial plan for interviews was fluid and open to change. At the access meeting the wardsisters did not question the research plan. They asked how much time I would need on the ward - I estimated approximately six months depending on how many nurses I managed to interview. Even on that score no guidelines were laid down. The sisters probably related to my research proposal as they would to any medical research proposal, simply wanting to

know my requirements so that they could arrange nursing rosters around it. Theoretically this should have made the entire process plain-sailing and maybe compared to fieldwork experiences of others, it was; it did not prepare me, however, for an undercurrent of resentment about my demands on the wardstaff by the second group of staff nurses who after all had no say about my presence, I was there before they started on the ward (See Section Three - discussion of renegotiation of access).

a) Hierarchy and access

Although permission to interview nurses on the ward was granted by the wardsisters and nursing school tutors, real permission to seek their opinions was never sought from individual nurses. Nurses on this ward did as they were told by superiors. In the access meeting with the wardsisters, I had emphasised that I felt that it was important that nurses should only participate if they wanted to, and to this the wardsisters naturally agreed. What I did not grasp at the time, was that autonomous decisions from the individual nurses themselves were impossible if the wardsisters had already granted permission. In retrospect I realise that my initial comments to prospective interviewees about the voluntary nature of the participation in the research, were meaningless, and were probably regarded by the nurses as simply politeness.

Looking back, I realise that I colluded with the wardsisters' decisions on behalf of their nursing staff, by encouraging them to plan future rosters so that all the nurses of each set would be on duty at the same time on two occasions, once at the beginning and once at the end of their allocations so that I could conduct group

interviews. Roster planning took place prior to nurses joining the ward, so on my first encounter with students, I could inform them about the proposed date of first interview.

When I first met nurses I realised how few knew anything about me. Two groups of nurses responded particularly positively during the first interview: those whose tutors had specifically prepared them for cancer nursing, and those whose tutors had told them about this study. For example one nurse brought along a book which she felt might be helpful in the research. Some had noticed my presence on the ward and were puzzled by it; few had enquired as to my role - another indication the nurses assumed that information would be imparted when timing was deemed appropriate by nursing superiors. If I saw newly allocated nurses on the ward I endeavoured to introduce myself. I seized the opportunity to describe briefly how they could contribute to the research - that I wanted to know from them what it was like working with patients with cancer; participation was being sought from all nurses but was of course voluntary, and that information gleaned was confidential and would not be fed back to their superiors.

b) Fieldwork tool - the use of the taperecorder

The only tool which affected respondents was the tape-recorder. I had discussed taperecording interviews at the access meeting with wardsisters. I justified the use of a taperecorder because a) I found it difficult to concentrate on the interaction and record at the same time and b) I felt that written recording might create anxiety in the respondents and might break the thread of the interview and c) I felt that by having an accurate account of the

interview on tape, there was no danger that I could remember comments selectively and thereby change inadvertently the views of the nurses themselves.

Both sisters agreed to the taperecording of interviews on condition that this was overt and that only I would have access to the tapes. Neither wardsister predicted that students would shy away from the machine; their apprehension related to confidentiality both regarding patients (names, diseases, personal details) and regarding their views about ward management etc.

The first students interviewed reacted violently to the presence of the machine, one saying, "If you turn that thing on, I won't say a word." Fortunately I was able to explore their anxieties, reassure them and then proceed with the recording. This reaction led to a prepared pre-recording talk to respondents where I explained the reasons for the tape-recorder and how this data would be used. This became a standard re-introduction to the research (most nurses had already received the explanation) in which I pointed out the mutual advantages of using the machine (that it would reduce the likelihood of misinterpretation of their views, that notes would not be left around the ward etc). I also emphasised that I was more than willing to turn off the machine if they wished to give me information "off the record". Nurses should indicate if I raised areas which they did not want to discuss. Because of their politeness, no nurse ever refused to discuss a topic, though a number indicated when they felt loathe to pursue the topic further.

c) Location and timing

The location of interviews had a considerable impact on the data generated. Before embarking on the fieldwork, I had envisaged that interviews would be conducted in comfortable surroundings sipping coffee and that this would be conducive for "constructive conversations" (Burgess 1984a p 106). I balked at Anne's suggestion of using the sister's office, because I felt student nurses were likely to feel inhibited there. In addition I did not want to intrude on the sisters' territory. Joan suggested the use of the diningroom, which was shared with the adjacent ward, commenting that it would have to be locked to minimise disturbances. At first this thought appalled me, but I soon noticed that all important meetings on the ward took place behind locked doors, which usually deflected even the most determined people.

Anne proposed that the optimum time for interviewing was in the early afternoon when the two day shifts overlapped and the morning shift had finished lunch. Whilst Anne was still in charge, she arranged that for the nurses to be interviewed to present their cases first at ward report (handover) so that interviews could commence promptly after lunch.

The format of the first interviews provided the basis for the remainder. These began with an introduction explaining the purpose of the research and the reasons for using the taperecorder. The topics discussed during interviews, however, evolved somewhat during fieldwork. This was in response to two factors viz. the methodological phases, and data from

observations and previous interviews relating to how nurses conceptualised their role on Taylor Ward. I shall now discuss topics covered during Phase One interviews.

d) Content of initial interviews

The initial interviews included both group and individual sessions with qualified staff in post (two sisters, three staff nurses) and group sessions with student nurses which took place within two weeks of their joining the ward. Since a purpose of the study was to ascertain whether nurses' views about caring for cancer patients changed as a result of working on a cancer ward the primary focus was to interview nurses first at the beginning of their allocations. In addition it seemed important to ascertain the views of the qualified nurses already in post in order to assess their influence on the experiences of student nurses.

I devised a checklist for the first interviews based on my previous experience, published studies and my initial observations. This related to three kinds of data :-

1. Nurses' conceptualisation of nursing and what nursing means to individual nurses.
2. Nurses' experiences of caring for the dying.
3. Nurses' experiences of support in both the general and specific sense.

The interview was broadly a non-structured interview which I tried to standardise as much as possible. Richardson (1965) suggests that the advantages of this interview type is that questions can be phrased in language easily understood and identified with by the respondent. The type of question can be

more flexible than in the structured interview and can be posed whenever the interviewer feels is most appropriate. I found that the sequence of topics varied .

The interview plan prior to the first interview comprised a check list of areas to cover:-

- a) Preconceptions - how had they envisaged the ward
- b) Was it different from what they had expected
- c) Did relationships with patients on this ward differ from what they had experienced on other wards?
- d) What were the satisfactions of working on this ward - were they different from other wards?
- e) What kind of nursing did they find the most rewarding
- f) How did the quality of nursing compare with that on other wards
- g) Did the disclosure policy affect them personally or the ways in which they interacted with patients
- h) Did patients levels of awareness about their conditions affect the ways in which they interacted with them
- i) Did working on the ward cause them distress at all, if so how was it manifested
- j) Their views on support for nurses- was it necessary, for whom, what kind etc.

Most firstwarders could not make comparisons between wards. During first interviews, firstwarders spoke about the differences in perceptions of cancer nursing between lay people (with whom they still identified) and more experienced nurses.

After a few interviews, I became aware that certain questions, particularly relating to disclosure practices, distress and support were off beam in a number of ways. This necessitated some changes in wording and in direction. Although this was most acute

during Phase One, it was a process that continued throughout fieldwork.

Prior to fieldwork, I had not predicted that nurses would make particular associations with certain items on the checklist. For example nurses answered general questions about quality of care in terms of pain relief. This emerged during initial interviews as crucial to most nurses; therefore if nurses did not raise this topic spontaneously, I did.

Certain questions were based on assumptions that I believed I shared with nurses e.g. that a disclosure policy existed with which nurses were familiar. Responses during interview indicated the contrary - most nurses did not assume that there was a disclosure policy. The topic of disclosure was emotive for nurses generating lively discussions and sometimes tense arguments amongst nurses during interviews. This topic also enabled nurses to raise their own agenda. Nurses usually expressed either praise or criticism of the ward.

I had assumed that nurses would relate questions about preconceptions to lay or personal feelings about cancer, but found that these depended on the reputation of the ward amongst nurses. Consequently I began to ask nurses what they had heard about the ward.

In summary, the process of refining my checklist was a continual one. It was necessary to make topics more relevant to my newly discovered understanding of nurses' frames of reference and experiences. I also endeavoured to remove implicit assumptions

from questions. The topic concerning relationships with patients, which were aimed at identifying whether nurses withdrew emotionally from terminal patients (Glaser and Strauss 1965; Sudnow 1969) also had to be reworked. Asking questions about which kinds of patients nurses preferred (evoking the traditional response of preferring male patients) (Bond 1982) was replaced with questions which explored whether nurses developed specific relationships with patients and if they identified with any types. This tack produced data suggesting that nurses identified with patients who resembled themselves or family members.

Ward management periods

The above discussion relates to the first methodological phase of fieldwork. This phase co-incides and is related to the first management period during which Anne, the sponsoring senior sister, was in charge. She left at the end of the first management period (also the first fieldwork phase). The second methodological phase includes both the second and third management periods. During the second management period Joan was in charge of the ward and helped by Karen, a locum sister. Joan had already tendered her own resignation but was persuaded to stay until the new permanent sister had started. Joan was rarely on the ward as she was using up a backlog of annual leave. The beginning of the second management period also saw the departure of three long staying staff nurses, who were replaced by newly qualified nurses. When Joan and Karen left, and the new senior sister Lynne started on the ward, the third management period can be seen to have started. By this stage, the "new" staff nurses had been in situ for over two months.

The interaction between the ward management periods and the fieldwork phases will be made more apparent in Section Three. During the first management period and fieldwork phase, the major methodological problems related to refining the questions in order to elicit quality data. During fieldwork phase two, problems related to my role on the ward; these will now be discussed.

SECTION THREE : THE RESEARCH PROCESS 2:

PHASE TWO : METHODOLOGICAL MODIFICATIONS

Methodological issues

This research was designed to ascertain whether nurses' conceptualisations of nursing cancer/dying patients changed over time. Nurses joining the ward were interviewed within the first fortnight then twice again at the end of their allocation, (six to nine weeks later) once in a group of peers, and once alone. The ward itself was a site of transient labour (Melia 1987) with students starting every fortnight. I interviewed all the nursing staff in situ at the beginning of the study, and followed all new recruits starting work on Taylor Ward over a four month period. Most students straddled both research phases, and all students were present during at least two management periods. The qualified staff in situ at the beginning of the study were the only nurses whose interviews were completed during Phase One and the first management phase.

Hence the situation on the ward was not static, with a number of variables changing between interviews. These related to

- a) changes in management - which involved management styles as well as ward atmosphere.
- b) the way in which I as a researcher was viewed
- c) the location and timing of interviews.

These changing variables were beyond my control but inevitably influenced the nature of responses from nurses interviewed during the different phases. The variations in data are discussed in Chapter Seven; methodological considerations will now be explored

using the same headings as Phase One to facilitate direct comparison.

a) The issue of sponsorship

Immediately after Anne and the incumbent staff nurses left the ward, I perceived that my role had become less secure. I had hoped that the new staff nurses would feel positively towards the research, and attempted to "renegotiate" with them. Karen, the relief sister was new to the hospital, as well as to oncology. She was willing to permit me to interview nurses, but viewed my needs as low priority on the ward. Frenetic activity replaced the smooth management of the previous six weeks and I sensed that the trained staff resented my requests to release nurses from ward duties for interviews. Joan's absences from the ward meant that her colleagues did not see clear evidence of her sponsorship of the research. The only way to continue with the study was to request that interviews took place on weekends when the ward was less pressurised. During weekends the diningroom was the social room for patients and relatives. Interviews then took place in the sister's or doctor's office whichever was free. Doors were not locked because disturbances were rare on weekends. Night interviews took place in the sister's office and the same applied.

Most of the weekday interviews were disturbed, usually by patients trying to gain access to the dining room. These disturbances also took place during the second interview with the replacement senior sister, Lynne and so concerned her, that she suggested we move to the nursing school which she proposed as the venue for all subsequent interviews. Unfortunately, this was towards the end of the study and only a few further interviews remained.

b) My role as fieldworker

During Phase Two I felt my position was becoming marginal. I became more concerned about my level of participation in interviews and realised that despite the risk of considerable emotional involvement myself, I would have to show that I too was prepared to expose my vulnerabilities if I expected nurses to do likewise. Although I had never nursed, nor happily suffered from cancer, I was able to draw on my experience of my previous placement (see section one) and as a hospital social worker. I was often asked for opinions about what was happening on the ward and found those questions particularly difficult (Burgess 1984a). During interviews nurses asked me personal questions which I felt more comfortable answering. Like Burgess (1984a) to have sidestepped these questions may have provided a "sanitised account" that many textbooks on interviews suggest (Oakley 1981) and my relationships with the respondents would have been compromised. Interviews often developed into lively discussions about terminal and cancer care, and occasionally my opinion was solicited about a particular situation.

Interview strategies were reviewed regularly during Phase Two to facilitate eliciting relevant data. For example during Phase One I hoped that student nurses would spontaneously discuss stress arising from nursing cancer/dying patients; consequently I only raised this with the trained staff. Some time elapsed before I realised that specific questions about emotional stress were inappropriate. My concept of stress related to emotions whereas nurses' concept of stress related to pressure of work; this

necessitated a rethink of how to get at the same data.

Nurses interviewed during Phase Two found it difficult to answer questions about their feelings, whether they got depressed or distressed and whether they sought or received support. (This is discussed in Chapter Seven). The strategy adopted to get nurses to talk about distress and support was to ask them to describe their most vivid memories of the ward.

Chapter Seven will demonstrate how nurses perceptions of the ward changed during the second and third management periods (Phase Two of the research). Their perceptions of me also altered because unlike Phase One, where interviews with me were part of the job and nursing management put aside time for interviews, the ambivalent attitudes of nursing management were conveyed overtly during Phase Two by emphasising the priority of completing work - hence giving students the opportunity to opt out or truncate interviews.

My role as fieldworker during Phase Two was characterised by continual renegotiation, first with staff nurses, and then with individual nurses. Despite mixed messages put out by the trained staff all the nurses agreed to participate in the study. The degree of enthusiasm amongst the trained staff varied and affected their contribution to the data. A few student nurses adopted their superiors' view of me as a low priority and postponed interviews at the last minute. Only one nurse was unable or unwilling to re-arrange another time.

Thus at many levels, I perceived my position as researcher on the ward as under threat. At the same time, I was surprised how nurses used me as a confidante or even sought my advice on psychosocial issues - a number of nurses suggested that they had found talking to me helpful and had enabled them to clarify their own views. During individual interviews, two nurses, one qualified and one student, asked me to turn off the tape recorder because they wished to share personal experiences with me, which they did not want recorded. Both nurses felt that this information was confidential but would enable me to understand why they reacted or acted as they did. Fortunately in neither case did the confidence shared create a conflict for me regarding confidentiality.

The original sponsoring wardsisters and the nursing tutor apparently anticipated that interviews could affect nurses. Oakley (1981) raises the question of the 'therapeutic' effect of talking: getting it out of your system" (p50). Many nurses, like the wardsisters during the placement, volunteered that the process of talking about their work led them to reflect on it. During Phase Two, with changes in structures of ward meetings (See Chapter Seven) the research interview with me became the only legitimate forum where nurses (particularly students) could raise issues from their own agenda with anyone. This was therefore a particularly important consideration at the time.

Joan and the nursing officer in charge asked my advice about interviewing a nurse with a psychiatric history. Would the interview process unsettle her? We decided that to exclude her would be counter-productive but that I would emphasise the voluntary nature of the interview, and would avoid "potentially

traumatic questions" or letting on that I knew about her history. My help was sought in recommending appropriate psychiatric intervention for her. This enabled me to feel that I could contribute some skills and provide some support for the senior staff who were clearly having difficulty in managing this problem. Interviews with this nurse did not have any apparent repercussions.

Interviews during Phase Two

a) Content of interviews during Phase Two

Data generated in second and third interviews were intended to be compared with first interviews to see whether the socialisation process had influenced nurses views and experiences of caring for cancer/ patients. Topics to be raised during second and third interviews were chosen on the basis of a) the pre-fieldwork assumptions b) observational data and c) nurses' accounts from the first interviews. Despite the fact that first interview data suggested that some of the pre-fieldwork assumptions were inappropriate, I decided to cover briefly those topics relating to stress and support in caring for dying patients, in case nurses' perceptions had changed over time. The topics covered during interviews two and three were broadly, ward atmosphere, nurses' assessment of the quality of nursing on the ward, their relationships with patients, the ward as a learning environment, what they perceived as appropriate demeanour for nurses - i.e. did they experience distress or stress and how was it managed on the ward or how did they themselves manage it, and related to this, was support necessary and/or forthcoming, from what source.

b) Location of interviews

All second and third interviews with student nurses (and most qualified nurses) took place during the second fieldwork phase. Second interviews were usually conducted in groups during nurses' last fortnight on the ward. Third interviews with first and second year nurses took place in the nursing school (in order not to disrupt ward routine) the week after they left the ward when they were consolidating their medical experience. (Third year nurses were allocated a four week holiday immediately following their medical placement so their individual interviews took place on the ward - their placements were longer so the time span remained the same). Individual interviews took place in a quiet single interview room in the nursing school which had been reserved for the interview by the relevant tutor. The atmosphere of these interviews differed considerably from those on the ward for several reasons. Nurses were *off the ward*, alone (without their setmates) out of uniform and out of scrutiny from their patients. Having left the ward and received their assessments their perceptions of the ward and of their experiences had sometimes changed. All these factors facilitated more individual expression.

c) Implications of changing variables (both management periods and research phases) on second and third interviews

At the outset of the study it was envisaged that data generated in second and third interviews would indicate changes in the nurse's approach to caring for the dying / cancer patients. Re-interviewing the same nurses would provide a new perspective to

understanding how nurses conceptualise their work over time. That the nurses' agenda might not facilitate this had not been predicted. For example student nurses used second interviews (the group interviews) to evaluate the ward particularly in relation to their educational expectations. During Phase Two students expressed considerable discrepancy between their expectations of the ward (based on the ward's reputation) and the reality. The topic of ward atmosphere had emerged from Phase One data - nurses had emphasised that the ward was reputed to have a friendly atmosphere. Students were most concerned with relationships amongst and between different ranks of nurses although nurse / patient / doctor relationships also featured high on their agenda.

Third interviews (individual) generated data about the private coping mechanisms of nurses - how they expressed their feelings and to whom; some nurses did not share feelings with peers and were reticent about acknowledging this in group interviews. During these interviews, nurses reflected how working on this ward had affected their perceptions of nursing cancer patients.

In conclusion, the second research phase presented a number of problems. Those caused by staff changes have already been discussed. In addition, Phase Two signalled the beginning of the subsequent interviews, the second and the third. These were conducted somewhat differently from the first, partly because nurses were more familiar with the research procedure. Changes in nurses' conceptualisations of cancer nursing which emerged in these subsequent interviews cannot be seen to be solely related to the experience of caring for cancer/patients. The changes in the ward situation inevitably affected nurses perceptions of the ward.

Although the repeated interview design did not provide straight - forward comparisons between nurses views at the beginning and the end of their placements because of the variables already mentioned, this design had considerable benefits for the study. Using the repeated interview design helped to identify the processes at work even if the method is open to criticism as a series of snapshots (Hall 1979).

Section Four describes the data analysis and how this led to the formulation of theory.

Content of data

Data was gathered primarily through interviews. The focus of these interviews was the nurses working on the ward. Additional informants were interviewed on a less formal basis (without the use of the taperecorder). Documentary evidence to provide corroboration of medical and nursing "facts" was sought from the nursing Kardex; this included admissions, discharges and deaths of patients, and nurses absences from work due to illness, or other reasons; educational information (e.g. looking at the prospectus) was found in the nursing school. The formal observation period of two weeks, as well as observations made during the six months of the study provided informative additional material.

Data generated in this study was expected to provide evidence that nurses working with cancer patients experienced emotional stress and distress. The design of the study was expected to contribute to the understanding of how nurses resolved this distress over time and which measures of support they favoured. High rates of turnover and absenteeism were predicted. On the contrary, permanent staff on Taylor Ward were exceptionally long staying; former student nurses requested staff nurse posts on Taylor. Despite the fact that because of immuno-suppression of patients, nurses had to report sick for minor ailments, low levels of sickness were reported.

Early interview material suggested that nurses' perceptions of stress did not corroborate previous studies; stress for nurses in

Suburban Teaching related to pressure of work, which was noticeably absent on Taylor Ward. Although I noted this during fieldwork, I dismissed this as a semantic problem and assumed that nurses were denying their feelings to me for a number of reasons (anxiety about feedback, hostility to my presence etc.) (Stimson and Webb 1975).

Like Hammersley (1984) the collection of data deviated from that proposed by Glaser and Strauss (1967) in Grounded Theory in several ways. They suggest that analysis should be concurrent with fieldwork, and that the two should inform one another. Despite the recognition that nurses' responses to caring for cancer patients differed from my expectations, my data collection still focussed on similar topics in interviews and observing interactions. In addition I relied heavily on the taperecorder for recording both my observations and the interviews and managed only to keep a skeletal transcription concurrent with fieldwork (Hammersley *ibid*). Hammersley's account (1984) of going to the opposite extreme of theoretical sampling, by collecting as much data as possible, influenced by ethnomethodological theory, seems rather familiar.

Time constraints limited concurrent transcriptions of tapes during fieldwork. Although I did not have the advantage of perusing instant transcripts, nurses responses to questions about pressures and stresses were so unexpected that they could not be ignored or explained away. Nurses grasped what I expected to hear and resolutely "denied" (as I thought) that stress emanated from type of patient. Only during a second attempt at data analysis did I realise that nurses' assessments of stress related to how the

ward was managed and whether they could practice what they considered to be good nursing.

Analysis

Further deviations from the grounded theory approach took place after fieldwork when tapes were transcribed into categories relating to interview topics. This was an attempt to organise what appeared to be unmanageable data around topics such as preconceptions, stress and support. In retrospect this manner of organisation obscured the main thrust of the data - the way in which nurses integrated aspects of stress into their professional ideology.

Thus analysis of the data into pre-conceived *categories was not* helpful and another tack was sought. Glaser and Strauss' concept of "theoretical sensitivity" (1967 p46) - conceptualising and formulating a theory as it emerges from the data seemed another way in. A decision was taken to look at a general area. Disclosure was chosen for three reasons; firstly previous studies of cancer wards have focussed on issues relating to aspects of disclosure; secondly disclosure can be seen to incorporate a wide range of potential behaviour patterns between a large number of actors, so could reveal a variety of responses; thirdly I recalled that nurses were equivocal about disclosure which suggested the nature of patients' illnesses might not be the primary factor which influenced nurses experiences on the particular ward.

Analysing data collected can be problematic in social science. Wallowing in reams of material waiting for theory to emerge can be soul-destroying. Taking an issue which has emerged as crucial in previous research is helpful because corroborating or refuting previous findings can provide a pointer towards, in this case, the nurses' worldview.

To a limited extent it was possible to undertake comparative analysis regarding the accuracy of certain events from different groups of respondents (students within years, trained nurses, tutors, doctors).

The theory emerging from the data suggested that despite expectations to the contrary, nurses' approaches to caring for cancer/dying patients did not appear to change over time. Other than firstwarders, nurses did not see *nursing as separated* into medical categories. Firstwarders, who were still grappling to adopt a concept of nursing, suggested that through observing that more experienced nurses maintained a self-controlled demeanour, they discovered that nursing the dying might not be frightening. This tallies with Field (1987) who suggests that responses of stress and distress in nurses working with dying patients become less frequent **as a result** of repeated exposure to this type of patient.

Evidence from this study suggests that experiences of stress and distress were rarely related to the patients conditions. Repeated interviewing of the same nurse, or group of nurses identified other causes of stress and distress, in particular how changes in structural conditions affect nurses (Heyman 1984; Robinson 1989).

It also demonstrated the strength of nurses' conceptualisations of nursing, that stress related to structural impediments to practice good nursing rather than to the nature of patients' conditions. This finding, at variance with what was expected, pointed to another body of literature, that pertaining to nursing, in the search for explanations concerning nurses' conceptualisations of caring. This necessitated including a second literature chapter (Chapter Six). As this throws light on the data, Chapter Six has been placed amongst the data Chapters.

Glaser and Strauss (1967) suggest that the optimal condition for generating theory is to enter the field with minimal preconceptions. My placement experience and subsequent reading had pointed to certain findings which I hoped to verify. Entering this particular setting with no pre-conceived notions might not have been feasible in this study, as access for a "woolly" project, in a highly deterministic environment would not have been possible. Fortunately, the abstract which I presented clearly suggested re-interviewing nurses to ascertain changes over time. The responses of those granting access seemed inextricably linked to the original requests - part of the inflexibility of scientific research.

Interviewer effect is discussed at length in the literature (Cannell and Kahn 1954; Strauss and Schatzman 1955; Lofland 1971). James (1983) discusses the problems of retaining the integrity of participating observation and the drawbacks and rewards of working in familiar settings. Different drawbacks and rewards operate when using interviewing as one's primary research tool. There are similarities between "spending time" on the ward

and interviewing nurses , and actually participating in the work. Nurses assumed that I would assimilate their assumptions and understand their views of ward atmosphere and ward routines despite the fact that I did not share in their work. This explains why I have had to write myself in to such an extent. Like Field (1987) I have relied considerably on "speech as data", although I am aware that this is open to criticism (Burgess 1984; Field 1987).

Like Smith (1988a) throughout fieldwork, analysis and even writing up, published material was constantly reviewed to see whether formal theories (Glaser and Strauss 1967) might shed light on emerging categories. Recent research in the nursing field (e.g. Melia (1987), Smith(1988)) especially in the care of the dying (James(1986) Field (1987)) (See reviews in Chapters One, Two, and Six) enabled the direction of the analysis to move from a stress model to one which encompassed conceptualisations of nursing. Methodologically this meant that the processes through which working hypotheses developed into the research question were influenced by concepts emerging from the data itself and in current literature.

The research findings generated from the collection of data and subsequent analysis are presented in Chapters 4,5 and 7.

CONCLUSION

A study of nurses' accounts of nursing cancer/dying patients arose from a long standing interest in the subject. Previous studies which reported that nurses experienced stress and distress from working with cancer/dying patients had been based on observational, rather than interview data. This study began with the premise that in order to understand whether support was necessary for cancer nurses, one had to elicit their accounts of how they conceptualised this work.

Gaining access to the ward through the wardsisters themselves, proved unproblematic. Unfortunately, the senior wardsister left shortly thereafter, and was not replaced for some time. The staff nurses also left and consequently the newly recruited staff nurses therefore found the researcher in situ. This created access difficulties for the remainder of the study.

Despite some difficulties in maintaining the goodwill of nursing management on Taylor Ward it was possible to conduct a study which was based on interviewing all the nurses who worked on Taylor Ward over a six month period. Additional interviews took place with other informants who worked on Taylor ward or were directly concerned with the education of student nurses on this ward. Further information was gathered from documentary evidence on the ward and in the nursing school.

This study was aimed at understanding how nurses experienced working with cancer/ dying patients. It was assumed that nurses

developed strategies for dealing with the emotionally difficult aspects of this work, and therefore repeated interviewing over time of the same nurses would detect changes in approach to this work.

Despite assumptions to the contrary, nurses who worked on Taylor ward did not find nursing dying / cancer patients *per se* problematic. Stress for nurses on Taylor Ward was not related to the condition of their patients. Aspects of grounded theory facilitated analysis, insofar as new theory could be constructed from the data.

The following chapters describe how nurses on Taylor Ward conceptualised their work. Chapter Four explores these nurses' views of nursing, in particular, good nursing care, and relates these to their concepts of stress. Chapter Five explores their views of support which relates to their views of a Good Ward. Chapter Six returns to the literature, and looks at concepts of caring within nursing. This is followed by Chapter Seven which looks at the interactions between Good Nursing and the Good Ward.

CHAPTER FOUR

UNDERSTANDING STRESS : NURSES' VIEWS OF GOOD NURSING

INTRODUCTION

Chapter Two reviewed studies about stress in nursing. These suggested that there are a number of factors which can be seen to contribute to stress ; these include characteristics of nurse and patient, the nature of the setting, as well as the patient's medical condition. The incurable condition of the cancer / dying patient in itself is believed to cause nurses stress with the result that they adopt strategies to restrict opportunities to talk to patients about their illness, or alternatively become involved with patients to the extent that it affects their general functioning.

Several studies demonstrated that hospital staff use strategies to control not only the amount of information given to patients (Quint 1967; McIntosh 1977; Bond 1978 quoted in Bond 1983) but also the kind of information patients can give nurses. This is achieved by nurses avoiding involvement with patients and consequently not getting to know them nor understand their problems (Bond 1982). In Bond's study nurses justified not broaching the subject of illness with patients on the grounds that it was not in the patients' interest - nurses should keep the ward atmosphere friendly and light-hearted; enabling patients to talk about their illness would simply make them despondent. This and similar findings (e.g. McIntosh 1977) can partly be explained by the congruence in goals between nurses and their medical colleagues in that nurses identified with the doctors' sense of failure when patients were not cured and died.

This study set out to explore whether the experiences of and responses to stress, in British nurses in a general hospital setting, were similar to those described in the literature and to suggest, if appropriate, support measures that might alleviate this. The methodology used sought the meanings of situations from the nurses' own perspectives which led me to realise later that the conceptualisations of stress of these nurses differed from studies of nurses on other cancer wards.

The assumption that nurses see the nature of the patients' illness in itself as a cause of stress has not been questioned in studies before. This chapter will demonstrate that the conceptualisations of stress of nurses on this cancer ward resembled general causes of stress in nursing (for example, pressure of work - see discussion Chapter Two, Section Three); nurses rarely attributed stress to the fact that patients had cancer or were dying. In addition, nurses generally viewed stress as having a physical, rather than an emotional component.

Thus nurses on this ward maintained that they did not perceive patients' conditions *per se* as a cause of stress. Factors which prevented them from practising what they conceptualised as "good nursing care" caused them stress. Nurses in this study used the phrase "good nursing care" to operationalise their concept of "good nursing". (The term "care" has numerous connotations and hence nurses' concepts of "good nursing care" have been termed "Good Nursing" in this thesis - concepts of caring within nursing are explored in Chapter Six).

This chapter takes as its theme "good nursing". Good nursing was what nurses were taught in the nursing school and was potentially attainable in the wards. The job of nursing dying patients which, according to the literature, fills most nurses with trepidation, fulfilled these nurses' criteria of good nursing. Nurses in this study had their own distinctive worldview which did not view patients according to their illness category but whether they could provide them with optimal nursing care. Chapter Six relates this finding to the differences between the ideology of nurses and that of other health care professionals.

Section One presents an account of the "world-view" of these nurses - their approach to nursing, their concept of "good nursing care". Section Two explores those factors which nurses cited as sources of stress - i.e. factors which **prevented** them from practising good nursing. The conclusion summarises the chapter.

SECTION ONE : GOOD NURSING IMPLIES CARING FOR PATIENTS

Students perceived that good nursing was taught in the nursing school. There they learned that their main priority should be to meet all the patients' requirements irrespective of their nature (affective/emotional, social, practical, physical, technical or other) i.e. nurses were expected to care for the patients. There was some variation amongst nursing school tutors regarding what constituted good nursing practice but student nurses generally accepted a number of principles. Staff nurses on Taylor ward, having also been trained at Suburban Teaching, shared these concepts.

Nurses talked about providing "good nursing care" for patients. This implied looking after all the needs of the patient, regardless of whether the lay person would define the work as "nursing". Three short quotes from nurses of different ranks give examples of good nursing care as they saw it practised on Taylor ward:-

N We learned a lot of detailed things like caring for patients, giving them bed baths, having time to do things like that, silly little things, well not silly, simple things, like cleaning their dentures or washing their faces and hands whereas other people wouldn't have time (First year; third (individual) interview)

SN You should make sure they're comfortable, free of pain, clean having their bowels open, getting rid of their waste, excreting. I think that's how one should look after patients on any ward, because everyone has the same needs. (Staff nurse; third (individual) interview)

Sr You've got to keep that patient so comfortable. Neat and tidy and they look really well cared for. There's no excuse at all for them developing pressure sores. (Sister; second (individual) interview)

Providing "good nursing care" entailed a number of other skills. These included non-technical expertise. Nurses and nursing tutors reflected that the nursing school emphasised that nurses should show empathy, not sympathy. The Shorter Oxford Dictionary (1983) defines empathy as:-

"The power of projecting one's personality into , and so fully understanding, the object of contemplation"

whereas sympathy is defined as :-

"to suffer with or like another; to be affected in consequence of the affection of some one or something else".

The ability to assess or **understand** patients' needs and to respond to them, without losing the professional distance, was the mark of the good nurse. The nurses' professional view of themselves related to their work satisfaction, could they provide a good nursing service.

Assessing and meeting patients needs

Certain aspects of ward ideology made it possible to practise good nursing on Taylor Ward. Like most other hospital wards, there was a daily midday meeting (ward report) where the morning shift "handed over" patients to the afternoon shift. (The ways in which ward report conveyed ward culture to nurses is discussed in Chapter Seven). Each student nurse was assigned a number of patients for whom she was responsible for a period of seven to ten days, depending on the off duty roster. This is in contrast to nurses in Smith's study (1988a) who were assigned patients on a daily basis. During ward report the problems of each patient on the ward were discussed. The emphasis was on the **patient's**

complaint (i.e. what the patient saw to be the problem) rather than on the nursing or management problems related to looking after that patient. Nurses said that on most other wards in this hospital treatment of the disease was seen to be the problem i.e. nursing issues related to disease categories. This can be seen as reflecting the centrality of the cure model. A staff nurse contrasts approaches on different wards:-

SN I worked on a cardiac ward - a lot of patients had cardiac conditions and the wardsister liked nurses to write down the condition as being the main problem whereas it states in the nursing process that the nurse should write down what the patient is complaining of and the patient won't say, "My main problem today is my myocardial infarction." He might say, "It's my bad heart", but he's more likely to say, "I'm breathless or I have chest pain". Whereas here, we don't say the patient's main problem is his lymphoma - his main problem is whatever he is complaining about - could be dysphagia - the fact that he can't swallow because he's having radiotherapy. So we actually leave it to the nurse to decide what the patient's main problem is. If we do realise that the nurse is having a problem in deciding priorities we will actually point it out, but we won't disagree with her flatly because of course she's doing the assessing and reporting.

(Staff nurse; third (individual) interview)

On Taylor ward nurses were expected to ascertain the patient's primary and secondary problems or complaints. In ward report nurses presented patients' accounts of their physical problems (pain, response to medication, discomfort) as well as practical or emotional problems (anxiety, agitation, worries about family, work etc.). Each area of concern was equally valid and students were encouraged to raise any issue that they thought might be important for the holistic care of the patient. Nurses learned that their patients' problems could be resolved through the following process:- assessing a patient's problems through observation and talking to the patient; then presenting the problems to their colleagues and superiors who would either advise the nurse how to resolve them or deal with the problems themselves.

Nurses were aware of the psycho-social dimensions of cancer. Yet wardstaff rarely utilised psychiatric and social work services to provide patients with emotional support. This lack of referral to psychiatric services is similar to studies by Maguire et al. (1980 quoted in Bond 1982) who suggest that doctors and nurses do not refer cancer patients to psychiatric services because they believe that emotional responses in cancer diagnosis and treatment are normal. In an earlier study Lee and Maguire (1975) pointed out that only when patients were unco-operative and disturbed were they referred for psychiatric investigation.

Bond (1982) found that only when patients were referred to psychiatric services were their emotional needs highlighted. This did not pertain to Taylor Ward. Nurses did not ignore the existence of depression in cancer patients and acknowledged that any cancer patient might become depressed. Nurses believed that it was within their own remit to deal with what they saw as reactive depression. They detected depression, like any other symptom, through observing or talking to patients.

N Talking comes naturally. If someone starts being upset, you don't just ignore them, you try and sort it out. But you would have thought that a social worker would do that more than you, but in practice they do tend to turn to nurses and certain nurses as well.
(Second year student; third (individual) interview)

Bond (1982) in a detailed study of nurse/patient interaction in a radiotherapy department found that nurses rarely spent as much as three minutes simply talking to patients (i.e. talking, as opposed to carrying out a technical procedure.) She suggests that nurses

had very superficial knowledge of their patients or of their feelings about their illness:-

apart from lighthearted social chatter, discussion of organic symptoms and the treatment regime were by far the most common subjects. Problems of a social or emotional nature were almost absent from conversations and when long periods of time were spent with patients it was not used to explore feelings. Indeed it was evident that on occasion when patients attempted to discuss how they felt or openly showed emotion, nurses engaged in tactics to divert, ignore or otherwise minimise patients' communication. When patients gave no overt signs of distress which staff could recognise, denied their illness and did not ask questions about their conditions, they were regarded as coping well since this behaviour posed no threats to nurses. (Bond 1982 p 14)

In stark contrast to Bond's quote above, nurses in this study viewed (and this ward legitimated) **talking to patients** as an essential component of "nursing care". This was the primary route of ascertaining patients' problems.

Sr I love to see the girls sitting on a bed talking to somebody - I'm very conscious that they're sitting talking to somebody - there's a difference between seeing someone sitting talking than a nurse sitting chatting. I think we have a role to play in the socialising of the patient because they're with us all the time ... the patient needs to have a bit of you and know a bit about your social life and what you're up to, but I think you also have to give them time to do all their important talking about themselves that they want to.
(Sister; second individual interview)

N I think Taylor Ward is different in that sense because there is an awful lot of psychological care, just sitting down and talking to the patients or letting them talk to you..... I like to be able to talk to patients, I don't think you can really assess their needs unless you can sit down and talk to them - on some wards you just haven't got the chance to do that - you may have 10 or 11 patients that want hoist baths so when do you get the chance to talk to them - that's not nursing to me. I mean that's not nursing the way I like it, I like to be able to get to know patients, and perhaps understand them a bit more.
(Second year; individual interview)

This opportunity to talk to patients enabled nurses to "reassure and encourage" patients - the catchwords of the ideology on the ward. In contrast to Bond's (1982) study, nurses' accounts of conversations with patients indicated that the content of conversation was not trivial. Nurses encouraged patients to talk about their worries even if these included concerns about their diagnosis, treatment or prognosis. Emotional / affective nursing was part of the job. In communication terms this implied that patients were enabled to express their concerns whereupon nurses could take appropriate action.

Nurses expressed professional pride in their ability to make judgements about patients' complaints. Although ample opportunities were presented for obtaining assistance from a senior nurse when necessary, nurses were willing to take some responsibility for decisions regarding their patients (cf. lack of accountability in Smith 1988a). Although student nurses were not expected to make final decisions about nursing plans for patients on their own, they were encouraged to consider alternative approaches to nursing care and make recommendations during ward report. This respectful attitude towards "the nurse who knows the patient best" enhanced the nurses' self-esteem. When nurses responsible for particular patients were not consulted for their opinion, they expressed discontent and dissatisfaction. This positive evaluation of the student nurses' opinions is in marked contrast with findings in Menzies' study (1959) where she suggested that the

student nurse is actively discouraged from using her own discretion and initiative to plan her work realistically in relation to the objective situation (p104).

Patients' needs were not assessed on the basis of whether technical or diagnostic (i.e. professional training) or mothering or domestic skills were required to meet them. An example of nurses' willingness to meet needs that did not require particular technical expertise was their concern that patients should not be constipated. (A number of the painkillers used in terminal care are constipating - see Copperman 1983).

N Here they're very concerned about the bowels and concerned for the individual's sake and it's really good nursing - you know that they really care, that's what's different about the quality

JK You think that the fact that they're concerned about the bowels is an indication that they're concerned about everything?

N Yeah, to a lot of people it's just a minor thing but it's so important on this ward and that's stuck and it'll stick with me through the rest of my career - it's funny I've learned so much on this ward
(Third year; third (individual) interview)

Patients' needs are not static and require constant re-assessment

Nurses in this study emphasised the importance of constant re-assessment and re-evaluation of patients' needs. Patients on this ward were at different stages of their illness. A number returned repeatedly to the ward over a long period of time, and finally died there. As patients moved along the illness trajectory their needs changed and they required different and sensitive responses from the nursing staff.

Nurses divided patients on Taylor ward broadly into three categories:-

- a) short stay treatment patients,
- b) long stay treatment / palliation patients
- c) terminally ill patients.

The short stay treatment patients were admitted frequently (usually overnight) during their initial or continuing courses of treatment. When bed space was limited, these patients being mobile and largely self-caring were admitted (or even transferred) to other medical wards in the hospital. Nursing management preferred where possible to admit all short term patients to Taylor ward because some required emotional support to deal with the shock of the diagnosis. Amongst this group were women patients admitted for caesium insertions for cancer of the uterus. As these patients were "radio-active", nurses were under strict instructions to restrict their interactions with them. Like the nurse who nursed Oakley (1986), nurses occasionally broke this rule when they perceived that a patient's nursing needs were not being met. Nurses felt frustrated that these patients received minimal nursing, but at the same time were concerned about exposing themselves to radioactivity.

The long stay treatment or palliation patients were admitted for extended periods of treatment, usually because they were deteriorating rapidly or because complications had arisen which necessitated careful monitoring and supervision of treatment. These patients required particularly sensitive nursing, as many still were hopeful of cure and anxious that nurses perceived and facilitated their personal agenda (this is discussed in Chapter Six).

The third group of patients were those who could be classified as terminally ill, who were admitted for pain control or "tender loving care". Nurses acknowledged that terminally ill patients sometimes had different nursing needs from those admitted for

treatment (Castles and Murray 1979). They referred to the terminally ill as TLC (tender loving care) rather than terminal, a term they saw as too clinical and rather static.

N Tender loving care is said in report when you know someone is dying - it's not necessarily pushing into mobilisation or treatment - because they know that treatment and other optimistic approaches are not going to work - usually when they say tender loving care it means that people are dying and needs lots of attention and listening and that sort of thing
(Second year student; first (group) interview)

Nurses noted that in addition to the physical changes in patients' conditions, frequently there were personality changes to which they had to adapt:-

N People's attitudes when they're dying - their behaviour changes and they give up or they won't do anything, they won't eat, things like that - it's very difficult when you're trying to say to someone, you must eat, it's horrible to sit there and watch them not eating at all and just getting thinner and thinner
(Third year; second (group) interview)

The patients who were terminally ill fell into two categories:-

- a) those who had already been admitted for palliative or even curative treatment and
- b) those who sought admission in order to die on the ward.

Terminally ill patients required more intensive nursing care than the other categories of patient i.e. they were the "heaviest" patients. Nurses expressed professional pride in their flexibility to respond to all the needs of these patients irrespective of whether they required affective / emotional, social, physical, technical, practical, domestic or other (nursing) skills. In principle, all patients regardless of whether they were terminal or not should receive this type of care; in practice, nurses

prioritised the terminally ill when forced to make decisions regarding who would receive holistic care:-

N I think you have to give tender loving care all the time whether they die or not, but it's just emphasised a bit more when they are terminally ill because treating the terminally ill you have to take extra special care to make sure that they're comfortable
(Third year ; third (individual) interview)

N With "tender loving care" (patients) they're probably getting worried that they're going to die and I'd like to sit and chat with them or to make them feel better
(Firstwarder; third (individual) interview)

Dying patients and their relatives were permitted idiosyncratic behaviour (Castles and Murray 1979). Nurses' main concern was that patients should feel safe and comfortable and not experience pain or anxiety. Nurses were unwilling to specify acceptable norms for patient behaviour. Keith and Castles (1979) quote studies which maintain that the tolerance of non-conforming behaviour is a form of permissiveness which creates conflict for nurses caring for dying patient. Nurses in this study did not express such feelings of conflict ; on the contrary they saw the relaxation of rules for dying patients as consistent with their philosophy of flexible response and individual assessment of patients' needs. None of the nurses criticised emotional responses of patients or relatives to medical crises.

Patients are individuals and as such should be respected

The emphasis on individual patient's complaints rather than on nursing or management needs conveys the flavour of the worldview of these nurses. Nursing could adapt to individual needs, and no individual whether during the curative or the terminal stage of

his illness should not receive the comprehensive nursing care s/he personally required. Nurses on this ward stressed individualisation of nursing care. Through presenting the **patient's** complaint nurses could describe the patient's view of the illness, treatment etc. Nurses were adamant that patients should have the opportunity to have some control over their future and hence expressed anger when medical staff continued with treatment against patients' wishes (This is discussed in Section Two).

An unusual example of the respect for individuals was the care extended to dead patients, when patients were no longer able to express their needs. Nurses extended the same kind of respect and optimal nursing care to patients whether dead or alive. Nurses were affronted by the lack of respect and courtesy shown by other hospital workers for their dead patients:-

- N It depends on your view of a dead person anyway - my view is that he's still a person lying there and I don't think of it as a corpse now - like when that nurse died, we both laid her out and the porters came to collect her and they take them down in this awful tin thing and when they lifted her body from the bed onto the thing, they wacked her head really hard on the thing and that really got me and when they wacked her head I said, "God, watch out, be careful, watch her head".
(Third year ; second (group) interview)

Other nurses reported a similar incident which distressed them. This occurred when the porters, rather than fetching a trolley of the appropriate length, insisted on forcing the body of a tall man into a small trolley. These examples demonstrate that nurses believed that dead patients deserved the same consideration and quality of nursing care as living patients.

Dying patients are not a nursing failure.

Nurses saw terminal patients as the ultimate challenge to providing total care (See similarities with Field 1987). They took pride that their skills enabled them to provide comfort and care for a dying person whereas professionals from other disciplines did not possess these skills. In contrast to most studies (other than Field 1987), terminal patients were not seen to be of low priority simply because they were no longer curable. On the contrary, dying patients require particularly sensitive nursing care which demands a high standard of physical, technical and emotional / affective skill.

Nursing management on the ward emphasised the opportunities this ward provided for putting into practice the ideals of "good nursing care" - the patient was seen as a whole person rather than as a disease category, bed number or sum of technical tasks. Dying patients could provide a challenge to nurses even if they were not "interesting" to doctors. Challenges to nurses are therefore different from challenges to doctors.

Nurses' views of optimal care for dying patients were similar to the ideology of the hospice movement, insofar as they saw relief from physical pain as an essential pre-requisite to good nursing. Each patient had a right to be pain free, and as good nurses they had to insist that adequate palliation was administered to their patients (Conflicts arising from this issue are discussed in Section Two):-

SN Pain control is a priority - if we can't do that, then we can't do anything... It's impossible to nurse patients when they're in agony, you can't do anything with them, you can't help them and they can't help themselves. That's the one thing you have no excuse for not doing
(Staff nurse; third (individual) interview)

Sr Pain control is a top priority equal with controlling nausea; I mean patients are very sick and depressed and they have problems, pain, nausea or whatever, that can be adding to the depression as much as anything else - you can't have somebody suffering, trying to sort out the depression and not get the pain right - there's no point in sitting for an hour talking to somebody if you haven't given them the right analgesics
(Sister; first (individual) interview)

The concept of enabling patients to suffer pain was unacceptable to nurses in this study. Other studies have suggested that nurses expect patients to bear a certain amount of pain without complaining (Strauss et al 1974). In these studies nurses were reported to tolerate some complaining but excessive complaining led nurses to label patients as "problems" (Castles and Keith 1979).

In this study, nurses, even firstwarders, observed that their assessments of the degree of patients' pain sometimes differed from that of the medical staff. A firstwarder describes this in relation to her perception that the main priority on the ward was pain relief:-

N I think that probably the most important thing on the ward was to keep people out of pain making sure they get their painkillers on time ... that sort of stands out in my mind as the primary aim - to keep them comfortable

JK And do you think this was achieved?

N On the whole, yeah. I remember going to the doctor one day and he said you can't tell if someone's in pain unless they tell you, so if somebody is very, very sleepy or unconscious it's obviously difficult to tell whether they're in pain **but you just use your own sort of feelings** - the sister will come up and say, "Do you think she's in pain?" and you can say yes or no.
(Firstwarder; third (individual) interview)

Nurses acknowledged that sometimes it was technically difficult to control pain. Nevertheless they generally perceived the medical staff to be at fault if pain relief was not achieved. They prided themselves on their ability to recommend appropriate painkillers to the junior doctors:-

SN The doctors will ask you about analgesia for a particular patient; some analgesia work better for one individual than for another - they'll say what's so and so been on and do you think this will help and they're asking for an opinion and if you don't agree they will listen
(Staff nurse; third (individual) interview)

When nurses have not been able to predict and forestall pain, the patient may become distressed trying to legitimate the pain (Strauss et al 1974). Nurses in this study acknowledged that they experienced distress when patients' pain was not controlled and they found loud expressions of distress intolerable. Wherever possible nurses tried to anticipate patients' needs for palliation. Nurses expressed feelings of professional failure and dissatisfaction when patients died in discomfort or in pain:-

N With some patients I've felt satisfied just making them comfortable, but with Mr. S., I don't think I was ever satisfied - I never felt satisfied with the way he was nursed - he was continuously in pain and I felt that anything I ever did for him on the nursing side of it, keeping him clean and comfortable didn't really help, because he was still in pain.
(Third year; second (group) interview).

Nurses' criticisms of medical staff who could not tailor treatment to the changing needs of patients as they neared death are discussed in Section Two.

Good nursing is a skill that can be taught and learned

Nurses believed that good nursing care was something that they could learn through teaching, as well as emulation. Good nursing care was not necessarily a feminine virtue; several nurses cited particular male nurses as examples of good nurses who provided good nursing care. These male nurses, for example, a male charge nurse on the ward, were not attributed with feminine qualities but believed to have acquired nursing skills. These skills encompassed all the components of nursing, including the emotional / affective which might be seen as feminine attributes (This is discussed in Chapter Six).

"Basic nursing" was the foundation and the essential ingredient of good nursing care. Without the skills of basic nursing, good nursing was not possible. Terminal patients provided an opportunity to perfect basic nursing skills, something which nurses on Taylor Ward strove to achieve.

Conclusion

Nurses on Taylor Ward believed that "good nursing care" incorporated the whole range of nursing skills. Frequently they emphasised that

Nursing care is nursing care
(Sister, second (individual) interview)

irrespective of the nature of the patient's condition.

Factors which prevented nurses on Taylor Ward from practising "good nursing" caused them stress or distress. These are explored in Section Two.

SECTION TWO: NURSES' ACCOUNTS OF STRESS

Nurses' accounts of good nursing were presented in Section One. Underlying nurses' accounts of stress was a particular view of what good nursing is, how it is operationalised, and that dying *per se* does not threaten this. As we have seen the main priority of all nurses on this ward (regardless of rank) related to whether or not they perceived that they were meeting patients' needs, irrespective of the nature of these needs. In most cases, nurses reported that they derived job satisfaction from meeting these needs.

Nurses spoke about a number of factors **within the job of nursing** *per se* which created conflict for them.

Working as a nurse

Simply "being a nurse" involved compromise and conflict. These compromises centred primarily around expectations of what nurses are and how they comport themselves.

Nurses were very conscious about their public image. They felt that the public demanded of them a certain standard of behaviour. Nurses commented that when they put on their uniform they had to don a smile:-

- N3 It's part of the job - when you put on your uniform you put on a smile
N2 that's it
N1 they expect you to be polite every single day and sometimes you 're really not in the mood for being nice all the time, are you?
JK So, what do you do, are you polite?
N2 Oh, yes, we're polite and then we go home and scream at each other

JK What does it do to you as people
N2 Screws you up
N3 Ruins your life
(Third years; second (group) interview)

SN Put in a totally different situation I wouldn't behave at all the same way and basically you have to become more stereotyped because it's a stereotyped job - you have to feel the same look the same and act the same, it's true, I think.
(Staff nurse; third (individual) interview)

Nurses suggested that British culture did not tolerate expressions of emotion in public. This interpretation that they had to fit into a particular mould sometimes created conflict for them.

SN There's a thing about crying in public anyway, like men should never cry, you just feel you don't show your feelings in public, so therefore if you start crying on a ward where people can see you, people don't like it. Only because they don't know how to deal with it, I think. You're embarrassed, you don't know what to say, how to react to someone who starts crying.
(Staff nurse; first (group) interview)

In addition nurses believed that the nursing school had certain expectations of their behaviour and sometimes found that they had to compromise personal values in order to meet these expectations. Despite variations in emphasis between tutors in the nursing school most nurses emerged from the foundation course (their first eight weeks of training) with the impression that as nurses they had to "fit in" (Melia 1987) to certain patterns of behaviour. These included a) as student nurses they "ought to know their place", b) they should respect the doctors' competence and not interfere with patient's treatment; c) they should not provide patients with information - this was the responsibility of the medical staff ; d) they should exercise self- control at all times - most nurses believed that nursing school tutors frowned upon any

demonstrations of emotion - the "stiff upper lip" philosophy prevailed :-

N With relatives and patients, I don't think it's a bad thing to show your feelings and in fact I think it's a good thing and I don't think enough nurses do it. I don't think that because you're a nurse doesn't mean you haven't got any feelings and you shouldn't show it to the relatives - I mean if you feel that way, then why not cry- it's a normal part of life, isn't it, it's a normal emotion and just because you're a nurse doesn't mean that you're immune to emotions, on the contrary

JK Do you feel that some nurses feel you shouldn't?

N Yeah, stiff upper lip - don't show your emotions to relatives and things; in fact I think we were told that when we first started, try not to get involved and don't do things like that in front of relatives.

(Third year; third (individual) interview)(my emphasis).

Some nurses suggested that the nursing school would assess nurses as unsuitable for the job if they could not limit demonstrations of emotion. In the following dialogue between two third year students, Nurse 1 agrees with the above contention:-

N1 If you're a nurse you're expected to be able to cope - if you do cry or you do have sort of emotional upset then that's alright but if it lasts longer than a day or two

N2 I've never felt any pressure on me about the way I should cope

N1 If it went on too long, then they consider that you weren't suitable for nursing - something short and quite sharp - you know half hour cry or whatever - that's fine, you can do that, but if it went on for longer than a day and you showed your upset for a couple of days later, then that's not expected of you, you have to put it out of your mind, you have to cope, if you didn't you wouldn't survive I don't think - you'd be too depressed
(Third years; second (group) interview)

Thus nurses had found that this pressure to control emotions was in certain settings a source of stress.

A number of nurses expressed a preference for nursing particular disease types. Parkes (1980) found that nurses tend to experience higher levels of anxiety and depression and less work satisfaction on medical as opposed to surgical wards (See Chapter Two).

She suggests that the instrumental role integral to surgical nursing, coupled with knowledge that the patients would get better, partly explained these findings. In this study, a number of nurses admitted that they preferred work situations where they could actively contribute to patients' recovery. These particular nurses also preferred working on very busy wards and undertaking technical procedures. Despite these personal preferences, these nurses perceived that "real" nursing took place on Taylor ward, equating real nursing with basic (non-technical) nursing. They believed their preference for surgical nursing related to a personal difficulty in interacting with patients (which was less crucial for surgical patients, many of whom were seen by these nurses as likely to recover).

Working within a multi-disciplinary team

Nurses saw their professional interests and the interests of their patients as congruent. Other disciplines have different agenda and consequently when these agenda were not in agreement, nurses felt uncomfortable, or stressed.

Ideological differences between nursing and medical philosophies relating to the cure/care discrepancy will be assessed in Chapter Six. Certain aspects of this created tension for nurses.

In contrast to the ward observed during my M.Sc. placement (see Chapter Three) clinical research was not a high priority for medical staff on Taylor Ward. Nurses were ambivalent about this as research carried status and therefore this ward was not prestigious in the hospital pecking order. On the other hand the low priority of research meant less potential for conflict between

doctors and nurses regarding the appropriateness of treatment for certain patients. Nurses commended the medical staff on this ward for their general willingness to accede to patients' requests for cessation of treatment and contrasted this with incidents that they had observed on other wards in this hospital.

Although most nurses agreed with the policy of not resuscitating terminal patients ("not for crash") this, paradoxically, sometimes had unfortunate implications for the manner in which patients died. A staff nurse describes an incident which occurred during her student days on Taylor.

SN We had a woman called Flora, who had cancer of the lung, and she was a very loud Cockney lady, was great fun, and she suddenly went downhill in her condition and she wasn't for "crash" i.e. wasn't for resuscitation and Joanna (another student) actually had to watch her die because none of us went in to help with respiratory distress, she went bright blue .
(Staff nurse; third (individual) interview)

When conflicts between nurses and doctors arose they usually related to differences in approach to pain relief (or to disclosure discussed later on in this section).

Nurses saw palliation as vital to terminal care in contrast to doctors who sometimes had difficulty in acknowledging the centrality of pain relief and continued to emphasise the potential deleterious effects these drugs may have on specific organs. Nurses criticised the inability of the medical staff to change gear from curative treatment to palliation. The following lengthy quote indicates a night staff nurse's feeling of impotence after vain attempts to alleviate the physical and emotional pain of a patient and her family:-

SN The next night I came on, she'd been crossed off her diamorphine and put onto diazepam, which did next to nothing for her - I couldn't understand it at all. Anyhow she was very, very agitated, she kept trying to get out of bed, you couldn't understand what she was saying. Her relatives that were there were getting very upset and they (the doctors) wouldn't give her any more diamorphine. So the next day when I came on, I said, "Look, she's got to have something else, she's in a bad way." Dr X (the consultant) said no, she did not want to give her diamorphine because she thought she was going to get better, she's in liver failure!! The next night I came on, she'd been crossed off her diazepam and all she was on was chlorpromazine; they'd given her a stat dose of diamorphine at four in the afternoon. I came on and they said, "She's quite settled now", and I said, "Well, it's not going to last long, is she written up for any more?" No, she wasn't. So I went to the houseman, and asked her to write her up for more and she said no, because the senior houseman had written for up for the stat dose of diamorphine and he had spoken to Dr X, who had said that a stat dose of diamorphine was fine but no more. So I said, "She is going to be all agitated in the night. What am I going to do?" So she said, "I don't want her to have any more, give her the chlorpromazine", which doesn't do anything. So during the night, she started to get very agitated again and the relatives kept coming up to me and saying, "She says she's in pain" and I was saying, (sigh) "Yes, I know, and there's nothing whatsoever I can do." And I was talking to the nursing officer and said, "What can I do?" and she said, "Nothing, if that's what they said, then there is nothing you can do." And I got really annoyed and said that I would like to get Dr X up here to see what she looks like and what she is like and what it is doing to the relatives and to (patient). I said, "It's alright for Dr. X, she's in bed, she's not worrying about it, she's not thinking about what this woman is going through".

(Patient's) boyfriend came into me and started to get upset and said, "She's in pain, and I know there is nothing you can do, I'm sorry I shouldn't have said anything", and I said, "No, you should have done, there is nothing I can do but in the morning could you see the houseman and ask him to write her up for some pain relief and that might help". Anyway she died at 7.25 in the morning in terrible pain and I couldn't believe it how they could leave her in such terrible pain. (Long monologue about how they couldn't go over the consultants' head). I was mostly upset that she had to die in so much pain, I knew for three days that she was going to die, so therefore the doctors should have known that and helped her to die peacefully for her sake and for the relatives sake. I think that is what this ward is about, those who are going to die, you should do as much for them as you can and if that means giving them doses of analgesia or what, then that is what you should do.
(Night staff nurse; individual interview).

Nurses cited other instances where medical staff had not ensured that a particular patient was pain free. This created personal stress for nurses, which sometimes led to direct conflict with doctors as well as management problems resulting from distressed (and often noisy) patients.

The discussions above have explored conflicts that arose for nurses from the job of nursing itself (particularly noting their accounts of personal stress arising from conforming to their perceptions of expected control of emotions) and from working with medical staff (particularly conflicts over pain relief which for nurses was an essential element of good nursing as already discussed). Most accounts did not identify the nature of the patients condition specifically as a frequent cause of stress, and on the contrary, shed light on how nursing dying patients could enable them to put into practice the principles of good nursing. Some nurses, however, particularly firstwarders, did find nursing dying patients depressing.

Dealing with death and the dying

Nurses felt pressurised when there was a run of deaths, which required putting into practice specific procedures (as opposed to general care). These procedures sometimes placed "time" constraints on nurses - see below. Some nurses, in response to direct questioning, acknowledged that repeated exposure to death could be stressful not only for emotional reasons but because a run of deaths brought more work (The circumstances under which this occurred are discussed in Chapter Seven).

Although, as we have seen, nurses found seeing patients in pain stressful most nurses did not identify nursing dying patients and dealing with death as stressful *per se*. Carlisle (1985) suggests that the individual's own perception of a situation determines whether or not it is seen as a threat or a challenge (See Chapter Two). This is compatible with the views of Marshall (1980) and Antonovsky (1987) who suggest that not everyone necessarily perceives a causative relationship between stress and emotional distress. Other than firstwarders (see below), most nurses on Taylor Ward perceived nursing the dying as a challenge, rather than a threat:-

SN I quite enjoy (nursing the dying). I like to think that I'm making their last moments in this life comfortable - in the final stages of their illness they need all the nursing care and I do enjoy that.
(Staff nurse; third (individual) interview)

N This ward fulfills what I see as nursing because it's basic nursing that the patients need. There isn't an awful lot of technology on the ward, we don't rely on a lot of other equipment, we're just basically nursing the patient.
(Third year nurse; third (individual) interview)

Although most nurses perceived caring for the dying as a challenge to their nursing skills and not distressing in itself, several firstwarders who spent the bulk of their time on the ward during the second (unstable) management period did experience caring for the dying as stressful. An example of this can be seen in the following quote:-

- JK Do you think there are any particular stresses and pressures on this ward?
- N I don't really know because I haven't worked on another ward; everybody says there is and I suppose there is
- JK What would these pressures be?
- N That you have to resign yourself to the fact that most of the people you're dealing with and perhaps going to get attached to are really very ill, they're probably going to die soon, if not while you're there. That's what it is, know that people that you like and become attached to haven't got very long to live or that they're going to get very ill - that's one of the worst things, seeing them coming in and obviously they're not healthy but that look o.k. and then you see them go completely downhill to a sort of a wreck - it's a horrible thing to see
(Firstwarder; third (individual) interview)

Key themes running through nurses' accounts of stress

Two themes unrelated to death and dying ran through nurses' accounts of their experiences of stress and distress. These themes, time and trust, could prevent or alternatively facilitate nurses' goal of "good nursing" and pertained to any ward.

a) Time

Most nurses on this ward correlated the term "stress" with pressure of work, in particular the time to do "good nursing". A number of factors constituted pressure of work, including staffing levels. A student nurse contrasts Taylor with other wards:-

- N You haven't got the same work as ordinary nurses have - it's very quiet. You don't do nearly the same work - we got lots of afternoons off whereas on other wards they really work hard. Everything is very spaced - it's such a different ward from nursing on other wards. You're just with people all the time that you know are probably dying, whereas on any other ward you've got all the nursing work plus probably that one patient too....One thing it wasn't, it was never pressurised, never, no. Well, there's 20 patients on that ward and all the other wards have got 28 patients; nearly half (on this ward) are so independent in that way I'm so used to just sitting down, chatting to people for about an hour, especially on late shift, watching tv, on other wards you just haven't got time.
(First warder; third (individual) interview)

Staff shortages have been identified as a cause of stress in nursing (Parkes 1980). These rarely occurred on Taylor ward. Despite the high nurse/patient ratio, however, there were occasions when nurses perceived themselves to be under pressure of work, ergo stressed. Certain routines were staff intensive and time-consuming and interfered with "normal work". A student nurse describes a typical scenario:-

N I think "time" (is a negative feature of the ward). Like drugs, it's a real bind, you know, because there are so many patients taking very strong analgesia and they need to have those on the dot when they're prescribed. And very often there's not enough staff on to do that and I find that sometimes you're just in the middle of doing something and you've got to do these wretched drugs. If only they could have provided somebody else just to do that, you know.
(Second year; second (group) interview)

Some nurses did perceive the specific nature of tasks unique to this ward as stressful:-

N2 There are so many stresses going on
JK What kind of stressful things go on?
N2 Just the everyday jobs. I find because you've got so many different things to think about - it's just the job - you've got to be concentrating on what's going on, you've got to remember everything, you can't write down anything from report on this ward in case you lose your notebook, so you have to remember everything
(Second year; first (group) interview)

Nurses felt pressurised when there were a high proportion of highly dependent patients (who needed constant surveillance):-

SN From the physical aspect I think it's been very heavy for the past few weeks in that we have a lot of what we call high dependency patients. If there are say just two nurses on a late duty, it can be very heavy because high dependency patients need an awful lot doing perhaps they need constant attention some of them. Studies have proven that a high dependency medical patient is the one who requires optimum amount of nursing care as opposed to a high dependency surgical patient.
(Staff nurse; third (individual) interview)

British nurses are trained by rotating at regular intervals through hospital wards and acquiring skills, knowledge and breadth of experience as they progress (See discussion Chapter Seven). Nurses of different ranks observed that adjusting to new circumstances (on an unfamiliar ward) was in itself time-consuming and consequently a pressure. This was particularly pertinent to firstwarders and to staff nurses, both adjusting to new roles:-

JK What kinds of stresses were you subjected to on the ward?

N I think it was hard enough coping with being a first warder, I mean that's a pressure in itself
(First warder; third (individual) interview)

Staff nurses, especially those new in post, also observed that the adjustment process, combined with new administrative responsibilities prevented them from talking to patients and finding out their problems first hand:-

SN Having to find the ward routine or trying to establish a ward routine as well as actually getting used to our new role, I'm finding rather a conflict, and I get so frustrated because I'm writing reports on things, like last night and the night before, and I think, "Gosh, all this is lies, I'm assuming things" because I haven't had time to get round to the patients to find out **exactly** what their problems are and how they've been coping throughout the day
(Staff nurse; first (group) interview)

The sisters also found that there were considerable demands on their time and that this was exacerbated by management responsibilities. Consequently they were prevented from spending as much time as they felt was necessary with patients:-

Sr I am very much frustrated with the administrative responsibilities that I have - I want to get in there and be with the patients and see them through but I've got to make up the off duty which takes me two hours and I've got to talk to all the social workers and the

paramedical people and I've got to talk to all the dieticians; I just get caught up with so many other things - you could honestly work a whole day and not see a patient.

(Sister; first (individual) interview)

Thus when nurses perceived that management or administrative demands took precedence over patient care, and this implied "neglect" of patients, they experienced stress. Student nurses, for example, were resentful when they had to disregard certain aspects of patients' needs (i.e. emotional) in order to complete paperwork and other tasks which they perceived as mundane or of secondary importance.

Management and administrative demands could therefore be a source of conflict for individual nurses, but equally smooth nursing management was required in order to be able to do "good nursing". The components of this will be discussed in Chapter Five. Chapter Seven will provide an illustration of the effects of unstable management on nurses' perceptions of "good nursing" and a "good ward".

b) Trust

The second theme that emerged from nurses' accounts related to whether they felt that they were enabled to establish trusting relationships with patients. Nurses' interactions with patients were influenced by the nature of patients' conditions; most students had anticipated this, but were surprised at the ramifications for themselves, patients and their relatives.

Disclosure

A central feature of work on a cancer ward which has been demonstrated to precipitate experiences of stress for nurses is the issue of disclosure (McIntosh 1977; Bond 1983). Healthworkers, including nurses, adopt strategies to avoid stressful encounters with patients (Menzies 1959; Glaser and Strauss 1965; McIntosh 1977; Bond 1978). Previous studies of cancer wards have also suggested that disclosure policies can be indicative of ward ideology. It is important to emphasise here that disclosure policies, practices or routines, should be viewed as not only a means of controlling information, but also a means of controlling behaviours of all the interactants. Taylor Ward did not have a uniform disclosure policy. On the contrary disclosure practices were varied and sometimes haphazard. Disclosure practices on Taylor ward thus ranged from full disclosure to deceptions regarding the nature of illness. As there was no formal system whereby nurses were told or could find out conclusively how much patients knew about their conditions some control was exercised over nurses' behaviour.

N For the first two weeks, I really didn't know whether a patient knew or didn't know that he had cancer. (Second year, second (group) interview)

The nursing notes (Kardex) contained scanty information about what patients knew, and often it was wrong or out of date. All ranks of nurses found this frustrating, the more junior nurses assuming, incorrectly, that the medical notes were more accurate. Night staff, in particular, complained about the lack of written information. They were acutely aware that day staff had better access to information than they did and were unable to rectify

this situation.

Most nurses began their placements on Taylor Ward with private beliefs about the rights and wrongs of disclosure. Many nurses believed that all patients should have access to full information about their conditions. Firstwarders at first interview saw the issue as quite clear-cut: patients should have access to full details about their condition:-

JK Do any of you feel very strongly whether patients should know or shouldn't know?

N3 I think they should know

N1 Yes, I do

N2 Yes, I do

JK You all do

N3 They 've got the right to know what's happening to their own bodies - there's nobody who's got the right to make the decisions whether they should know or not - definitely not a doctor

N2 Yeah

N1 And also if you've got an honest relationship that is a basis to start off with, isn't it?

N2 It's a boon

N1 That to me, I'm sure the patients would be a lot happier if they know that you're not trying to hide anything from them. I'm sure they know if you do it (hide information).

N3 That's like the doctors telling the relatives but not telling the patient and if the patients find out, then they think, "all my relatives have been coming here thinking one thing and I've not known".

N2 I would hate that, it's so terrible.

(Firstwarders; first (group) interview)(my emphasis)

Not only student nurses expressed these views. A sister joining the ward concurred:-

Sr I feel that if you can't tell the patient the truth then you don't really care

(Sister; first (individual) interview)(my emphasis)

In addition to favouring disclosure for moral reasons, firstwarders felt that non-disclosure had and could in the future place

them in tricky situations as well as having implications for their quest for trusting relationships with patients (The ways in which nurses learned to respond to these situations will be described in Chapter Five). The following three quotes come from the same three firstwarders, spanning the entire time period these nurses were on the ward:-

N3 The very first day that I came onto the ward I was very nervous, it was the first day in my foundation unit that I'd been up to the ward, the lady patient said, "You can tell me that I am going to die, the others won't tell me, but I know - you can tell me that I'm going to die, aren't I?" I really didn't know what to say, I knew she was but, I was really stuck for words, I just didn't know what to say, it was quite frightening in a way.
(Firstwarder; first (group) interview discussing her first day on the ward, two weeks before she began her allocation)

N1 Well, we're the ones who are put in an awkward position when they do ask questions. Take this lady for instance, the doctor didn't tell her why she was in

(JK The doctor told her she was coming here to be cured?

N1 Yes, she's got bony metastases everywhere I think and he did tell me but I can't remember what her primary was - well, maybe she's the wrong person to tell, but I think she should have been told something, she thought she had arthritis which is making her leg stiff and obviously not understanding at all what's wrong with her and when she asks us, I mean, it's so awkward.

JK So you feel that patients should or shouldn't be told depending on what kind of disease they've got?

N1 Yeah)

(Firstwarders; first (group) interview, talking about their first fortnight on the ward)

N3 You're constantly on edge in case they ask you something

N2 A patient will sometime say to you, "Am I dying?" that's a hard enough question - but I thought, "Ooh, what do I say?", I just don't know. The fact that the poor lady did die a little while later, I really felt bad about it.. that made me think - ugh, it (would have been) horrible to have said that but I could not have said, "Oh yes, you are dying"

N3 Well, you can't say that, it's like if someone says to you, well, am I ugly, tell me straight

N2 You've got to be tactful, it's very difficult if somebody throws that question at you like that.

(Firstwarders; second (group) interview - eight weeks after first interview, see above)

These firstwarders (who spent the bulk of their allocation on the ward during the second management period) reflect the uncertainty experienced by nurses when they do not know what patients have been told, described by McIntosh (1977) and Bond (1982):-

While this uncertainty remains, nurses explain their avoidance of communication about the patient's illness, even if it does not involve explicit revelation of the diagnosis, by a fear of being responsible for divulging information that the doctor does not wish revealed and to which the patient may respond in a manner harmful to himself and difficult for nurses to control (Bond 1982 p 16)

Most nurses who entered the ward convinced that it was in all patients' interests to have full access to information, modified their views whilst on the ward. This partly reflects the socialisation process in that these nurses have begun to question these issues, as a result of observation and experience. Some nurses attributed their change of view to discovering a) that many patients were terrified of a diagnosis of cancer and b) that such a revelation might precipitate rapid deterioration. The first quote below comes from the same set of firstwarders (see above), the others from qualified staff:-

JK What actually happens about telling patients on the ward
N2 It varies, when I was down in clinic with Dr X, I asked her about it and she said she never ever ever, if a patient asks her something, she won't lie, if they say, "Am I going to die", she'll either say, "Well you've got, she never puts a time on it, even if she knows it's going to be two months, she'll just say, "Yes, you're dying, you have cancer". She says it's like telling me I'm going to get run over by a bus next week, it's just like I felt about it - for someone to know that they've got two months to live, I know lots of people have various feelings, but I really feel strongly about it, I wouldn't like to know, I don't think it's a very fair thing to tell people - that's one thing she never does, but if someone asks her, she makes her own opinion, she'll tell them , you are going to die, you are seriously ill....
(Firstwarder; second (group) interview)

SN I'm sure that some people that are told that they've got six months to live, about a month later, they're dead, they just give up
(Staff nurse; third (individual) interview)

Sr Sometimes telling the patient is as traumatic as not telling them, depending completely on the person's character. A patient, for instance, who was told his full diagnosis and realised immediately what it meant, he wasn't going to get better, just went downhill from then onwards and wouldn't speak to the registrar who told him - every time the registrar went into his room, he wouldn't speak to him - he'd done this terrible deed, telling him.
(Sister; second (individual) interview)

Once nurses began to accept that not all patients wanted to be in control of their illness, they no longer viewed non-disclosure as a cause of stress for them, nor feared patients' questioning. This move away from wanting to provide patients with full control over their lives to the philosophy of "patients' wishes must be respected" can be seen as an indication that nurses gradually adopt for themselves the emphasis on individualisation of care (Another view might be that this reflects the pressure on nurses to 'fit in' with the prevalent culture). If one accepts the first explanation this may be seen as reflecting an acceptance of ward philosophy that not all patients want to have details about their conditions but they require sufficient detail to reassure them and motivate them to undertake treatment or accept palliation. As with all other areas of care, decisions were based on the assessment of the individual patient's needs (See Section One). As long as nurses felt that the disclosure issue did not impede the trust they were building up with the patient, they were willing to accept variations in disclosure practice.

For some (primarily, junior) nurses, the disclosure issue remained a cause of stress throughout their allocation to Taylor ward. They felt that the denial of information to patients, irrespective of patients' apparent wishes, inferred suboptimal nursing practice in that they were forced to collude with deceptions imposed from above.

Most nurses found it less stressful and more satisfying looking after patients who knew what was wrong with them. Even some first warders fell into this category:-

- N1 You see, somebody like Mrs D., it was quite good, you know, because she knew all about her condition
- N2 Yeah
- N1 She knew what was going to happen to her, she was able to talk about any aspect of it and I felt I could get on much better with her
- N3 Yeah
- N1 Because it was a completely honest relationship, you weren't trying to hedge around things because you didn't know things. You knew exactly where you stood with her and I think that was a lot easier for her relatives as well. She would talk about it to her relatives and I think that because she was prepared to talk about it, they were prepared to come and see her, because they knew they didn't have to avoid her. Like when they said, "You're going to Wilson House" and they said, "It's a terminal care place " and then went into her and said, "We've got you a place in Wilson House" and I thought what if someone didn't know that they had cancer and they were put in there and someone said, "Oh, yeah, it's a terminal care home". It's enough to kill you off straight away, just finding that out.
(Firstwarder; first (group) interview)

Disclosure is a complex issue (Bond 1982) because it is difficult to define what constitutes telling, how patients are told (verbally, non-verbally), what patients absorb and how they interpret the information they receive. Nurses in this study acknowledged these issues, citing cases where patients had been told repeatedly, but appeared to repress this information. In

addition, nurses saw disclosure as a **process** of providing information, rather than announcing the "death sentence" all at once. They categorised the stages of this process:-

Telling patients their specific diagnosis

Describing the disease process to patients

Explaining the purpose of the treatment

Discussing alternative types of treatment

Alerting patients to possible side effects of treatment

Explaining symptoms related to secondary involvement of tumour

Telling patients why treatment plans been changed/abandoned

Explaining the expected disease trajectory to patients and how this would implicate future functioning

Informing patients that they have reached the terminal phase

The implications for patients of "finding out" worried the trained nurses for the reason that this might damage the trusting relationship they were trying to build up:-

SN On the whole they did tell patients and I think they should because I think it's much better to be told than to find out. Its better for somebody to actually tell them in the right way because ... it does happen that patients find out or have fears - I mean, let's face it, outside the ward there is a notice which says Taylor Ward - Oncology unit - you only have to look up what oncology means. So surely it's better to say you've got cancer but we're going to try and treat it, you are not necessarily going to die. I think that way it's better rather than for them just to suddenly find out they've got cancer and they think "Oh, my God, that's it!"
(Staff nurse; second (group) interview)

More experienced nurses (and this included some students) did not view disclosure as potentially creating problems for their nursing because they felt able to find out what a patient knew:-

N We go into that room and we don't know - eventually we do
(Second year ; first interview)

Trained nurses knew how to ascertain the extent of the patient's
knowledge from the patient him/herself:-

Sr I know on the whole what they know

JK How do you know?

Sr By talking to the patients (and talking to the doctors)
(Sister; second (individual) interview)

In addition qualified staff felt they could facilitate the
disclosure of information to patients. They saw disclosure as a
serious nursing issue which required careful planning to decide
whether a patient should be informed, who should disclose, when
and why.

Sr I think patients are told at different times, different
stages, **when they are ready**, in many ways, I think - I
think the doctors don't tend to *rush in telling their*
patients and I think that's the right way to do it - when
one just gives the patients a chance to think things
through themselves.
(Sister; second (individual) interview)

When the nature of the condition created anxiety for a patient,
(i.e. the patient was "ready to be told " - see above quote) it
was essential to respond quickly with information. Nursing
management saw patients' anxieties per se as a **nursing** problem in
contrast with their counterparts in Bond's (1982) study who saw
disclosure of information as likely to create **general management**
difficulties. Nurses in Bond's study (1978) believed that:-

open discussion by patients of their feelings and the
possible consequences of their illness would do more harm
than good by precipitating even more stress than was
already present. In the short-term patients would show
excessive emotion by becoming hysterical, crying or
withdrawing from reality by becoming morbid or even
suicidal. In the longer term hysteria would turn to
despair and result in a loss of hope which could reduce
life expectancy (Bond 1982 p 17)

Despite their exposure to discrepant disclosure practices, and a gradual acceptance that many patients would not benefit from being given full details of their condition, nurses remained adamant and consistent throughout their placement on Taylor ward that were they or their family to be diagnosed with cancer they would want full details of their condition at initial diagnosis. This can be seen as consistent with the view that most people (healthy or ill) maintain that they would prefer to be given full information (Hinton 1967; McIntosh 1978) or at variance with findings in Bond's study (1978) where over half the nurses maintained that if they themselves contracted cancer, they would not want to be told, because they equated cancer with a death sentence.

Nurses in this study felt that as nurses they would probably know if they had cancer. Nonetheless they maintained that if the situation arose they would insist upon full disclosure to enable them to plan for whatever future they had left:-

N The thing is, if it was me, and I was told that I'd got warts and they were curing it by radiotherapy, I'd be very annoyed if after a month, two months, they came up to me and said, "Look, we've been treating your warts, they haven't got any better, in fact you've got cancer, you've got a month, maybe two or three months to live". I'd be so angry because the whole time I'd be thinking, oh, next year I'll be doing this.
(Second years; second (group) interview)

Many nurses, both student and qualified, described incidents where diagnoses had been withheld from members of their own family. In retrospect they believed that this issue had been mishandled and had precipitated stress for all concerned.

The above discussion of disclosure has explored how nurses began to accept a diversity in disclosure practices on the ward, and acknowledge that although some of them viewed non-disclosure as immoral, as nurses they had to accept that they should not impose their personal approach on patients. At the same time, the doctors' disclosure practices had the potential for damaging trusting relationships between nurses and patients and consequently could lead to conflict between doctors and nurses. Although conflicts of this nature were usually satisfactorily resolved (see Chapter Seven), on occasion this did create tension for nurses.

Most nurses agreed that the responsibility to disclose information to patients lay ultimately with the consultant (McIntosh 1977 ; Bond 1978). In this study, the trained staff were able to convince doctors to disclose information to patients if they perceived that this lack of information was causing the patient distress. This contrasts with senior nurses in Bond's (1978) study who faced interactional difficulties with patients because doctors' communication practices (with which they sometimes disagreed) were always aimed at avoiding disclosure. Nurses in this study were more concerned about the manner (as opposed to the content) in which some doctors disclosed information to patients. Although most incidents describing covering up the truth had occurred on other wards, this did occur occasionally on Taylor ward and will be discussed later in this section.

Nursing management emphasised certain aspects of sensitive disclosure practices that they saw as essentially humane interactions. A sister described an insensitive interaction which

she observed on another ward the previous day:-

Sr I think you've got to tell them at the right time as well which on some other wards (they don't). Yesterday I came across a lady who had just had a D&C, and the consultant said, "You've got some disease there", and walked off not saying anything else, leaving the patient sitting there.
(Sister; second (individual) interview)

Nurses believed that the timing and location should be planned carefully. The choice of who should tell, as well as the manner of the delivery were crucial:-

Sr There is a time and a place and who should tell them depends on how well you know the patient and the way you tell them and the position in which you tell them. You could be standing up and they're lying down, you should sit down and get to the patient's level, that's important, I think. Although you're not supposed to sit on patients' beds, you've got to, sometimes.
(Sister; first (individual) interview)

Nurses were concerned that doctors should plan the disclosure around the patient's timetable:- the patient should not be exhausted having spent the day in radiotherapy or rushing along the corridor or entertaining visitors when information was disclosed. Ideally, other ward staff should be present or briefed immediately, so that they could re-iterate what had been discussed if the patient requested confirmation. Nurses also suggested that when revealing information doctors should be prepared to respond to patients' questions and deal with possible expressions of anger, fear, grief or other emotions.

McIntosh (1977) found that doctors believed that patients should not be told they had cancer unless their condition was curable. He proposes that doctors classify patients according to the extent of

their disease. The routines of disclosure employed vary according to the disease category, in terms of severity and stage of treatment (McIntosh 1977). Bond (1982) suggests that doctors' unwillingness to disclose full details to patients might partly be explained by their concern about the patient's reaction to this news. By using illness categories as the basis for communication, doctors avoid having to grapple with decisions based on personal characteristics (Bond 1982). Using an individualised approach to care, however, implies integrating social criteria into the decision making. In this study, nurses were extremely critical when doctors based their disclosure decisions on social class and financial criteria. For example:-

SN He will tell some people he feels that need to make arrangements, like wills, winding up businesses as if because they have these responsibilities, they are going to be able to accept it. Again what's the difference between a worldly person and an ordinary man with a wife and three children, perhaps they would like to settle a few things
(Staff nurse; first (individual) interview)

Several nurses felt that the more articulate, intelligent patients were told simply because they demanded the information.

Conflict with medical staff regarding the disclosure issue also related to nature of the content disclosed and objections to the use of (functional) uncertainty (Davis 1963) and deceptions by doctors when explaining patients' conditions to them. Studies about communication between health workers and cancer patients have suggested that uncertainty is used by doctors and nurses to restrict interactions with patients and to inhibit patients from seeking information (Waitzkin and Stoeckle 1972; Hall 1979; McIntosh 1977). In defence of their medical colleagues, nurses

suggested that sometimes the doctors genuinely did not have the answers and were therefore forced to respond to questions with hedges or uncertainty (rather than admit ignorance). (As nurses generally had a very high opinion of the doctors on Taylor ward, they were quick to provide explanations to qualify certain criticisms - see discussion of teamwork in Chapter Seven).

Although the medical staff were willing to act upon sister's assessment that patients needed to have full details and even accepted sister's judgement when she told patients herself, according to the nurses when the medical staff disclosed information they phrased it in a positive vein, encouraging patients to retain hope and motivate them to accept treatment (McIntosh 1977). As in other studies of information regulation on cancer wards (McIntosh 1977; Bond 1978) consultants on Taylor Ward were reported by nurses to use uncertainty to ensure patient co-operation with treatment. This can be seen to reflect medical ideology (emphasising "cure" as the goal of medicine) which in this case was sometimes in open conflict with the core of good nursing practice (See discussion in Chapter Six).

Nurses maintained that patients were often told that they would receive "drug treatment to help them get better". The specific condition was rarely disclosed. Patients were occasionally fobbed off with hedges or euphemisms :-

N Lots of doctors seem to say - you've got a little growth or a little lump
(Second year; third (individual) interview)

Sr I heard Dr A telling Mrs Lewis that she has an ulcer , that she has to have this **material** inside her
(Sister; first (individual) interview)

Nurses often felt that covering up was inappropriate and not conducive to the co-operation with treatment the doctors were seeking. In essence it threatened the trusting relationships nurses were trying to establish with patients. The male charge nurse contended that sometimes doctors were patronising to patients:-

SN What I do find unnecessary is sometimes, if a consultant goes round and they don't really know how much that person knows and then they'll sit on the edge of the bed and say, "We've found this little complication in the liver but I'm sure we'll sort it out, we'll give you a little (treatment)", and he's really putting that person's intelligence down, talking to him a little bit like a child sometimes and maybe that day that person has said to us, "I think maybe I've got cancer", and then the doctor will come and sort of talk down to them and they'll never make them any more aware of the facts than they are. I find sometimes that that can be wrong. I think it's just very inappropriate and how stupid to say a thing like that, how stupid of him not to consider the person, but it's not always their fault because they don't always know what the patient knows.
(Charge nurse ; first (group) interview)

Nurses were angry when they felt forced to collude with a deception. Lies obstructed good nursing. Interactions between nurses and patients were strained if nurses felt that they had to be "on their awares" (as they put it) when talking to patients. Nurses maintained that good nursing was based on a trusting (Bond 1982) and honest relationship between patient and nurse and deceptions compromised this relationship and their sense of professional integrity. In order for nurses to ascertain patients' real concerns, patients needed to trust them with confidences. Thus nurses did not utilise the strategy of "uncertainty" in dealing with patient's questions. Chapter Five will illustrate an alternative to the strategy of uncertainty - how junior nurses learned to use (genuine) lack of knowledge as a technique for deflecting patients' difficult questions to more senior nurses or

medical staff. Although nurses retained their belief in trust as an essential element of good nursing, they came to see that trust was not necessarily synonymous with providing patients with information themselves, but with an obligation to respond positively to patients' need for information by passing the request on to senior colleagues.

Conclusion

Stresses for nurses on Taylor Ward related to certain features of their work. These included adjusting to the ward, pressure of work as well as issues relating to the nature of patients' conditions and interacting with patients and with other disciplines. Time and trust were themes which seemed to be central to nurses' accounts of stress and conflict; both time and trust were seen to be essential pre-requisites for good nursing. In Chapter Five, I shall examine the ways in which certain rules of behaviour were means by which nurses were supported in their aim of providing good nursing. Arising out of this chapter are three issues, related to nursing cancer/dying patients, which had the potential for creating stress for nurses - the management of death, the management of information and the management of emotions. In developing these examples in Chapter Five I shall illustrate how the good ward supported nurses in the three areas identified here as potential sources of stress.

CONCLUSION

Nurses on this ward did not conceptualise causes of stress as related to patients' specific medical conditions. Similar to Field's (1987) findings, but in contrast to most other studies, nurses did not differentiate between nursing dying or other types of patients. They acknowledged, however, that the absence of technical requirements enabled them to provide these patients with "basic nursing", the stuff of nursing care.

In contrast with other studies of cancer nursing, nurses on Taylor ward did not develop distancing strategies to avoid conversations with patients about their illness or emotional issues. On the contrary, nurses viewed talking to patients as an essential component of good nursing as only through conversation could they ascertain the nature of patients' problems.

Stress for these nurses usually related to whether or not they were enabled to give patients the comprehensive "nursing care" they assessed them as needing, irrespective of whether the individual tasks were physical, technical or emotional/ affective. Nurses experienced stress when aspects of their job or other professionals affected whether or not they could provide patients with good nursing, for example when pain relief was inadequate. The twin themes of time and trust either facilitated or prevented nurses from meeting their goals.

The worldview of these nurses related to a professional identity, a pride in doing their job properly. Certain factors enabled nurses to do their job well. Smooth nursing management was a crucial factor. The importance of this will be discussed in the next chapter.

CHAPTER FIVE

UNDERSTANDING SUPPORT : THE GOOD WARD

INTRODUCTION

This chapter seeks to complement the data presented in Chapter Four. There is some difficulty in separating out the data, due to interaction between the worldview of the nurses studied, and the opportunities to practise good nursing as provided by Taylor Ward. Chapter Four presented nurses' accounts of factors which prevented them from practising good nursing as well as a number of principles of their worldview; this chapter illustrates how the structure of the ward supported them in their endeavour to practice good nursing.

The manner in which the ward was organised affected whether or not nurses experienced stress or perceived themselves as in need of support. This chapter will examine how ward organisation played a part in reducing or dealing with factors which could have become potential causes of stress. Chapter Seven will illustrate circumstances when nurses were not protected from experiencing stress.

Nurses kept referring to Taylor Ward as a 'Good Ward' and this chapter presents these accounts. It is possible to separate analytically two issues fundamental to the nurses' accounts:-

- a) what constitutes a Good Ward and
- b) what are the means by which a Good Ward is supportive.

In Section One the notion of a good ward will be unpacked. The argument runs as follows : a good ward is one where there is congruence between the nurses' worldview and nursing practice; in a good ward, nursing management is seen to be in control and not compromising nursing ideals to other professions; a good ward also has visible features of cleanliness and tidiness and appears to be well organised. In summary in a good ward nurses are subjected to the minimum of stress (See Chapter Four).

Section Two demonstrates that a Good Ward is supportive to nurses because the Rules of Behaviour are clearly defined. Nurses can find out what is expected of them and how they should behave i.e.the rules are viewed by nurses as providing them with protection rather than sanction. Control over behaviour can thus be seen as benevolent rather than malevolent. Additional psychological support is not required on a good ward, because the structures provide a secure framework within which to work and learn.

Section Three presents nurses' accounts of what they perceived as appropriate additional support measures for nurses working with cancer patients.

The conclusion summarises the chapter.

SECTION ONE : THE GOOD WARD : NURSES' CRITERIA

This section describes the ward when nurses evaluated it as a "Good Ward". Although this study commenced during the last few weeks of what I term the first management period, this period extended retrospectively for more than a year, and hence the reputation of the ward was solid and well-known amongst nurses in the hospital and in the nursing school. In the Good Ward, nurses rarely experienced stress. It was precisely because the ward was not experienced as a "good ward" throughout the study, that the importance of and features of the "good ward" became so apparent.

Discrepancies between nursing practice as taught in the nursing school and nursing as practised on the ward, have the potential for creating conflict for nurses (Melia 1987). Nurses' questions prior to commencing ward allocations indicated the degree to which the opportunity to practice good nursing was crucial to their evaluation of wards.

Nurses in this study judged a "Good Ward" as one which appeared to be organised, well managed, efficient, and friendly. Patients looked comfortable, happy and pain free. Nurses worked quietly, competently and confidently. Taylor Ward had the reputation within both the hospital and the nursing school, of meeting nurses' criteria of a "Good Ward" because it provided an opportunity to practise "Good nursing". Those features which facilitated this will now be described.

The ward atmosphere

Student nurses were impressed by the ways in which they were welcomed onto the ward. Nurses about to start new ward placements are often apprehensive. One of the more disturbing features of the rotational nature of nurse training is the constant re-adjustment students have to make to conditions and personalities (Menzies 1959; Melia 1987). Initial impressions of nursing management and a welcoming atmosphere can signal what kind of experience the student might expect.

SN I think I was apprehensive before I started on a new ward anyway. I came to get my off-duty from the ward and you get an atmosphere from the ward then. The staff were very friendly and that makes a lot of difference. It was a good atmosphere whereas perhaps on a busy surgical ward, sometimes you get brushed off a bit as a student when you first come on to the ward. And it seemed calm.
(Staff nurse; first (individual) interview)

N When I first come on the staff nurses approached me and said, "You're going to be new nurse on here," and they were so friendly, that was the first thing that impressed me.
(Second year ; first (group) interview)

Nurses associate friendly staff and supportive superiors with work satisfaction (Trygstad 1986). Demonstrations of collegiality, and friendliness on the part of the trained staff facilitated a rapid adjustment of newcomers to the ward.

Students were impressed by the rapidity with which they were expected to participate in ward report where they were reassured by the high profile of all student nurses, even firstwarders (See discussion in Chapter Seven).

The staff were well established

Nurse training, at both trained and student levels, accentuates range rather than depth of experience. Hence even trained nurses tend to change jobs frequently. Staff nurses are encouraged to move after six months. The qualified staff on Taylor Ward, at the beginning of this study, were unusual in that all of them had been on the ward at least a year, many approaching two years. It was clear to students that the trained staff were comfortable and very familiar with the ward. Student nurses viewed this as a sign of stability and commented on the contrast in ambience when nursing management changed (See discussion re instability in nursing management in Chapter Seven).

Ward management

Staff shortages have already been seen to be a cause of stress for nurses (Parkes 1980). The Directorate of Nursing Services prioritised this ward with regard to staffing. Staffing levels on Taylor Ward were kept constantly high; there was no reduction of establishment in line with the fact that Taylor Ward only had 20 beds, 8 fewer than other wards in this hospital. This was specific hospital policy regarding the "cancer ward" acknowledging the need for flexibility in space and patient/nurse ratio. Efforts were made to ensure that Taylor Ward was always fully staffed and did not require "locum" nurses to be transferred from other wards when nurses were off sick, on holiday etc.

The nursing school selected several medical wards in the hospital as appropriate training grounds for students. Student nurses from all three years were assigned to Taylor Ward, usually there were two or three students from each year assigned to the ward concurrently. The students observed that the high staffing levels and low patient levels facilitated "good nursing". Nurses had sufficient time to do a good job (this was discussed in Chapter Four).

- N They have the time they don't have on other wards - they have the time, they can give individual attention and that's what I like to be able to do - I'd really like to be a good nurse and by that I mean do everything for the patient I possibly can, like if they want to chat - just care for them
(Second year; third (individual) interview)

In addition the pace of work was considerably slower:-

- N On other wards the pace is much faster physically. I mean, here it gets heavy, I think heavy is the word and then it gets really busy on Fridays with cytotoxics, but the pace is definitely slower, it has to be, you need more time to discuss with the patients.
(Third year; second (group) interview)

Thus the consequences for nurses of a higher staff / patient ratio was the ability to practise good nursing, and not having to adopt a technological or task orientation simply because of a heavy work load.

Nurses interpreted the superficial appearance of a ward as an indication of the quality of nursing management:

- N It was quite clean and tidy which means it's fairly well organised. I'm not a person that thinks that its got to be clean and tidy before the patients are ok but if the

ward is clean and tidy it does mean that things are getting done. The patients looked fairly comfortable and that impressed me at the time.
(Second year ; first (individual) interview)

a) The organisation of nursing work

Student nurses were impressed by the clarity with which nursing work was allocated. The delineation of work was clear to all nurses. The nursing school had recently adopted the "Nursing Process" philosophy of patient care. (The nursing process as it has evolved in Britain will be discussed at length in Chapter Six). There was considerable variation between wards regarding the implementation of the principles of the nursing process. This largely depended on the approach and management style of the ward sister (Smith 1988a makes a similar point). In contrast to Field's (1987) findings nursing management on Taylor Ward had embraced many aspects of the nursing process - the emphasis on the patient's problem, rather than his/her diagnosis has already been discussed in Chapter Four. Nursing management on Taylor ward emphasised individualisation of patient care (incorporating patient allocation), which implied that individual nurses were responsible for all the needs of specific patients over a particular period of time. Patient allocation contrasts with the more traditional form of nursing whereby nurses are assigned a number of tasks on a daily basis e.g. all the bed baths on the ward. Surprisingly, the concept of task allocation was foreign to most student nurses, who maintained that they did not know how task allocation operated.

The use and management of routines in nursing are well documented (McIntosh 1977; Bond 1982). Routines are believed to be the primary route through which nursing management maintains control over nurses and ensures that work is satisfactorily completed (e.g. Menzies 1959). Although certain routines were abandoned in favour of "individualised care", student nurses were impressed by the punctuality of drug rounds, which they saw as essential, and also the less exacting routines, for example menu taking.

Although there were some exceptions to this during the second management period (see Chapter Seven), nurses of all ranks evaluated the standard of nursing care on Taylor Ward as extremely high.

SN I think the quality of nursing care is better on this ward than on a lot of other wards - partly because of the staff, and the ratio of students we get, and also the emphasis by the trained staff on oral care, not just to think about the body, but parts of the body. I think the standard of nursing care is higher here than on other wards.

(Staff nurse; first (individual) interview)

Several nurses attributed this high standard to teamwork and the degree of nursing autonomy.

b) Autonomy and teamwork

Nursing management could plan their own pace and were not dependent on other hospital staff to the same extent as nurses on other wards. For example, there were fewer directives from doctors regarding technical procedures than might be found on a surgical ward. Field (1987) maintains that the

central feature of relationships between doctors and nurses is that doctors control large areas of nursing work. They do this both directly through 'doctors orders' specifying clinically relevant nursing tasks associated with therapeutic intervention into and management of disease processes, and indirectly through their general instructions about nursing work (1987 p152-3).

Nurse managers on Taylor Ward were "professionalisers" (Field 1987) rather than "traditionalisers" in that they had sufficiently high professional self-esteem to challenge "doctors' orders". Nursing work was negotiated between consultants and wardsisters. Student nurses learned that decisions were not unilaterally handed down from the doctors but that the trained staff actively participated in discussions regarding patient management.

The extraordinary relationship between the medical and nursing staff on this ward was remarked upon by many nurses, both student and qualified alike:

SN There is more of a team on this ward between the medical and the nursing staff. On some wards it's almost as if you're working against each other and not together. It's better in that respect. The medical staff rely far more on the nursing staff for things and I think you can do more. It puts you on an equal footing. Perhaps because there is no cure, the fact that everything they do is treatment, it's like us, we're not actually giving any cure you feel you're doing as much as them - or as much as almost anybody else can do for that patient because of their diagnosis as well
(Staff nurse; third (individual) interview)

Nurses observed that the medical staff on Taylor Ward had an respectful attitude towards nurses. Even the consultants noticed the students; junior doctors were observed asking students about the patients for whom they were responsible, which drugs worked well etc. Nurses were seen to have knowledge about patients' concerns and their advice was sought about a range of issues

(including pain control as discussed in Chapter Four). Wardrounds (see chapter Seven) illustrated how nurses' opinions were valued by the consultants, when the charge nurses presented patients' nursing issues, complementing the junior doctors' observations.

Nurses did not express feelings of subordination to doctors or other non-nursing professionals on the ward. They perceived nursing management as working in conjunction with other professions, as "partners in care", rather than as inferior to them.

c) Nurse training is possible

One of the criteria upon which students assessed wards was whether the ward enabled them to meet the requirements of the nursing school. Each rank of student nurse was expected to acquire certain skills and experience during each ward placement. In theory each student nurse was assigned a nursing school tutor who supervised training from start to finish. This was to ensure continuity for students in a system which was characterised by constant change of environment. During this period, however, the nursing school was somewhat in flux and "lines" were changed due to staff shortages. Students found the instability in the nursing school most unsettling and consequently were particularly concerned that the "training" element of their ward placement was satisfactory. Even where long term relationships with tutors existed, students were loathe to report their anxieties or concerns regarding their educational needs to them. Tutors were seen as holding the key to their quest for qualification and therefore were seen as unsuitable confidantes. In addition,

students were aware of tensions in the relationships between the nursing school and the hospital nursing service and did not want to appear partisan.

Taylor Ward had the reputation amongst students of thorough teaching. This can be explained by attitudes of the trained staff towards learners, as well as the way in which the ward was managed. Student nurses suggested that the higher staff/ patient ratio (and consequent lower work load) facilitated better teaching conditions as well as opportunities to spend more time with patients. The trained staff were reputed and reported to be willing to demonstrate procedures as well as work alongside students.

N You learn things better and you've got more support.
(Second year ; second (group) interview)

During the first and third management periods most nurses commented that Taylor Ward was exemplary in the way in which they were able to put into practice principles of good nursing taught to them by the nursing school. The opportunities to consolidate "good nursing" skills outweighed any negative features of the ward.

Many students particularly firstwarders, however, expressed concern that unlike their setmates on other medical wards, the absence of hi-tech medicine meant few opportunities to learn essential nursing techniques, such as bandaging, dressings, putting up drips etc. Third year students observed that they were assigned the heavier patients, who were very time consuming, and hence had relatively little opportunity to acquire their

managerial experience which was the primary purpose of the third year "medical" allocation.

Hence some students found the discrepancy between their quest to do both "good nursing" (see below) and acquire the relevant technical skills problematic. This issue is explored in Chapter Seven.

d) Nurses were encouraged to practise good nursing

Acclimatisation to Taylor Ward was facilitated by a compatibility between ward policy and the nurses' worldview insofar as nurses did not experience conflict between what they believed they ought to do for patients (i.e. what they had been taught to do), and what they could put into practice within the confines of their job on the ward (cf. Melia 1987). Nurses did not feel that they were compromising their ideals of "good nursing" (as described in Chapter Four), nor coming into conflict with nursing management in order to fulfill their ideals. Good nursing was practised on Taylor Ward. This included providing patients routinely with services often regarded as additional niceties on other wards; for example mouth washes were normal practice on this ward. Nurses were expected to meet all the needs of the patients, regardless of the nursing components thereof. They were encouraged to have feelings of humanity and empathise with patients. This was not inconsistent with the view that nurses should not become overinvolved with patients.

Nurses were enabled to develop close relationships with patients because they had limited access to information about their conditions. The rules of behaviour which clarified the boundaries of acceptable behaviour and nursing practice will be discussed in the following section.

SECTION TWO: RULES OF BEHAVIOUR FOR NURSES WORKING ON TAYLOR WARD

Nurses in this study did not appear to manifest the expected signs of distress. This section seeks to explain the methods of social control over nurses by examining the process through which nurses learned to interact with patients. Interactions with patients were prescribed through a set of rules, some of which resembled those nurses had encountered previously, and others which may be seen to be unique to this ward. These rules were conveyed to nurses in a positive way, rather than purely in the form of sanction (See discussion of ward report in Chapter Seven).

When nurses first entered the ward they did not have a homogeneous view of what was expected of them there, both in terms of work and in terms of comportment. Their impressions of appropriate professional demeanour were a mixture of lay views, views expounded in the nursing school, and the behaviour of qualified staff in wards where they had worked previously. From their first visit to the ward, nurses looked for clues and cues relating to acceptable nurse/patient, nurse/relative, nurse/nurse and nurse/doctor interaction.

How were the rules conveyed?

The rules of behaviour were conveyed to nurses, overtly and covertly at ward report and reinforced during work on the ward itself. Ward report as a forum for conveying ward culture is discussed more fully in Chapter Seven. Certain rules which became apparent during ward report are relevant for this discussion. Chapter Four illustrated how nurses were expected to ascertain and respond to all aspects of patients' needs. These expectations were made explicit to nurses during ward report.

On Taylor Ward, student nurses usually were assigned to patients in pairs, (each student having ultimate responsibility for half of the group of patients) with one nurse of lower rank, the other a comparative veteran on the ward! This across rank interaction enabled nurses to learn how nursing was done on Taylor ward and gave nurses a sense of being supported by their peers and superiors. This is in contrast to Trygstad's study (1986) where nurses reported little work satisfaction which she related to minimal contact with peers. Cross rank help was one aspect of nursing practice on Taylor Ward which nurses felt was unusual and enhanced their experiences on the ward. Working with a colleague reduced the anxiety reported by Menzies (1959) that nurses reputedly worry about performing unfamiliar tasks incorrectly and consequently inviting reprimand. It also reduced nurses' emotional isolation (Bond 1982) in that nurses could share their feelings with their partner. Similar findings were reported many years ago by Whyte (1946) who studied human relations in the restaurant industry during wartime; he identified social support as a crucial factor which enabled waitresses to maintain an emotional equilibrium: when waitresses worked in pairs they were less likely to cry or express other emotions towards the customers (further similarities between his findings and this study are elaborated further on in this section).

Through observing activities on the ward itself, nurses were able to ascertain acceptable patient/nurse and nurse/nurse interaction patterns (Bond 1978 had similar findings). Ward report was another forum where nurses could observe interpersonal relations amongst staff (See Chapter Seven).

Nurses reported a number of examples of how they learned the rules on Taylor Ward. Three examples will be described here. The first relates to the way in which death was handled, how students who were unfamiliar and possibly fearful of corpses observed the **matter of fact but not callous** way in which death was managed on the ward. The second example examines how information about patients was handled and how this was structured to enable nurses to engage with patients, but without becoming overinvolved with them on a personal basis. The third example relates to the ways in which nurses were able to express emotions on the ward. This illustrates how nurses were enabled to show their feelings, were supported to express them and then encouraged to return to complete their work.

The management of death

Death rates were probably no higher on Taylor Ward than on many other medical wards in Suburban Teaching Hospital. Only the more junior student nurses had not encountered death before. Despite this, several nurses entering the ward expressed anxiety about precipitating patients' deaths, finding them dead, and having to lay out bodies.

Patients in the terminal phase and after death were discussed with the same care and concern as other patients. Through discussions on the ward and in ward report, the qualified staff conveyed their concern that patients died "good deaths" and that bodies were delivered safely to the mortuary.

a) Anticipating death

Death was seen to be a normal occurrence on this, a cancer ward. Death rituals were predictable. Glaser and Strauss have documented how nurses predict deterioration and death and plan their work accordingly (1965, 1968). Nurses in this study did likewise. When the nursing staff predicted that the end was near, efforts were made to relocate the patient into a side ward.

N We make an effort if someone is dying, we try to transfer them so that we can nurse them properly without having to bang into things and there's privacy for the relatives to grieve instead of drawing curtains around when there's a corpse there
(Staff nurse; third (individual) interview)

This facilitated round the clock visiting and privacy for the patient and his/her family as well as easy access to the patient for nurses and doctors, both before and after death. As a number of deaths were noisy, messy or disturbing to observe, this was clearly advantageous for the other patients on the ward. Moving dying patients to side wards implied that other patients were less likely to be disturbed (or take note) when death occurred.

Nurses found anticipated deaths much easier to manage both practically and emotionally (see articles in Schoenberg 1972), than unexpected deaths.

b) Death routines

When a patient died, certain procedures were activated. These were taught in the nursing school and mirrored on Taylor Ward - hence no conflict for nurses. This entailed temporarily abandoning regular ward routines in favour of "death activities" (Sudnow 1969).

The task of informing relatives usually fell to the most senior nurse on duty. Relatives, if they were not present on the ward at the time of death, were telephoned from the sister's office. Trained staff acknowledged that they found this task particularly difficult (see discussion in Chapter Seven).

If a death occurred when relatives were en route to the hospital, student nurses were instructed not to grant them access to the patient's room nor furnish them with information. They were told to usher relatives into the sister's office and then summon the most senior nurse. Students talked about these incidents, describing their difficulties in dissuading relatives from going in to the room where the corpse lay. The existence of clearly defined rules regarding behaviour under these circumstances were reassuring to the student nurses: "I knew what to do".

Nurses starting placements on the ward often expressed anxiety about coming into contact with death and in particular laying patients out. Many different societies associate superstitious beliefs with corpses (e.g. Choron 1963) and consequently one can assume that nurses may find laying out traumatic and stressful. In this study those nurses who had never laid out a body before expressed similar anxieties. Their fears about dead patients were not restricted to the process of laying out - they worried about precipitating a patient's death through touching him / her and also were anxious that they might be the first to find a patient dead. By the end of their allocation on Taylor Ward, however, even firstwarders no longer feared dead patients. Indeed seeing their patients dead helped them to accept the reality.

N I think it's difficult to accept that somebody's died if you don't see them in death, yes, because when I was on the ward quite a few patients died and I only saw a few in death and I could accept that they were dead, but some of the other patients, who died when I was off the ward, I just can't accept that they're dead - I **know** that they're dead, but I just can't see them being dead -it sounds a bit strange
(Firstwarder; third (individual) interview)

Nurses described experiences with death on other wards, especially how fearful they had been of laying out. Two third years described how they had "coped" with this fear:-

N1 The only other time I laid anyone out was with you on nights - it was the first time we'd laid anyone out between us so we sort of detached ourselves from the situation by going through the procedure by saying, "this is point one, this is point two, point three" and again we weren't emotionally involved in it (didn't know the patient)
(Third years; second (group) interview)

Within a week of starting work on Taylor Ward, many nurses appeared to become less anxious about laying patients out. Student nurses observed that their peers who had started their placement on Taylor Ward before them, approached laying out in a matter of fact manner and seemed to want to do it. Nurses expressed regret if they were off duty when a patient for whom they had *recently* been responsible died, because they felt that laying out gave them an opportunity to provide the final touch of a good job. Laying out was seen as the legitimate form of saying "good bye" to patients. Where nurses perceived themselves to have had a relationship with a patient, they found laying out was cathartic and enabled them to "do something" with their grief. Laying out a patient properly was part of their concept of good nursing (See Chapter Four). Nurses were disappointed if a patient's religious

affiliation prevented them from laying him / her out.

Laying out was usually done by two student nurses supervised by a trained nurse.

JK What actually happens when somebody dies on the ward?
What do the nurses do?

N (The one in charge takes care of the relatives or phones the relatives). Two students lay the patient out. If there's not a third year there, then a staff nurse lays the patient out with another student; they won't leave two first years or a first year and a second year to do it and then it's either a third year or a staff nurse who takes them down to the mortuary as well; it's very rarely a first year or a second year again - it's quite a shock if you've never done it before.
(Third year; third (individual) interview)

In contrast to Menzies' (1959) study the trained staff acknowledged that at first students might be anxious about this procedure and hence kept a high profile during the process always asking students

N Whether you are alright, whether you can cope, if you need a hand with anything.
(Second year; second (group) interview)

Nurses said that they continued to explain procedures to patients even after death. A third year student describes how a second year nurse reacted to her extensive explanations to the patient during laying out:-

N1 The second year that I was doing it with was quite upset by it - I'm not sure if it was because she was a religious person or whether it was just her nature but she was quite upset - she wouldn't stay in the room with him by herself - if I went to fetch anything she'd come out - she was frightened in there. And she was quite upset - she wouldn't talk to him either - I can't help myself - I mean I would say to him, "I'm just going to turn you", I couldn't break off that quickly in my mind that he was dead so when we turned him to put a sheet under him I would say, by mistake, I suppose, "We're just going to turn you now", and she was upset by that but I

just couldn't shut myself off that quickly so I would say, "We're just going to sit you up now, Mr W." You can't help yourself - she was upset by that and said, "He's dead, you can't talk to him anymore."

JK Did you think she was strange in the way she reacted?

N1 I didn't worry about her - what she did was perfectly normal, just that I myself can't shut myself off that quickly to somebody dying - I suppose - it may be nerves but I just have to talk to patients. It's instilled in us, unconscious patients, you always talk to them - you tell them what you're doing

N2 It depends on your own view of a dead person anyway - my view is that he's still a person lying there and I don't think of it as just a corpse now.....I always talk to them for some reason, a bit of respect as well, they're still a person. As you say it's still instilled into us that when a patient's unconscious and also when a patient dies, the last thing to go is their hearing - hearing is very acute till quite a while after they die, they believe, no one can prove it, but they can still hear for quite a while, which I also think of in the back of my mind as well.

(Third years; second (group) interview)

The quote above represents the views of most of the nurses in this study. "Good nursing" can continue after death, until the nurses no longer have responsibility for the patient.

c) The effect on the ward

Most patients died at night which facilitated minimal disturbance to the ward's routines.

N1 People tend to die at night for some reason, whether it's more peaceful and that but most people tend to die at night

N2 Or very early morning

(Third years; second (group) interview)

Patients who died in a side ward, were taken off the ward and down to the mortuary in the sluice lift. When a patient died in a four bedded ward, nurses closed all the curtains in the room.

- Sr If they're in the ward in the bed, then they're put in the big bathroom
- JK How do you take them out of the bed?
- Sr You draw the curtains around the other patients, and take the whole bed out
(Sister; third (individual) interview)

Those nurses assigned the task of laying out the patient then proceeded to lay him/her out as quietly as possible. When the porters came to collect the body, the ward grew still. Nurses crept about closing the curtains around all the beds on the ward. No explanation for these events was offered to patients.

- N1 They never actually tell the other patients, but you go round closing all the curtains
- N2 The patients very rarely ask if any other patient has died, either. I think they assume that he has died but they never ask do they? (to N1)
- N1 Very rarely, probably more so on this ward but they do the same procedure on every ward
- N2 They draw the curtains down the pathway where the patient's going
(Third years; second (group) interview)

When death occurred during the day all the wardstaff other than those nurses involved in accompanying the body, congregated in the opposite corridor from the projected route of the trolley. The body was placed in the trolley and removed by porters as unobtrusively as possible. No one spoke - the ward remained quiet, out of respect for the patient who died.

- Sr I think it's what you're taught to do, everyone's a little quieter, talks in lowered voices and nobody smiles for an hour, because it's not respectful to go around grinning.
(Sister; second (individual) interview)
- N There is usually an atmosphere in any ward when someone dies, it's as though everyone sort of knows - you tend to be quieter when someone dies
(Third year; third (individual) interview)

The quiet had another function, it enabled nurses to carry out their tasks with minimal emotional contact with their other patients and allowed them time to compose themselves if the death had unnerved them in any way. Slowly the ward returned to its normal pace. Nurses did not discuss the effects of these death routines on the other patients on the ward. It would appear that patients did not question the nurses about who had died or what had happened.

The nurse who had had the final responsibility for the patient then proceeded to sort out the patient's possessions (something which frequently precipitated tears) and prepare the bed for the next patient. The clarity of the routines to be used, the rules to be observed, and the high visibility of senior nurses willing to give practical help or simply give reassurance that they were doing the job well, combined with the knowledge that it was legitimate to "feel" emotions such as grief (see Management of Emotions to follow) enabled nurses to deal with death on this ward.

The management of information

a) Information about patients is carefully regulated

Chapter Two referred to Glaser and Strauss' (1965) definitions of awareness contexts. As Taylor Ward was a regional radiotherapy unit many nurses assumed that as a result of the referral procedure very few patients could be classified as having closed awareness - having no idea that they had a malignant disease.

Nurses also assumed that curious patients would ask the meaning of "oncology" as the ward was labelled "oncology unit".

N All the patients here do know it's a cancer ward even though they don't admit to it
(Third year; second (group) interview)

Despite the notice outside the ward and nurses' assumptions that "most people know that radiotherapy is a form of cancer treatment" nurses noted that a number of patients "didn't seem to know". Nurses suggested that most patients could be described as fitting into the suspected awareness (where they suspected they had a malignancy) or a mutual pretence awareness (where wardstaff and patients both knew that patients knew they had cancer but did not acknowledge this verbally to each other).

N I think they know and we know but none of the two of us actually say it
(Second year; third (individual) interview)

A substantial proportion of patients knew their diagnosis but not their prognosis:-

N It does seem to me that a lot of the ladies know where their primary is - they might know that they have got breast cancer or whatever - a lot of times I've heard well, it's all over, spread to all the bones and a lot of the patients don't seem to know that. I mean Mrs J., she's going to have a pin put probably into her plate because it has just eroded away. I don't think she knows that - she knows she's got cancer of the bronchus, but nothing about it's spread all down her leg and everywhere else - she doesn't know that. There are a few patients that don't know how far they are
(Third year; second (group) interview)

Only a few patients openly acknowledged that they were fully aware of their diagnosis and prognosis (open awareness). Although the

more experienced nurses preferred nursing patients who could be classified as in the "open awareness" category because they saw the other awareness categories as potentially damaging to the trusting relationship they were building up with patients (see discussion in Chapter Four), firstwarders sometimes found that they lacked the communication skills to deal with patients who openly discussed their impending death:-

N2 Mr J is a bit of a hard one at the moment, because he's got something like six months. He said, "I've only got a short while"... and he sits there and says, "I've got cancer in my belly, I can't walk, I've only got about six months to live, I'm going to smoke".... he says, "What's the point in living" and I just don't know what to say. I can't say, "Oh , come on." I say, "You're always moaning" and he goes, "Well, what have you got to moan about?" This sort of thing, he's the only patient I've really found hard - **sometimes I'm really stuck for words**, because he says it quite bluntly and you can't dispute it. He knows he's going to die and he is..... If it's someone that doesn't know, I always go, "Oh come on, you're going to get better, or you'll be out of here soon, or if they're moaning , I'll say, "Oh come on, you'll be walking around in a bit, and I always talk like that in hope - but if he knows, what can you say?
(Firstwarder; second (group) interview; my emphasis)

Only firstwarders on Taylor Ward reported giving patients this type of false reassurance (illustrated in the above quote and frequently reported in the literature).

The issue of whether patients knew their diagnoses only became important for more experienced nurses if patients expressed concern about this (Chapter Four). Many nurses shared patients' limited awareness. This contention will now be substantiated.

Shortly after joining the ward, nurses learned that information was "rationed". Nurses were explicitly told that ward practice forbade the use of notebooks. The trained staff justified this by

suggesting that patients needed to be protected. Some patients had limited knowledge about their conditions and nurses needed to exercise supreme caution in order to avoid inadvertent revelation of information. Students, however, were not expected to be able to recall all the details required for nursing patients discussed during ward report and were encouraged to refer to the nursing notes (Kardex) or approach any trained nurse who would provide them with essential information required to nurse the patient.

Students were told that they should not attempt to answer patients' questions about diagnosis, treatment or prognosis. It was quite legitimate for them as students not to know the answers. They should empathetically establish the nature of these concerns and refer the matter immediately to a superior. The qualified staff, therefore, retained control over what student nurses might reveal to patients at the same time as reassuring these nurses that patients' requests for information would be met.

The way in which Ward Report reflected ward ideology will be discussed further in Chapter Seven. Suffice it to mention here, that students became aware that the medical staff and senior nursing management regarded information about patients as confidential and only passed on to subordinates (and this sometimes included staff nurses) details which they perceived as essential in order to nurse the patient properly.

i) Limiting information protects student nurses from answering patients' questions and proscribes conversation topics

Student nurses concurred with this practice insofar as they

usually believed that they had access to the essential information they required to provide their allocated patients with both nursing service and emotional work.

N We get enough information to know what nursing care they need and then if they turn out not to know anything at all we can sort of say a bit about, like if it were a caesium, explain a bit what sort of treatment they were going to have
(Firstwarder; third (individual) interview)

Students rapidly learned that all aspects of information about patients' degree of knowledge regarding prognosis, treatment or diagnosis were not regarded as their remit on Taylor Ward. At first some nurses resented the fact that they did not know how much patients knew:-

N There's this big secrecy - we don't know who's been told
(Second year; first (group) interview)

When students were privy to information patients requested, they found patients' questioning stressful, and whilst resorting to withdrawal strategies when first on the ward, they gradually learned to respond according to ward practice by notifying their superiors:-

N If you have a difficult situation all you'd have to do is, say, "I've just got something to do, won't be a moment, I'll come back to you" and just rush and ask staff nurse about that.
(Firstwarder; second (group) interview)

After a short time on the ward, students observed that they were protected from the dilemma of whether to impart information if they did not possess the knowledge to answer patients' questions. In other words they saw this control of information as safeguarding them as well as patients.

Students who had worked on other wards shared the view that irrespective of patients' conditions they had to exercise caution when talking to patients about their illness.

N There is this unwritten rule that you don't discuss what's wrong with people
(Second year; first (group) interview)

The process of understanding the rules regarding permissible topics of conversation was fairly rapid. Students joining the ward were apprehensive that patients might pump them for information. At first they reported using similar responses to patients' questions as other studies have revealed - they limited their conversation time and range of topics or even withdrew from questioning patients. The following quote is from the first interview with a firstwarder who had been on the ward a week. Her response reflects the nursing school policy which placed responsibility for providing information firmly in the hands of the doctors:-

N You often have to look back in the book or have to ask a sister because the sisters normally know. But I sort of worm my way round trying not to make them ask me the question, "What is wrong with me?" you know, but if they did ask I'd just say, "see the doctor"
(First warder; second (group) interview).

Students discovered that there were certain situations which they were too inexperienced to handle. For example, if a patient was upset, and might require information, a qualified nurse should be called:-

N I go and see sister or staff nurse and say so and so is being rather upset, you know, I'm not sure what's wrong with her, is it possible for her to talk to the doctors or somebody that knows or is in that position. Because I might know and then something awful happened next or one of the relatives got very distressed about it, then I'd have to cope with that. I think its just for my benefit as much as for anything else that I don't have that responsibility
(Firstwarder; third (individual) interview)

Students new to the ward observed that more experienced nurses did not respond in an abrupt way to patients' questioning. It was important to establish the patients' concerns, whatever their nature. The admission procedure of patients to the ward entailed nurses asking the statutory questions relating to patients' perceptions of the illness which they later noted down on the Kardex. Senior nursing management warned students that patients might persuade them to provide answers and that they should therefore handle questioning carefully. At the same time students should exercise caution and not obstruct patients' questioning as this would damage the trusting relationship they should build up with patients. Thus when patients began to question nurses, they were told to ask the patient what s/he had been told, and by whom, and to take the patient gently through these events. Student nurses should never confirm nor deny information that patients said they had received. The purpose of this strategy was to ascertain whether the patient was genuinely worried and also to reassure him/her that the nurses were concerned. If after this discussion the patient still appeared anxious, a trained nurse would repeat this process and make a decision regarding the disclosure of further information to the patient. In this way, patients' access to information was controlled as well as nurses' behaviour.

Facilitating patients' questions was a technique learned by imitation and experience. As students advanced, they believed that they became more skilled at assessing patients' concerns and levels of awareness without divulging facts themselves:-

N It starts off with the treatment. You know, "What's my treatment about, I've been to so many places and I've had so many different types of treatment and nothing's worked, is this treatment going to work, will the pain go, when will I get better?" And then I say, "What do you mean by getting better?" and then I might say, "What does better mean to you tomorrow?" and then they might say "I'd like to be eating tomorrow", and I'll say, "We'll see what we can do towards that" and then I ask them what they see better as being in the long term and how we can go about that.
(Second year ; second (individual) interview)

Even staff nurses expressed anxiety about imparting information to patients, claiming that without specialised oncology training they did not have adequate communication skills. Unlike nurses in Bond's study (1978) the trained staff on this ward did not falsely reassure patients in an attempt to "avoid problems".

On Taylor Ward, nurses did not use the strategy of "uncertainty" described in many other studies of cancer wards (McIntosh 1977; Bond 1978; Melia 1982). Anxious patients should always be reassured and encouraged that **action** would be taken to resolve their concerns. Avoiding questions or responding to them with "uncertainty", and/or withdrawing from patients, could unsettle them as well as affect the ward atmosphere. A senior member of the nursing staff would resolve the issue when patients wanted information. "Certainty" therefore related to a clear conception on the part of both nurses and patients regarding who controlled information.

In addition to restricting conversation topics with patients directly nurses learned to be cautious when talking to one another in patients' earshot. For example, student nurses described asking trained nurses how certain drugs worked:-

N You have to be careful what you say - this morning I wasn't thinking and the nurse gave a cytotoxic drug and I said to her, "What's that for", and she said, "I'll tell you later"; we couldn't talk about it in the room; the patient knew he had cancer and he knew that the drugs were for the treatment of cancer but we couldn't talk about it in the room in case we upset him.
(Third year; second (group) interview)

Students were thus caught in what might have been a dilemma on other wards of being told explicitly to find out patients' concerns, and implicitly that they should not answer certain categories of question. Students' accounts suggest that patients learned rapidly that students' information was limited but that they could arrange immediately for questions to be answered by a senior member of staff.

ii) Limiting information sets boundaries for interactions between student nurses and relatives

Nursing management recognised the ease with which nurses could (and did, in some instances) identify with patients' relatives. Student nurses were regarded as quite vulnerable to sharing relatives' grief and needed guidelines regarding appropriate behaviour in order to be able to retain the professional dimension and function well.

Consequently students were issued with a number of clear directives concerning behaviour towards relatives. One such guideline regarding announcing a patient's death has already been described (see p 188). Students were instructed to refer questioning relatives to the trained staff. When relatives became very emotional students acknowledged that they lacked the skill to cope:-

N After I had asked a member of staff to talk to him (Husband of patient) about his wife's condition, he came up to me about two hours later and said, "What's the matter with my wife?", and I said, "Weren't you told by another member of staff", and he said, "I was told she was sleeping but she's dying, isn't she?", and he burst into tears and I didn't know how to cope

JK What did you do?

N I went and got someone else who I felt was capable of dealing with the situation

JK Another nurse?

N Yes, because at that moment I couldn't have dealt with it successfully - I could have said, "Yes, she's dying" and tried to explain it, but he was in such a state, I thought I'd just make it worse.

(Firstwarder; third (individual) interview)

The position of relatives with regard to access to information was fairly explicit on Taylor Ward. Medical and nursing management believed that relatives' questions should be answered fully. Sisters perceived disclosing information to relatives as fairly unproblematic.

Relatives were assigned some responsibility regarding what patients were told on the assumption that they knew the patient best and therefore could predict the patient's reaction.

Relatives' wishes were respected unless the sister assessed that a patient's distress would be alleviated by disclosure; she then disclosed some information and notified the relatives thereof.

It appears that senior nursing management were concerned that relatives might prise information from student nurses. Consequently, student nurses were instructed not to reveal details of diagnosis / prognosis to relatives. This directive was all encompassing. For example students were forbidden to give any information to relatives over the phone unless instructed by a trained nurse. Students found this directive helpful:-

N If relatives rang up we were told beforehand that we were never to say anything - it just helped if we found ourselves in a sticky situation.
(Second year; second (group) interview)

A number of nurses criticised the policy of open disclosure to relatives without similar conditions for patients. These issues remained generally unresolved although they accepted the practice and adhered to it.

b) Information about patients is regulated through the medical and nursing hierarchy

Many patients on Taylor Ward were referred from other hospitals. Consequently the medical staff on the ward, including the consultant, often did not know what patients had previously been told or had guessed. When this information **or any other information regarding patients** became a nursing or medical issue, it was wherever possible, discussed amongst the medical team and the sisters who met frequently. Decisions were then made by the

sisters regarding how much information different ranks of nursing staff required. An interview with the relief sister, who questioned this practice, revealed that a number of details regarding patients were carefully filtered before transmission to junior nurses:-

Sr I was having a chat the other day with a doctor and another (qualified) nurse and they were saying that junior nurses shouldn't be told a patient's social problems because they're too immature to cope with (them). ... I disagreed strongly that even if they did that (mocked the patients) they are told right from the start what you're allowed to say and what you're not allowed to say about patients, because if you respect someone you don't go round talking about them really. If you stop them having the information they won't be able to understand why the patient might be terribly upset one day. It's often the junior nurse, the first year nurse that the patient tells. How are you going to get total nursing care if you don't tell them the social problems.
(Sister; second (individual) interview)

Control over information was quite overt, observable during Ward Report. Thus within a short time of entering the ward, nurses discovered that the medical staff and nursing management controlled access to information about patients and that the degree of information given to them depended primarily on their rank.

c) Nurses will be sanctioned if they provide patients or relatives with information without permission

Ward myths abounded relating to previous students who had asked patients how they felt about their cancer. The message is the rule implicit in one of the myths:-

N It has happened on two occasions that first warders

knowing the patient's diagnosis have gone up to them and just generally having a chat with them asked, "How do you feel about your cancer, how does it affect you?" and the patients didn't know they had cancer. Well the patient was very distressed and said "What do you mean, I haven't got cancer, it's not me you're talking about". That's all I heard about it....

JK How did the student nurse feel?

N Well, she wasn't aware that she'd done something wrong

JK Was she told that she'd done something wrong afterwards?

N She was told, yes, but I don't know what her reaction was. I never actually spoke to her, but I know she was told that she shouldn't really go up to people and say "How do you feel about cancer?"

(Third year; second (group) interview)

Nurses new to the ward became aware rapidly that neither the senior nursing staff nor the doctors would tolerate nurses providing information to patients without permission. Such behaviour would result in severe punishment. The trained staff thus conveyed certainty to students regarding disclosure practices:-

SN The doctors would be very cross if a student went round saying, "You've got this and you've got that" when they have no right to, no position to
(Staff nurse; second (group) interview)

This position was confirmed by a student:-

N If I feel I'm getting out of my depth as far as their prognosis or anything goes, then I'll carefully suggest that they should talk to some senior member of staff about it - **I haven't got into any deep water like that at all**
(Second year ; second (individual) interview; my emphasis)

This quote illustrates succinctly that students knew that it was not part of their remit to disclose information to patients.

d) Conclusion

Nurses were provided with what their seniors saw as sufficient information to carry out their jobs efficiently and empathetically. Trained nurses, particularly sisters, were able to ascertain patients' levels of awareness through talking to them. When information issues distressed patients, nurses learned that through their actions it was possible to facilitate disclosure.

Although at first nurses questioned the purpose of such careful control over information, and expressed concern that they might err, they gradually began to see how the system worked to their own advantage, providing them with protection against over-involvement with patients, without denying them the opportunity to practise good nursing.

The management of emotions

Managing emotions in people work or service industries has been extensively researched (Hochschild 1983; Smith 1988a). Whyte (1946) explored this issue when studying the restaurant industry during wartime America. In attempting to explain the phenomenon of "crying waitresses", he suggested that supervisors could implement a number of organisational features to reduce pressures within the job and the likelihood of waitresses breaking down in front of customers and consequently leaving.

a) Do nurses have emotions?

The nursing school of Suburban Teaching implicitly denied that student nurses had emotional needs which could not be met by the

tutor / tutee relationship. For this reason a "social secretary" for student nurses was appointed rather than a counsellor, which had been the alternative considered. The primary task of the social secretary was to assist in arranging the student nurses' leisure time activities (School of Nursing Handbook). Her duties as listed in the handbook clearly precluded counselling homesick or distressed students!

The Director of the Nursing School maintained that should students have emotional problems they could turn to their tutors. Several tutors, however, described incidents where students had broken down on the wards but not turned to them for support. These tutors acknowledging students' emotional needs, regretted that because of the structure of the relationship, student nurses in distress were unlikely to turn to them. This has already been corroborated by students' versions in Chapter Four. The explanation given by tutors suggested that student nurses were anxious not to be labelled and in any way jeopardise their careers.

The Director of the Nursing School talked about the "professional armour" of nurses. This protected them from becoming "involved" with patients. Student nurses believed that the nursing school discouraged "involvement with patients" and frowned upon expressions of emotion at work. This somewhat contributed to their anxiety about working on a cancer ward, where patients whom they nursed intensively might die.

There was no consensus between nurses about perceived policy relating to demonstrations of emotion on hospital wards (as

opposed to the expectations of the nursing school) but they assumed that they were expected to control their emotions at work. Nurses who had broken down on previous wards had been sanctioned (See discussion in Chapter Seven).

The ability to cope in situations of stress was one criterion upon which student nurses were judged during each ward placement. This was consistent with the professional image projected by the nursing school. Professionals do not express their personal feelings to their clients. Such actions would corrode the distance required to maintain professional boundaries.

Consequently nurses (other than firstwarders) had developed strategies on previous wards for masking their feelings (like the crying waitresses in Whyte's (1946) study, nurses at Suburban Teaching learned how to handle their emotions through experience). On occasions when they had felt unable to control themselves, nurses tended to rush into the sluice or the loo until they felt composed. It took some time before they realised that Taylor Ward was tolerant of displays of emotion. Firstwarders, experiencing their first hospital placement, did not express anxiety about their end of placement report and naively assumed that they would not be sanctioned for legitimate expressions of grief or distress:-

N I don't think anyone would think it's off if you were upset about anybody on here. I've never been that upset but if ever I was, I don't think I'd be ashamed of it on here, and I wouldn't expect anybody to think any the less of me because of it. I'd be most annoyed if anybody showed that they were because it's anybody's right to be upset.
(Firstwarder; second interview)

Although the more experienced students gradually became less secretive about their feelings they did not hold homogeneous views regarding their superiors' responses to displays of emotion:-

- N1 We've all been upset but you have to hide it because we've got a report to get at the end of our eight weeks and it does say in that "can control herself in situations of stress" so you've got to just try and hide it.
- N2 No, I wouldn't try and hide it, I'd just go away somewhere and cry - why shouldn't I cry?
- JK So there is quite a lot of emphasis in this nursing school on controlling yourself?
- N's Definitely
- N2 If you were blubbering away in the drug room it would soon come up on your report - I don't think they'd try and understand.
- N3 I think they'd try and understand, try and be nice
- N2 It does depend on the ward. I think it would be more acceptable here and on the leukaemic ward - they expect you to be upset and the staff give you more support.
(Third years; second (group) interview)

Even staff nurses shared the students' uncertainty about the boundaries of permissible behaviour. Nurses were expected to get on with their work and complete it. At the same time it was accepted that some situations were very difficult to handle emotionally and that nurses **occasionally** would be unable to cope:-

- JK What happens when people get upset on a ward like this - how do they control themselves?
- SN2 Sometimes they don't. There was a case yesterday and this particular nurse didn't cope with it and I think it showed itself this morning, she got very irritable and she was in tears towards the end of the morning but we sorted it out and had a chat about it.
- SN1 Everyone is going to react differently but I think on the whole if somebody gets very upset, I mean I wouldn't frown on anybody who got upset, I wouldn't consider them unprofessional. Perhaps it depends on the situation, but I don't see that they shouldn't if that's the way they feel best getting it out of the system; someone like me who tends to bottle things up all the time probably is no better off in the long run. I probably get it out of my system in other ways, take it out on people when I get home or something. I've probably felt like crying and perhaps had to walk out of the room and escape from it rather than facing it.

- SN4 I'm the one who wanted to cry - I was taking his wife to see the patient and I thought SN1 gave me very good advice not to cry and I asked you (SN3) to take over
- SN3 That's right , yes
- SN1 You can share the load, that's true - it's not as if it's just you, well, sometimes there is.
- SN4 On this occasion we both had a cup of tea and a cigarette and sat down and talked about it.
- SN1 You don't have to always be on your own about these sorts of things.
(Staff nurses; second (group) interview)

b) Permissible demonstrations of emotion

Certain expressions of emotion, such as anger, were never acceptable on the ward and subject to sanction. Nurses shared beliefs that professionals did not express anger to colleagues or clients (patients or relatives). This incorporated the view that selfish interests need to be repressed in favour of the professional or collegial image. The superficial impression of empathy and control needed to be maintained. They walked and talked quietly on the ward. It was inappropriate for them to voice conflict.

- SN It's not either expected of you or beneficial to you or the people whom you are looking after. You're not just thinking of yourself while you are here. It might make me feel better by shouting at somebody but it's not going to make them feel any better, it's going to get me into trouble and everyone else involved. You need to control yourself in public and this is where we are , in public, we're on display trying to be professional people, we can't get away from it. That's probably why I didn't like nursing at first because I couldn't really behave how I would normally, but then you learn that you've got to think of other people.
(Staff nurse; third (individual) interview)

Nurses believed that they would be severely sanctioned for outbursts of anger.

Senior nursing staff on Taylor Ward believed that in specific circumstances it was quite reasonable for nurses to show certain

emotions, for example, grief. In fact, they felt that an ability to express emotions reflected a human concern and indicated a level of caring in a nurse that reflected a high calibre professional. A rider, symptomatic of this professionalism was, however, a belief that nurses should not break down in front of patients.

When patients died, nurses felt comfortable expressing their feelings in front of relatives and were permitted to do so as long as other patients were not present. There was a shared understanding amongst nurses that it was acceptable within certain limits to cry in front of relatives:-

N As long as you don't go screaming hysterically on the ward when a patient dies, I mean there's no harm in sort of crying with the relatives, I don't think, as long as you can still be a support to them.
(Third year; second (group) interview)

A second quote from a sister illustrates how trained staff differentiated between behaviour in front of relatives as opposed to patients:-

Sr If nurses were standing (crying) in the midst of the ward that would bother me because that would bring distress to the patient that they didn't understand. If they were sitting with a relative and suddenly started crying with the relative, I think that can be alright in its place. At the same time one of our nurses did cry with the relatives and got very upset because she had cried with the relatives and I said, "Well that's alright but you've got to step back and get on with the practical organisation." You've got to say to them, it's alright to express emotion and relatives often appreciate that you can express that but at the same time you've got to stand back and become professional and say, "I did feel that way but now I've got to get on with it; do what has to be done." So it's alright to cry, but, you're always there in your nurses' role if you like. By that I mean you can't let yourself become the incapable relative. You can't take their place.
(Sister; second (individual) interview)

Despite frequent expressions of emotions with relatives, nurses' emotional involvement with relatives ended when the patient's body left the ward. In contrast to nurses in James' (1986) study, nurses on Taylor ward were not encouraged to attend funerals (although one sister said she had done so in a previous job) or retain social contact with relatives. In contrast to Field's study (1987) the trained staff had no difficulty in disentangling themselves from relatives. They did not ever consider themselves to be emotionally involved. Despite this, nurses were pleased to receive cards and letters expressing relatives' appreciation. This evoked momentary reflection when nurses evaluated their nursing care of the patient.

c) Where could demonstrations of distress take place?

Nurses entering Taylor Ward, assuming that expressions of emotion were discouraged in all wards in the hospital, were surprised to notice that colleagues were sometimes upset "in public" and that the trained staff acknowledged that distress was perfectly "natural". Unlike the trained nurses interviewed by Menzies (1959) who acknowledged to the researcher only, that as students they had experienced distress, trained nurses on this ward reassured distressed students that they as students and now as qualified nurses also experienced similar feelings. The fact that students and trained staff on the ward described incidents where they had broken down in front of nursing superiors to newly arrived students, implied that it was permissible to acknowledge feelings that were part of the normal human repertoire. Nurses were not expected to be "nurses and wear a smile" all the time (Melia 1982).

There were some guidelines regarding how a "distressed" nurse should comport herself. Nurses should absent themselves from patients if they felt on the verge of tears, make sure that another nurse could attend to the patient, if necessary, and then come into the sisters' office and off load. A qualified nurse would make herself available to listen to the nurse and reassure her. Nurses were encouraged to have a cup of tea, a good weep and talk about their feelings. Thereafter they were normally expected to be able to reassert self-control and to return to the ward to complete their day's work. (The ways in which this procedure reflected ward ideology will be developed in Chapter Seven).

d) Expressions of distress should be time limited

Although the trained staff acknowledged that it was healthy to express emotions, they believed that it was in the nurses' interests to set limits. Through enabling nurses to express emotions within certain boundaries nursing management reduced the likelihood of total breakdown from either extreme reaction - no expression of emotion at all, or permission to collapse completely. The following interview with a staff nurse illustrates her belief that nurses need to learn to compose themselves after displays of emotion:-

SN I think to carry out your job professionally and be able to cope with it, you've got to be able to limit the amount you show; I'm not saying you have to totally show nothing but you have to limit it - I don't think it's a bad thing you have to do it.

JK Do you think that by limiting what you show, you learn to feel less?

SN You want to know whether you're still suffering the same

and you can hide it or whether you're not feeling so much. I think you must still feel it - I don't think you can stop feeling it if you've got any humanity at all.. I think you can learn not to show it, I think you can learn to control your emotions and by doing so lessen the traumatic effect....If you do become very emotional about somebody, say a relative upset you when the patient died, in a situation like that if you let your emotions out of control, you're going to suffer far more traumatic feelings. If you can just stop yourself, then I think although you still feel something, you don't feel so bad, you don't get quite the after effects - if you let yourself go, you end up by breaking down. If I broke down, then I would totally have lost control of my emotions and I would feel a ..lot worse for doing that than if I could just control my emotions enough not to show everything I might feel.

(Staff nurse ; third (individual) interview)

e) Responses of other staff to displays of emotion

On each ward nurses had to gauge whether they could comfort colleagues who were upset. These responses reflected nurses perceptions of appropriate behaviour on the ward. If nurses thought that consoling a distressed friend on the ward might aggravate the situation, they endeavoured to accompany the friend into the loos of the neighbouring ward.

On Taylor Ward such action was unnecessary. Nurses reported that both their colleagues and their superiors on the ward were very supportive when they felt distressed. They found most comfort talking to other nurses who could fully understand the situation i.e. worked on the same ward (This finding is similar to Whyte's (1946) crying waitress study).

f) Sanctions for excessive displays of emotion

Prolonged expressions of distress about a patient's death were not acceptable and liable to sanction. Nurses perceived that although the qualified staff were sympathetic and supportive when they were

distressed, they were expected to regain control within the same shift and continue with their work. They usually found this rule helpful:-

N It was just useful to tell Sister why I was upset, but then as soon as that was over, she said, "The thing is, you've got to get back to work because you've got other patients." It wasn't, "You go home now", type of thing "and have a sleep", it was now you've got to get back on the ward and look after your other patients. Which I think is fair enough. In a way I felt that it was fairly therapeutic to have to actually go back to the ward, but I wouldn't have felt happy going back on the ward earlier (Second year; third (individual) interview)

A number of nurses broke down regularly. Only a few were sanctioned. Before sanctioning a nurse her other characteristics were taken into account. Hence a nurse who excelled in certain respects yet was seen as responding too emotionally might not be penalised or categorised as over demonstrative:-

SN There is one nurse who is very sensitive and she cries occasionally but she's really good - she's amazingly good and she is so sensitive towards the patients' needs and towards them. I don't mind when they cry - this particular nurse had cried with her friend - they came into the office and I noticed she had a blotchy face and I asked her what was the matter and she started crying again... we just had a chat in the office and I sent her home early - I just think she had just had such a busy morning the nurse was coming to her days off and had been on that side for quite a long time and it all just wound her up until in fact she started to cry.
(Staff nurse; third (individual) interview)

Nurses believed that if they showed that distress incapacitated them indefinitely (for more than a shift, for example) this might result in a criticism on their placement report. Most accounts of nurses who frequently demonstrated emotion and were unable to complete their work took place during the unstable management period. This period will be discussed in Chapter Seven.

The question of suitability for work on Taylor Ward was raised in the nursing school when assessing firstwarders for their first hospital placements. Taylor Ward was one of several which provided nursing students with medical training. The nursing school, however, viewing Taylor as particularly stressful for nurses, claimed that they selected, rather than allocating on a random basis, firstwarders for Taylor Ward on the basis of previous (voluntary or paid) nursing experience and on grounds of maturity ("more settled"). During this study, however, the firstwarders on Taylor Ward had alphabetically consecutive names, suggesting that this policy was not always implemented (This was confirmed by the tutors who had selected the students for this ward). There was no policy regarding the allocation of second or third year students to Taylor Ward - they simply followed the line to which they had been assigned.

A number of trained staff talked about nurses whose emotional make-up was regarded as unsuitable for this ward. These included nurses who were over-sensitive, and who found the empathy rather than sympathy practice difficult to carry out i.e. nurses who tended to identify strongly with patients or relatives. From the description of her interview for the job, the sister revealed that trained staff who felt unable to conform to the disclosure practices were unlikely to be appointed.

g) Conclusion

Expressions of distress on a hospital ward can unsettle the ward atmosphere as well as impose pressure on other members of staff who may have to shoulder the responsibilities of the distressed

nurse as well as their own. For these reasons it was important for nurse managers on Taylor Ward to create a socially supportive environment where emotions could be expressed, yet within certain boundaries. The system of creating a supportive peer group and a sense of integration onto the ward (see Chapter Seven) facilitated rapid response to nurses' distress.

Through observation of other students and their own experiences of responses to expressing emotion, students developed a shared understanding of what was allowed on Taylor Ward. This unverbaliised understanding of acceptable behaviour mirrored the views of qualified nurses. Nurses thus came to believe that qualified staff tolerated certain expressions of emotion within the boundaries discussed above. Qualified staff responded to demonstrations of emotion by reassuring students through words and actions, that feelings of grief and despair were understandable and permissible as long as they were able to compose themselves after a period of time and return to complete their work. Uncertainties about the acceptability of expressing emotions that arose during an unstable management period will be discussed in Chapter Seven.

Conclusion to Rules of Behaviour

I have used the examples of the management of death, the management of information and the management of emotion to illustrate some of the organisational mechanisms by which Taylor Ward was supportive to nurses hence earning its reputation as a good ward.

The rules of behaviour facilitated good nursing practice and offered protection from potential breakdown rather than sanction for nurses working on the ward. A cycle of mutual support within a framework of limited knowledge and clear boundaries, enabled nurses to fulfill their ideals of good nursing practice whilst working on Taylor Ward.

SECTION THREE : NURSES' VIEWS ON ADDITIONAL SUPPORT NEEDED

Leisure as tension-releasing

This chapter commenced with the assertion that nurses' concepts of support were at variance with accounts of other nurses working on cancer wards. Nurses' perceptions of support were usually linked to a well managed ward with supportive, non-punitive qualified staff. It is relevant however to point out, that when questioned about support needs, a number of nurses suggested that they lacked good leisure facilities and that improved opportunities for leisure would enable them to "work off" their tensions in a physical sense. Similar findings were reported by Baldwin (1981).

A number of nurses used the hospital swimming pool before or after work. Others suggested that better sports facilities were required proposing a gym with an attending physiotherapist (for back problems characteristic of nurses). Nurses' emphasis on leisure as providing support can be seen to be part of the same belief system which led to the appointment of the social secretary in the School of Nursing. The statement of her duties includes arranging sporting fixtures with other nursing schools, in addition to planning parties, theatre outings and suchlike.

Students regarded the provision of leisure time as crucial to coping. Third year students felt that impending examinations greatly reduced their leisure time and consequently made them vulnerable to stress. They suggested that reduced ward responsibilities during the pre-examination period would be a supportive measure.

The concept of psychological support

Although nurses understood what I meant as support, i.e. in a psychological sense, many felt that this was inappropriate. A great deal of suspicion surrounded psychology and psychologists. Some nurses reported that they absented themselves from psychology classes in the nursing school.

Those nurses who viewed the concept of support positively were divided regarding how it would best work on Taylor Ward. Some students who assumed that trained staff aired their personal feelings at the Social meeting, wondered whether they could participate there.

Student nurses who had worked on geriatric or psychiatric wards were positive about the concept of outside "counselling". They had found group discussions within the context of work (similar to Baider and Porath 1981) helpful and would have found it beneficial, but not essential to their functioning, on this ward. Nurses who had not experienced this were hostile to the idea.

A number of trained nurses felt that they had benefited from a structured support group to discuss feelings during previous placements or at other hospitals. This included the newly appointed sister who at first interview expressed her intention to start such a group; the quote below illustrates how having tried this once, she acknowledged at the second interview that this form of support group would not necessarily work on Taylor Ward.

Sr One day things on the ward were pretty heavygoing and we decided to all sit down and discuss the ward and how we're coping and how we're handling certain situations and what we did was we sat down to have this discussion but we went right off at a tangent, we had an absolute laugh about something that was totally irrelevant, we just had a real sort of good laugh, nothing to do with the ward and afterwards I said to the doctors and trained nurses that were there, that didn't really work out as it was supposed to, we were really supposed to be talking about how we felt and our problems and we all agreed that what we really wanted, all we needed was to sort of sit down as a group **and know that we were all finding it difficult, we had acknowledged that...**
(Sister; second (individual) interview)

Conclusion - the concept of structural support

Nurses viewed the structure of Taylor Ward as supportive. This reflected a belief that when individuals flagged, the structure of the ward would repond in aid. Hence nurses envisaged response to need as it arose as more appropriate than organised support:-

N I think a group would have seemed strained. I think if you want to talk about something it must be spontaneous. I think organising something like that would be a total waste of time because I don't think you're letting your feelings show really. I think setting aside a certain time like that is creating an artificial situation. I think if you want to talk about something, you talk about it whether it's to other members of staff or to friends.
(Firstwarder; third (individual) interview)

SN If one was going to have counselling sessions every Wednesday from 2-3, a) nurses might not feel perplexed by anything anyway and b) we might be too busy, so it should be, I think, spontaneous.
(Staff nurse; third (individual) interview)

In contrast to nurses in Bond's study (1978), most nurses discussed their "problems" with their peers and found this cathartic:-

Sr I've got the two sisters to talk to .. I would talk to them and all the qualified staff should support each other

(Sister; first (individual) interview)

N I think you have to go and talk it out with somebody; we seem to discuss things, don't we, if anything's happened on the ward, we get together and have a little chinwag about it

(Firstwarder; second (group) interview)

N Depends what it is, if it's about another student then I'd probably talk to (setmate), if it's generally about the ward, then any student

(Third year; first (group) interview)

Sr You identify people who are good listeners

(Sister; second (individual) interview)

The concept of seeking support amongst their other networks also prevailed. Some nurses (a minority) spoke to their boyfriends, parents or flatmates about work issues that troubled them. Alternatively nurses suggested that they compartmentalised work issues separately from their private lives. They suggested that they found the distraction of their private lives very therapeutic. Nurses were quite clear that they did not want to be forced to discuss their feelings with colleagues or superiors.

The Terminal Support Team

Several months prior to commencing the study Suburban Teaching Hospital had introduced a Terminal Support Team to facilitate care in the community of terminally ill patients who had been in-patients in the hospital. This Team consisted of four nurses, a part-time doctor and a part-time social worker. A substantial proportion of patients referred to the team came from Taylor Ward, hence members of the support team were frequently preparing patients on the ward for discharge. Several nurses, particularly

the trained staff, availed themselves of opportunities to enlist support from members of this team. The existence of such a team is important to this study because it signifies that the hospital management acknowledged that the needs of terminally ill patients differed from those of other in-patients in the hospital.

CONCLUSION

Chapters Four and Five have concentrated primarily on nurses' accounts of working on Taylor Ward during stable management periods (first and third). Stable management with a congruent worldview to that of the majority of the nurses created an atmosphere on Taylor Ward which nurses perceived as supportive. Although some nurses experienced support on an individual basis, most saw the organisation of the ward as the basis of support. Staff / patient ratios were kept high; the trained staff were friendly and apparently derived satisfaction from their work. Nursing work was well - organised with clear directives regarding expectations of students. Students perceived a congruence between the nursing school's version and the ward's implementation of nursing (cf Melia 1987).

Although ultimate responsibility for patients lay with the medical staff, medical and nursing staff worked together as a team, with senior nurses willing to confront doctors on issues that challenged their views of good nursing.

Like all nurses joining wards, nurses had to learn the rules (Melia 1987). Conflicts for nurses were reduced because nurses perceived that these rules both protected patients (whom they saw as their main priority) and themselves. Issues such as disclosure and management of emotions did not constrain nurses as they might have anticipated. On the contrary, nurses observed that patients who clearly wanted information had access to this, and that nursing management perceived that good nursing inevitably evoked emotional responses in nurses. Student nurses developed a shared

understanding of what was permitted on Taylor ward. This unverbaliised perception of acceptable behaviour mirrored the views of qualified nurses.

Nurses viewed the organisational support provided for them by the ward with its clearly defined boundaries as helpful and not oppressive nor overtly punitive. This perception of support obviated the necessity for counselling.

Thus for most nurses, working during the stable management periods (one and three) the concept of additional emotional support seemed superfluous. The middle management period, however, presented a conflict for nurses between their worldview, derived from their view of good nursing, and nursing as practised on the ward. Chapter Six, in looking at Care and Context, explores the literature which explains the assumptions underlying the worldview of these nurses. Chapter Seven analyses what happened when nurses perceived a discrepancy between ideology and setting.

CHAPTER SIX

LITERATURE REVIEW TWO : CARE AND CONTEXT IN NURSING CANCER PATIENTS

INTRODUCTION

The previous two chapters have demonstrated that the concerns of nurses in this study related to whether or not they were facilitated to provide "good nursing care" on a "good ward" rather than issues of stress and support as discussed in Chapter Two. Instead of emphasising the nature of patients' illnesses, or stress relating to the disclosure issue, nurses spoke about "caring" and good nursing practice and linked these to developments in the nursing world, in particular the nursing process. It is possible that this study, taking place during a turbulent period in nursing, when questions about its right to professional status were being publicly discussed, reflects some of these issues in the nurses' accounts. It is relevant, therefore, to look once again at the literature, specifically at the origins of the nursing process and the effect that changes in the nursing world have had on inter-disciplinary relationships in order to understand what nurses in this study meant by nursing care and caring.

The fact that nurses in this study spoke about "nursing care" is of interest in itself. As we have seen in Chapter Four good nursing care is central to their ideology, but is not analysed by them. I therefore need to exercise caution in using the word "care". Chapter One identified confusion in the use of nursing terms and explained the reasons for the terms used in this thesis.

This chapter is about the origins and interpretations of "nursing care" in a number of contexts (historical, social, and physical). Section One presents an historical overview of "nursing ideology". This examines the development of "nursing ideology" since nursing constituted itself as a discrete profession. In particular, it examines current debates surrounding the nursing process, attempting to analyse the beliefs that underpinned it, the reasons for the enthusiasm with which it was adopted and the flaws which may explain the lack of universal acceptance of the nursing process. The nursing process as a professionalising strategy will be discussed.

Section Two looks at how caring can be seen to be part of nursing ideology. This section examines the differences between care and cure, including power and gender associations as well as important distinctions within the concept of caring. The place of these different aspects of caring within nursing is assessed with reference to previous studies. The interplay between science and caring is discussed with particular reference to feminist arguments. This section concludes by identifying the complexities of the concept of caring and therefore the difficulties in constructing a conceptualisation thereof.

Section Three looks at the field of terminal care. The perspectives of the various parties concerned with caring for the terminally ill are presented, assessing the balance between the emotional work and the technical service required. The ideologies of the different healthworkers looking after the dying are examined. The place of terminal care in medical and nurse training is assessed, with an emphasis on how this fits into the

prevailing medical model. Attitudes towards dying patients as well as ethical issues will be discussed.

Section Four looks at the contexts in which terminal patients are looked after. The traditional emphasis on curative care will be contrasted with the modern alternatives of hospice and domiciliary services.

The conclusion pulls together the strands of the chapter by looking at how current "nursing ideology" relates, if at all, to terminal care. It will be argued that terminal care can be one area where nurses are able to do good nursing, and can make a statement regarding their distinctly different ideology from that of their medical colleagues, that looking after the dying should not be regarded as a nursing failure but as a nursing strength. As nursing does not operate independently of other disciplines, in order for good nursing to be possible, certain conditions are necessary to implement these ideals.

SECTION ONE : A HISTORICAL OVERVIEW OF NURSING IDEOLOGY

Nursing ideology from Nightingale to the 1950's

Conventional views of nursing history (see discussion by Davies 1980) implying that nursing "began" with Florence Nightingale have been challenged with more recent studies suggesting that the traditional focus on individuals, or on the chronology of events, sublimates the "everyday practice of nursing, of its working arrangements in relation to itself and to the wider organisation of the hospital" (Williams 1980 p 73). Traditional histories omitted descriptions of how nurses perceived their work and accounts of what nurses actually did. Williams (1980) suggests that the standard histories of nursing must also be seen to represent the occupational interests of the authors who were usually doctors or nurses.

The way in which nurses conceptualise their work per se and its relation to other workers in the health services has emerged in this thesis as a crucial determinant of how nurses experienced working on different wards. This suggests that there may be considerable discrepancy between nurses' perceptions of what they do and lay perceptions of nursing. Hence it is relevant to look at studies which have attempted to re-examine the history of nursing using socio-dynamic techniques in order to understand the background to the perceptions of nursing held by nurses in this study.

Modern British nursing reflects the heterogeneous class origins of nursing pioneers (e.g. Smith 1988a). Historical analyses of nurses'

backgrounds have suggested that pre - Nightingale nurses (i.e. untrained nurses) were from domestic servant classes (Abel-Smith 1960). Despite subsequent criticisms of the skills of these nurses,

Some of the nurses were of the best type of woman - clever, dutiful, cheerful and kind, endowed above all with that motherliness of nature which is the most precious attribute of a nurse. (Miss Pringle in "Nurses and Doctors" Edinburgh Medical Journal May 1880 p 1049 quoted in Abel-Smith 1960 p 5)

In the mid nineteenth century opportunities for paid work for the higher class woman were scarce. By insisting upon training and proper pay procedures for nurses (which might be seen one of her main contributions to nursing) Nightingale enabled upper class women to enter an occupation hitherto populated by "lower class" women. Her primary concern was related to improving standards of hygiene on the wards. This enabled her to gain respectability from both the scientific (medical) and the non-scientific worlds (Carpenter 1977).

The origins of modern nursing were based on a different model of health and illness from that of the medical profession. The nursing model was based on environmental factors whereas the medical model was based on healing. Nursing became identified with the ideology of hygiene, rather than defined by the specific tasks nurses were undertaking. The implementation of these principles implied "controlling rather than indulging patients in the interests of hygiene" (Carpenter 1977 p 67).

The establishment of nursing as a legitimate occupation can be seen as a unique instance where women designed and established a career for themselves within a health care process which was

already dominated by men (Garmarnikow 1978). Garmarnikow suggests that because the sexual division of labour cut across class boundaries, it should be seen as patriarchal rather than rooted in class or capitalist divisions. Other analyses (e.g. Carpenter 1977) maintain that nursing simply mirrored Victorian society with the educated upper class nurses at the top of the nursing hierarchy. At the same time all nurses, being women, were subordinated to the male dominated medical profession.

The image of the characteristics of a good nurse, (see Miss Pringle above) persisted even after the introduction of nurse training. Nightingale's nurse was synonymous with the good woman. This model, based on moral character, was replaced with that of the woman's skills from her work in the family. The nurse was equivalent to the mother, the doctor to the father and the patient to the child. The nurse was seen to be "caring" for the sick, aiming primarily to prevent the conditions which might endanger the health of the population - in other words "the individualised arm of the public health movement" (Dunlop 1986 p 663). Nurses' adherence to the ideology of hygiene persisted till the end of the nineteenth century. Nursing continued to be seen as work for women but the reasons for their qualification had altered slightly - their femininity, mothering and housekeeping skills replaced the good woman = good nurse image (Carpenter 1977; Garmarnikow 1978). Thus women's suitability for nursing now related to her skills, rather than her moral character. "Care" in the public domain was seen to be linked with "love" in the private domain. Nurses were expected to understand and accede to patients' views of appropriate nursing responses (Dunlop 1986).

The medical profession in the mid-nineteenth century was struggling to establish itself as the primary healer competing with traditional healers, both male and female. Trained nurses, by virtue of their higher class status, posed a threat to the medical profession (Oakley 1984). The roles of doctors and nurses were constantly being redefined and changing in content. Nightingale in today's terms might be seen as having encouraged holistic care with her "nursing the room" dictat which entailed a fair amount of domestic work. As the doctors increasingly took on technical tasks, they were willing to cede certain activities to trained nurses. In turn nurses then transferred some of those domestic tasks not directly relating to patient care (encompassed in "nursing the room") to non-nurses - an action sanctioned by the medical profession. Under the supervision of trained nurses, domestics were allocated tasks relating to "hygiene", which hitherto had been the unifying thread in nursing (Carpenter 1977). Nurses took on responsibilities not related to sanitary concepts. Indeed it would appear that their perception of what trained nurses did was changing. In addition trained nurses handed over to untrained staff bedside care which they defined as simple work and not requiring training (Dickinson 1982). Patients were still defined by medical criteria but the nature of nursing became unclear. Despite changes in the way nursing work evolved, the medical profession retained control over nursing.

Nurses at the beginning of the twentieth century did not see themselves in competition with the medical profession; it would appear that they simply accepted the subordinate role acting out the obedient model demanded by Nightingale :-

A nurse should never diagnose. When required she should report clearly and concisely upon the symptoms she has been able to witness, but she should stop there. A nurse who realises her part of the work may be of invaluable service to the doctor and patientwe nurses are and never will be anything but the servants of doctors and good faithful servants we should be, happy in our dependence which helps to accomplish great deeds. (Hospital 7th April 1906 p 11 quote in Garmarnikow 1978 p 108.)

This contrasts with the assertive model as envisaged by Oakley (1986). Representing the feminist position she (1984) describes how until the 1930's and 1940's the "feminine environmental" model of nursing was retained. Nurses still linked "care" and "love" but were encouraged to act as if they were the one who loved the patient (Dunlop 1986). Dunlop explains the importance of the "as if":-

The "as if" is important in marking a transition from the "love" of the private domain to the "caring" (in the emergent sense) of the public domain. It is also suggestive of the way that nursing retained the linkage of the private domain between "care" and "love" (Dunlop 1986 p663)

By the mid twentieth century medical science had incorporated significant scientific and technological developments and nurses had become identified with the curative - technological model of medicine. Their position vis a vis the medical profession was clearly subordinate resembling that of other ancillary health workers who supported the curative medical version. Power rested in the hands of the highest paid worker, the doctor, sanctioned by the state. The medical profession consequently determined the nature of the work undertaken by the occupations subordinate to them (Oakley 1984).

Throughout their history, nurses have been receptive to changes in work content. This pattern continued with nurses absorbing more technical responsibilities in response to medical innovations, and

untrained staff were allocated basic nursing care which had become split into clearly defined tasks (Dickinson 1982). By the mid - twentieth century, British nursing had become very fragmented with different grades of nurses performing different functions - a task allocation method of organising nursing work.

In summary: Nursing ideology as it appears during the latter part of the nineteenth century moved from a clear statement that nursing was about ensuring standards of hygiene amongst both the sick and the wider society to a closer identification with medical ideology. As nurses slotted into a position subordinate to doctors, as their handmaidens, and acquired more technical expertise, they also indicated that "caring" did not have to be taught, by assigning this to untrained nurses. They therefore gave up the two areas in which they hitherto could claim their own spheres of expertise, that of hygiene and that of caring.

Changes in nursing work and in nursing ideology had evolved gradually. By the nineteen - sixties there was no clear statement of what nurses believed possibly because few studies explored nurses attitudes and beliefs. The perspective from the 1980's is that by the 1960's most nursing work had become task oriented with patients referred to as diseases or bed numbers, and individual nurses being allocated specific tasks to complete during their shifts. Some studies report situations where patient / nurse communication was limited preventing nurses from developing close relationships with individual patients (e.g.Menzies Lyth 1988). The "ideologies" of the past (hygiene and "caring") had been eroded through scientific advancement, and nursing had not responded with alternatives. "Basic nursing" was low status and

relegated to the least qualified.

Nurses began to voice some discontentment with the rather nebulous and/or conflicting views of what nursing was about, and expressed dissatisfaction with contemporary nursing work (de la Cuesta 1983):

The principle themes of discontent were: a rejection of a task oriented approach to nursing, the lack of individualised care, the low level of nurses' job satisfaction and the superficial nature of the nurse - patient relationship. (de la Cuesta 1983 p367)

The nursing world reacted with a number of responses to these themes, the most important being the nursing process. This caught the imagination of nurses and has continued to be a major force in nursing to the extent that unless textbooks present the nursing process as the pivotal feature, they have become unmarketable (Hardy and Engel 1987).

What is the nursing process?

Hall, in the USA coined the term "the nursing process" (Kozier and Erb 1988) and hence the content of the nursing process can be seen as shaped by the American context (de la Cuesta 1983). In the 1970's, British nursing rhetoric embraced this concept and adapted it to local conditions (ibid). The British version of the nursing process has been difficult to define, an interesting problem in itself. Various attempts at analysing the nursing process have proposed it as a theory, an ideology or a method (Miller 1985a). A commission of senior nurses admitted difficulties in defining the nursing process on the grounds that "the nursing process is nursing" (Castledine 1987).

Despite difficulties in conceptualising the nursing process, the Nursing Research Liaison Group agreed upon a definition:-

The nursing process is a planned, systematic approach to the care of the individual patient or client (Castledine ibid p 8).

A number of other studies support the above interpretation of the nursing process as a method of organising nursing work (de la Cuesta 1983; Aggleton and Chalmers 1986; Hardy and Engel 1987; Kozier and Erb 1988; Smith 1988a,b). An overview of the purposes and activities of the Nursing Process reinforce this view by describing it as a five step nursing procedure:- assessment, analysis, planning, implementation, and evaluation (Kozier and Erb 1988). Yura and Walsh (1983), the authors of a textbook on the Nursing Process and widely quoted as the authorities on the subject describe it as :-

an orderly, systematic manner of determining the client's problems, making plans to solve them, initiating the plan or assigning others to implement it and evaluating the extent to which the plan was effective in resolving the problems identified (quoted in Miller 1985a p36)

Smith (1988b) in a recent analysis of the content of nurse training found that student nurses conceptualised the nursing process as

a work method rather than in conceptual terms related to its underlying framework of living activities, communication and affective/psychological patient care. (Smith 1988b p22)

That the nursing process contains beliefs, concepts, theories as well as methods is not disputed. (The extrapolation of these beliefs into a nursing ideology replacing the predominating medical concepts is questioned by Smith (1988b) and others). For example Miller (1985b) suggests that although nursing process

theory contains methods, it also contains implicit beliefs about nurses, nursing and patients. Castledine (1987) talks about concepts rather than beliefs. Correct use of the nursing process should involve the following concepts:-

providing each patient with individual **care** of a high standard acceptable to both the patient and the nurse communicating effectively with, and involving both the patient and his family in his **nursing care**;
maintaining continuity of **care** between members of the nursing team;
communicating effectively with other colleagues (both with **carers** and other concerned professionals);
providing a clear written record of **nursing care** (for professional and legal purposes);
developing effective methods of evaluating **care**
(Castledine 1987 p8 - my emphases)

The above quote indicates two hallmarks of the nursing process pertinent to this study - firstly , the expectations that nursing should incorporate a written and explicit element describing how it should be implemented for each individual patient. Secondly the multiple and ambiguous ways in which "care", "nursing care" and "carers" are used. Most statements about the nursing process emphasise the centrality of care; but how do nurses conceptualise "care"?

The concept of "care" is central to the nursing process, but the meaning is confused. Sometimes care is used to mean work or service, in other treatises it is used to imply some emotion. The ways in which nursing process documents use the term will be unpacked using the strategy of replacing the term "care" wherever possible for the rest of the chapter and substituting the terms delineated in Chapter One (See further discussion about concepts of care in Section Two).

The development of the nursing process

The nursing process was greeted initially with great enthusiasm on both sides of the Atlantic and despite undergoing a number of transformations both in the US and the UK remains popular amongst nurses. As mentioned above, the concept is rather woolly, however, and confusion regarding what it is, is historically in keeping with nursing ideology. Therefore the questions relate to why nurses were so keen to adopt "their own" ideology.

The RCN implicitly sanctioned the Nursing Process in a discussion document proposing that it should be used as a framework for nursing practice and education. The General Nursing Council issued a statement in 1977 supporting the nursing process:-

It is suggested that the concept of the nursing process provides a unified thread to the study of patient care and a helpful framework of nursing practice (quoted in Basford 1987)

Despite sustained enthusiasm the nursing process was not implemented in its original form in the US nor the UK neither with regard to the "care" ideology it expounded, nor in relation to the practical elements. Explanations for the non-implementation of the original Nursing Process abound (e.g. de la Cuesta 1983, Basford 1987). These relate both to idealised expectations of what nurses could do within the confined frameworks of their jobs and to the nature of the nursing process theory.

In brief, nursing histories and "care plans" (the sheet where nursing priorities for individual patients are set out) did not fulfill the function for which they were intended, in that they

emphasised the physical or medical orientation and were based on medical rather than nursing diagnoses (de la Cuesta 1983). Nurses viewed care plans as potential sources of sanction and control and were uncertain how to use them. With regard to the "new" ideology of "care", nurses found that "care" even in the individualised or holistic sense was hindered by ward structure and hospital routines (de la Cuesta 1983). For example the introduction of the nursing process did not lead to a re-organisation of nurses' shifts but expected them to integrate the new concepts into an old job, and existing system. Nursing process theory had placed greater emphasis on routine physical care than on new nursing roles. This, coupled with the possibility that nurses find it difficult to conceptualise a ward without routines, meant that the ideology of individualised and holistic care became secondary to that of maintaining the equilibrium on the ward (de la Cuesta 1983).

Flaws inherent in the nursing process

The practical implementation of the nursing process superficially resembles certain aspects of medical care, for example using the term "diagnosis". Nurse leaders, (e.g. Castledine 1985) endorsed the scientific components of the nursing process emphasising that care plans should demonstrate that prescribed nursing care is supported with research and/or scientific data. This imposed an academic veneer on nurses whose training had been primarily practical. Yet instructing student nurses in the use of careplans has not been integrated into nurse training ; nurses often confront them for the first time on the wards (Smith 1988a).

Hardy and Engel (1987) suggest that careplans, nursing histories and data evaluations were incorporated into the Nursing Process because nurses were assumed to lack problem solving skills. Through these procedures nurses are expected to analyse certain aspects of work with patients, but not taught how to re-integrate this information. The nursing process can therefore be seen to adhere to a mechanistic model. This interpretation views the nursing process as paradoxically inhibiting nurses' creativity in designing individually tailored nursing plans (ibid).

The nursing process emphasises the provision of holistic and individualised care as well as suggesting that patients should be involved in their own care. This assumes that nurses possess interpersonal skills:-

We failed to identify the skills required to implement this method of care and the theory behind the concept. Had we done so we would have realised nurse's deficiency in one particular area - communication skills (Basford 19 p24)

Questions are still asked of the Nursing Process - is it indeed a useful decision making approach or might other approaches, for examples, a systems approach, be more appropriate for nursing ? Despite the arguments, the RCN both implicitly and explicitly endorses its implementation and has produced booklets to

take nurses through the concept by identifying areas of conflict and trying to resolve them.....looks into the everyday difficulties of the introduction and use of the nursing process (RCN 1986)

The considerable backing to the Nursing Process from the nursing establishment has thrust it into many nursing settings, with varied success and a great diversity of implementations (Fretwell

1985; Walton 1986; Field 1987; Smith 1988a). Consequently most learners hold unclear views of the nursing process reflecting the confusion surrounding it (Walton 1986) and diversities in practice and theory. Findings from this study, however, suggested that student nurses had some perception of nursing process principles.

The rapid introduction of the Nursing Process gave rise to another debate. This concerned the extent to which the nursing process was a smokescreen for nurses' professionalisation goals (Mitchell 1984; Walton 1986). De la Cuesta (1983) notes that in the USA, the nursing process was indeed seen as a vehicle to achieve professional status; this was less apparent in Britain. Walton (1986) questions the desirability of professional status for nursing, as well as

the accountability and autonomy which accompany professional status, and the legal liability they confer (Walton 1986 p 81)

The "professional" status of nursing had for some time been the subject of considerable argument; in 1969 Etzioni dubbed nursing a semi-profession; subsequently numerous studies have examined "professions" and debated the status of nursing. This study does not address this question. At the same time, in exploring how nursing conceptualises "caring", it is necessary to acknowledge that these debates exist.

Walton (1986) reviewed nursing process literature and places the nursing process in the wider health and social care arena. She identifies similarities and differences between the development of the nursing process and parallel changes in other professions e.g. task centred practice (in social work) and forms of medical audit. She points out that a number of principles attributed to the nursing process for example, patient-centred care designed to meet

the needs of individual patients, were accepted long before it was introduced. She suggests that the main issue for debate should be the whole process of nursing and its relationships with other professions, rather than the nursing process per se which she sees (and we have already noted) as beset by confusion despite changes in emphases to accommodate models, theories etc. Even

nursing models or theories like the nursing process and care plans before them, risk being seen as a panacea for all nursing's ills. Like the nursing process and care plans, they are expected to fulfill different purposes simultaneously: to serve patient care needs by providing a comprehensive framework for their assessment; but also to further the professional/academic desire to create a unique body of nursing theory and delineate nursing's boundaries (ibid. p83)

Such debates about the nursing process highlight how nursing in recent years has indicated a willingness to conceptualise itself as separate from medicine with a discrete body of knowledge and identifiable skills. Exploring notions concomitant with the nursing process indicate further confusions in terminology, particularly with respect to the term "care". "Care" can be seen to incorporate the different components of nursing, affective/emotional, technical, physical, practical and even preventative. Although nurses in this study did not conceptualise the nursing process specifically in terms of a nursing model, they referred repeatedly to the way the principles as well as the methods of the nursing process were implemented on Taylor Ward. "Caring" for these nurses transcended the different components of nursing and was embodied in their conception of the nursing process.

The next section will discuss the origins of caring in an attempt to understand the backdrop against which nurses (in this study and in the wider society) conceptualise care - seen by them as the fundamental component of nursing.

SECTION TWO: CARING AND NURSING

Background

"Caring" as a component of nursing has evolved from nineteenth century philanthropic thought when care related primarily to prevention of dangerous conditions (See Section One). Although Nightingale used "care" to refer to hygiene, with regard to the affective / emotional aspect of nursing, she expected nurses to demonstrate what would now be interpreted as empathy (Dunlop 1986). As we saw in Section One, during the last century, nursing was closely identified with love and home life, at first linked to love in moral sense, then to nurturing, as a wife or mother. Care (as illustrated by the case of nursing) and love of different types were closely connected. The term care and the many ways in which it is used has, however, resulted in a confusion within the nursing profession and beyond, about what care is. Accounts from nurses in this study both identified the centrality of "care" to them and corroborated the general confusion regarding a definition of care. When nurses spoke about nursing care, this encompassed most aspects of nursing: affective/emotional, social, technical, practical and physical. In addition, when illustrating how they handled certain situations, nurses, like those in James' study (1986) separated caring into different behaviours. For these nurses, therefore, caring was nursing, yet was not defined. This section will look at how nursing has addressed the question of caring and explore whether feminist critiques of caring can further an understanding of the complex relationship between nursing and caring.

In the past few years, British nursing rhetoric has emphasised caring as nursing work, in line with their American colleagues (Smith 1988a). McFarlane (quoted in Smith 1988a)

claimed that nursing was about "helping, assisting, servicing, caring" rather than the stereotype of the nurse as the doctor's assistant involved in cure". She also drew attention to the Briggs report, which in 1972 had declared nursing and midwifery to be the 'major caring profession' (Smith 1988a pp13-14).

Despite such pronouncements coupled with the enthusiasm for the nursing process (which emphasises caring aspects of nursing) Smith (1988a) suggests that British nursing rhetoric continued to emphasise the physical and technical aspects of nursing. Findings from her study investigating quality of nursing, suggest that current British nursing practice also values nursing service (physical/technical) over the caring components of nursing. She proposes that nurses learn to use a technique, where they appear to care, which is similar to that used by airline stewardesses, called 'emotional labour' by Hochschild (1983). This enables nurses to provide or withdraw at will caring behaviours from patients in the same way as they might do with nursing service. Smith notes similarities between nurses and airline stewardesses in the face to face contact with the public and the production of an emotional state in another (1988a p 33). Smith suggests that nurses do emotional labour in response to lay expectations and professional rhetoric.

In contrast to Smith's findings, nurses' accounts in this study suggest that for them "really" caring is fundamental to "good nursing" and transcends all aspects of nursing. These nurses did not appear to emphasise caring simply in response to lay expectations or nursing rhetoric, nor did they describe routinely

grimacing when patients rang bells, and replacing the grimace with a smile at the patients' bedside. Nurses in this study maintained that caring was fundamental to all aspects of nursing - for this reason it is therefore important to explore concepts of caring, both within and without nursing, to attempt to understand the meaning of caring for these nurses.

Nursing theorists in the USA have accentuated the caring components of nursing (and some studies suggest that this is now reflected in nursing practice - e.g. Dunlop 1986). In 1966, the policy statement of the American Nursing Association nursing asserted that "caring is the essential and universal concept underlying nursing practice" (Larson 1987 p 187). This position was ratified by a number of prominent nursing theorists, for example, Benner, Watson and Leininger:-

Care is the essence and the central, unifying, and dominant domain to characterize nursing: it is an essential human need for the full development, health maintenance, and survival of human beings in all world cultures ... yet care has not received the same degree of attention by professionals and the public as cure (Leininger 1984 p3 quoted in Kozier and Erb 1988).

Despite clear statements such as the above, and the fact that nurses have used the terms nursing care and caring for more than a century (Kozier and Erb 1988) many American nursing theorists noted that these terms are not universally understood and are not adequately acknowledged nor defined. Kozier and Erb (1988) have explored and contrasted descriptions and definitions of caring most commonly referred to in the American nursing literature. Although nursing theorists have looked at caring at the conceptual, model designing level, they have not tested its applicability to clinical nursing practice (Larson 1987).

Leininger, like Kozier and Erb (1988) therefore notes a need for nursing research to develop the concept of caring in nursing by exploring caring behaviours:-

until the behavioral components of caring are clearly defined, "caring" will remain a nebulous term open to many interpretations. Behaviors, unlike attitudes, can be observed, quantified, and discussed in fairly concrete, understandable terms (Leininger quoted in Larson 1987 p 187).

The School of Nursing at the University of California, San Francisco in conjunction with their department of sociology has generated a considerable amount of high quality health care and nursing research (e.g Strauss et al. 1964). Patricia Larson (1986, 1987), associated with the same department, undertook such a study by exploring perceptions of nurse caring behaviours amongst oncology nurses and patients.

Larson (1987) surveys earlier studies which sought to develop 'scientific tools' for quantifying caring behaviours. She quotes Ford who found that nurses defined caring as feeling genuine concern for the well-being of another and giving of oneself (ibid). In Ford's study, listening was identified as the crucial determinant of caring behaviour and provided the model for caring.

In Larson's own study (1986, 1987), she investigated nurses' and patients' perceptions of caring. (The lack of congruence between these groups is discussed in Section Three). She developed the Care Q questionnaire (which requires respondents to sort cards into certain categories) and administered this to nurses (and patients) in oncology wards. Using this methodology she asked nurses to identify certain behaviours which they believed gave

patients a sense of being well looked after. Six themes emerged from the data.

- 1) the accessible theme (gives medication on time, approaches the patient first)
- 2) explains and facilitates theme (teaches the patient self-care, suggests questions to ask the doctors),
- 3) comforts theme (listens to the patient, touches the patient),
- 4) trusting relationship theme (puts the patient first, offers reasonable alternatives),
- 5) anticipates theme (knows when the patient has "had enough", anticipates the difficulties of the "first-time"),
- 6) monitors and follows through (knows how to give and manage i.v.'s, makes sure others know how to care for the patient).

Nurses' perceptions of caring behaviours tallied with results of similar studies (Larson 1986) in that nurses emphasised the attitudinal dimensions of caring - providing an individualised caring and affective approach (listening, touching, talking). Larsons' findings, using a different methodology, have marked similarities with accounts from nurses in this study as reported in Chapters Four and Five.

Larson's attempt to ascribe behaviours to caring in nursing might be open to criticism by feminist analyses (see below) on the grounds that by adopting "scientific tools" (rather than developing a methodology most suited to the respondents), her methodology may be seen as directed at the male dominated establishment to legitimate her findings. Some feminist theorists would suggest that nursing research should abandon "scientific tools" and develop their own discreet conceptualisation of what they do as nurses. Many analyses of caring emerging from nursing

(e.g. described by Dunlop 1986) reflect implicit belief in the "power of science" and traditional scientific methods (This was referred to in Chapter Three). The use of similar research tools to those used by their medical colleagues provides evidence of this. It is important, therefore, when assessing these studies to bear in mind feminist critiques which identify the pitfalls of analyses which embrace research tools developed in another discipline.

Despite methodological reservations, Larson's findings should be seen as very important for the reason that they demonstrate that nurses integrate caring behaviours into cure and vice versa and do not separate cure from care. Care and cure (see below) have often been referred to as mutually exclusive. In support of Larson's findings, theoretists have recently been suggesting that care and cure are interdependent, for example, Benner (quoted in Kozier and Erb 1988) suggests that "caring is often frankly curative because it facilitates healing" and Leininger proposes "that there can be no curing without caring, but there may be caring without curing" (ibid p 10).

The origins and development of the concept of caring - the feminist position

Dunlop (1986) traces the origins of the words "care" and "cure". Care comes from the Old English verb "carian" which means to trouble oneself. As an Anglo-Saxon word it had "vulgar" or lower order associations. "Cure" on the other hand has its origins in French (from the Latin), the language of the conqueror (Dunlop ibid). The different origins of "care" and "cure" thus suggest a long standing class difference in the terms as the higher orders

"cured" whilst the lower orders "cared" (Dunlop *ibid*). She proposes that the relationship to power has been retained with those providing "cure" continuing to exercise control (Dunlop *ibid*). Although Dunlop does not see care as a static construct, she suggests that it has always been associated with negative and lower-order connotations, including gender differentiations. It is not co-incidental that

"cure" is associated with a high-status, predominantly male occupation which jealously guards access to the term, whilst "care" is relegated to women (Dunlop 1986 p 662).

The medical profession fought for, gained and has retained control over the provision of health care, incorporating scientific developments in order to edge out traditional healers from the health arena. The medical practitioners embraced the ideology of "cure" (with higher status connotations, as we have seen). "Cure" ceased to be implemented simply by hands on skill, (which arguably could have been provided by "carers") but became synonymous with scientific developments which have contributed to revolutionalising medical treatment and creating a mythical aura around the concept of "cure".

This change in emphasis began in the last century when medical practitioners, (usually men), intruded into a number of spheres which had traditionally been the domain of women (e.g. child-birth, childrearing and healing itself). This resulted in women, mothers and nurses alike, assuming roles subordinate to the medical authorities (Davies 1984). The public began to use scientific medical facilities rather than traditional healers because it was believed that the former could ensure better health for the population (Davies *ibid*). Indeed statistics supported

this by demonstrating considerable improvement in mortality statistics, although this was due to public health rather than curative medicine (McKeown 1979). Those (usually women) who had previously provided care lost control over the charges, becoming subservient to the male doctor with scientific knowledge.

This scientific knowledge is what Waerness (1984) perceives as a new kind of male authority. The issue of how scientific knowledge has been used by men to control women is worth exploring. Waerness (1984) quotes Wittgenstein to illustrate her point that scientific knowledge should not be seen as the simple arbiter of what constitutes knowledge. Hilary Rose (1983) cites Alfred Sohn Rethel of the Frankfurt School who sought to explain the social origins of

the highly abstract and alienated character of scientific knowledge.... he suggested that the abstraction arises with the circulation of money; but he went on to argue that the alienated and abstract character of scientific knowledge has its roots in the profound division of intellectual and manual labor integral to the capitalist social formation. Scientific knowledge and its production system are of a piece with the abstract and alienated labor of the capitalist mode of production itself (Rose 1983 p 80)

Graham (1983a) and Waerness (1983) argue that traditionally men have evaluated women's work using a so-called scientific model, (Graham cites the survey method as an example of this) and only recently have women begun to question the validity of such an approach :

science's rationalist culture and the models of behaviour which it propagates, are contradictory, if not hostile, to the feelings which women see as their own. (Waerness 1984 p 195)

Waerness suggests that feminist research needs to examine the use of traditional scientific concepts and models which may explain why crucial problems regarding the contexts of care-giving work are overlooked. Her contribution to this exercise is to reformulate the traditional view of the social actor and attempt to reconceptualise "rationality". She postulates that:-

there exists something that should be called "the rationality of caring", of fundamental importance for the welfare of dependents, and at the same time different from and to some degree contradictory to the scientific rationality on which professional authority and control in the field of reproduction is legitimated. (Waerness 1984 p 195)

Graham (1983a) points out, however, that survey research which is a fundamental component of traditional sociological inquiry has in fact contributed substantially to an understanding of women's lives. Although much of this research has been conducted within a model of society which is consistent with the ideology of Western capitalism (Graham *ibid*), these research findings have identified aspects of women's lives which hitherto were inaccessible to social scientists. The caring aspects of women's lives can be seen to have been revealed in such work.

As we have seen, feminists have criticised the scientific basis of social science inquiry on the basis that this is not only bound to the capitalist system, but also does not question the patriarchal system of western society. A feminist perspective, therefore, should view science and technology as integral to both a capitalist and a patriarchal system (Rose 1983). Rose (*ibid*) suggests that current critiques of women's roles within science must be complemented by developing a feminist critique of existing science and a feminist natural science. Rose questions the

mythology that science can be neutral, suggesting that even critiques of science emerging in the 70's were sex blind. Not that the critics were racist or sexist, but that the theoretical categories which traditionally have been used to criticise science could not facilitate analysis which could explain why science was bourgeois and male. Rose proposes that in order to understand why science is interpreted in a "male" way, feminists need to look at the sexual division of labour in the household:

Women's work is of a particular kind - whether menial or requiring the sophisticated skills involved in child care, it always involves personal service. Perhaps to make the nature of the caring, intimate, emotionally demanding labor clear, we should use the ideologically loaded term "love"..... This emotionally demanding labor requires that women give something of themselves to the child, to the man. The production of people is thus qualitatively different from the production of things. It requires caring labor - the labor of love (Rose 1983 p83)

The feminist literature thus throws light not only on the position of women as carers within the family (highlighting particularly the case of childbirth and childcare) but on the relationship between nursing (one of the traditional female dominated occupations) and caring. Feminist contributions to constructing a conceptualisation of caring will now be explored.

Can one conceptualise caring?

In the nineteenth century, care, having a philanthropic connotation was clearly the province of women. Changing interpretations of "care" over the years did not change the status quo - women predominantly provided care in both private and public domains (Stacey 1981; Graham 1983b). Stacey (1981) observes that until recently social scientists have largely ignored the fact that women undertake the bulk of caring, what (after Hughes 1971

and Stevenson 1976) she terms "people work", and that this has implications for economic and sociological inquiry.

Recent feminist analyses have begun to explore the implications of women providing care in paid and unpaid positions although this is still virgin territory (Ungerson 1983b). Some social scientists from a number of disciplines are turning their attention to this field. The work of a few, applicable to the study of nursing will now be reviewed.

Graham (1983b) argues that:-

the experience of caring is the medium through which women are accepted into and feel they belong in the social world. It is the medium through which they gain admittance into both the private world of the home and the public world of the labour market. It is through caring in an informal capacity - as mothers, wives, daughters, neighbours, friends - and through formal caring - as nurses, secretaries, cleaners, teachers, social workers - that women enter and occupy their place in society (Graham 1983b p 30).

The problem of conceptualising caring is tackled by Stacey (1981) who suggests that contemporary social science lacks adequate concepts to deal with human service and people work because:-

sociological concepts and terms were devised by men about the male world of the public domain and about the family as it was seen by those men These concepts and terms are inappropriate to deal adequately with the private work of the family. They are also inappropriate to deal with those tasks of education, nurture and care when they move from the private to the public domain, from the historical domain of the women to that of men. The concepts are also inappropriate to deal with those tasks which, like nursing, are undertaken in both the private domain (unpaid) and in the public domain, where they are paid at market rates depressed because they are "women's work". (Stacey 1983 p 7)

Waerness (1984) agrees that there are conceptual difficulties in constructing a theory of care-giving work (as she terms it) and takes the negative stance that:

there is no conceptual framework that can be applied in analysing experiences and activities transcending our traditional sociological dichotomies like public/private, home/work, labor/leisure. (Waerness 1984 p 186)

Graham (1983b) sees caring as a central concept in social policy despite the difficulties in defining care, and as we have seen suggests that the experience of being cared for and of caring is intricately connected with our self-definition and how we interact with others. She defines caring as a

concept encompassing that range of human experiences which have to do with the feeling concern for, and taking charge of, the well being of others. This definition alerts us immediately to the question of meanings and entailments: "feeling concern" and "taking charge" have both psychological and material implications (Graham 1983b p 13)

Graham proposes that "caring demands both love and labour, both identity and activity, with the nature of the demand being shaped by the social relations of the wider society" (p 13). Waerness (1984) shares Graham's view that caring encompasses both labour (activity) and feelings. She draws attention to the reciprocity which is assumed between people caring for one another and to the fact that caring tends to be associated with women who are providing what she terms **personal services**. She suggests that women carers can experience the provision of these services as something they have to do, rather than choose to do, because of their subordinate position in the family. Thus if analysing caring as a labour of love, one has to differentiate between caring for dependents or superiors and caring in reciprocal

(symmetrical) relationships. This is necessary because the different categories of caring relationships raise different questions and problems for the caring (women) themselves.

Ungerson (1983) also tackles the problem of **caring about** and **caring for** someone. This is useful because nursing history would suggest that this differentiation has been blurred with nurses unable to keep to the latter model, entering the former and then getting "emotionally involved" (See Chapter Five). Nurses in this study also confused these issues, repeatedly suggesting that patients should be cared **for** as if they were relatives. Ungerson suggests that caring for someone, in the sense of providing service for their needs, does not necessarily imply caring about that person. Caring for somebody takes up time whereas caring about somebody does not:-

Thus caring for a person, or as Roy Parker has recently renamed it (Parker 1980) "tending" a person has two important distinguishing features; firstly, it describes provision for needs where the sense of obligation on the part of the carer is socially rather than affectively constructed, through payment of services rendered or the exigencies of a social norm. Secondly, the practice of "tending" consumes time, often - though not always - in such a way that the carer is unable to combine tending with other time-consuming activities (Ungerson p32 1983a)

Nurses in this study clearly saw their work as "caring for" patients (to use Ungerson's term). Smith's (1988a) argument would seem to be that such tending (Parker 1980) or caring for (Ungerson 1983a) does not need to incorporate caring about - the affective dimension (Ungerson 1983a). This can be "faked" by nurses to conform to public and professional expectations and consequently serves to protect them from emotional involvement and any resultant stress. This show of affect is itself work, which Smith (1988a) terms "emotional labour".

Yet for nurses in this study and those studied by Larson (1986) and James (1986), "caring about" was as much a part of nursing as "caring for". This was not faked and did involve an element of personal involvement. Both affect (emotional work) and service were essential elements of "nursing care". This is well summed up in James' (1986) use of the term "carework" (See Section Three).

As we have seen, nurses in this study put equal emphasis on the emotional work (emotional/affective) and nursing service (technical/physical aspects of "nursing care"). Like nurses in Larson's study, they separated out some components of care into emotional work, others into nursing service, and combined the rest. This is consistent with many analyses of caring which as we have seen have separated it out into components of labour (technical/physical) and love (emotional/affective) (Graham 1983b; Rose 1983).

Feminist analyses of caring, like analyses of "science" emphasise the importance of gender associations (patriarchy), as well as other social and economic issues. The capitalist and patriarchal system has contributed to the lower status of nursing in relation to medicine. The predominantly scientific basis of health, has enabled the medical profession, dominated by men, to maintain control over carers (see before). Feminist debates such as those reviewed above, which call for a total reconceptualisation of caring and look at it from a woman's point of view, might be seen to raise the expectations of a change of status for the carers. How far these debates will result in any change of status is difficult to assess as yet. Modern developments within the British

nursing profession, particularly the high profile status of men in nursing have complicated this issue (Oakley 1986). For feminist theories to be implemented, it would seem that the fabric of the social structure in the wider society would have to change.

Summary

"Caring" as a concept has had a chequered career in nursing history. In the nineteenth century caring was a fundamental component of nursing, as nursing skills were based on women's experiences and feminine attributes. As nursing allied itself with the development of scientific medicine, caring became progressively devalued and relegated to the least skilled. By the mid-twentieth century however, nurses had become disillusioned with their role ambiguity and sought clarification about nursing ideology. The nursing process although now not viewed as an ideology, emerged to define aspects of nursing and embraced caring as a concept instead of curing (the remit of the medical profession). Nurses, however, locked into the scientific model, have attempted to analyse "caring" using traditional scientific methods. This is problematic because the nature of caring transcends a number of conceptual categories and therefore traditional analytic tools do not deal adequately with this construct.

Nurses in this study reflected the general problem of compartmentalising caring into constituent parts. They were clear however, that caring for them was a conceptual ideal. "Nursing care" for nurses on Taylor Ward was synonymous with caring as the embodiment of nursing.

Conclusion

The feminist arguments cited in the discussion above, have highlighted the power and gender associations which accompany the care/cure dichotomy and suggest that neither care nor cure can be seen as gender neutral. Cure as we have seen has the backing of scientific knowledge, the legitimation of which is also gender linked. This explains the original and continued view that care is less than cure, but not what either of them are. Despite the distinction that can be made between cure and care, their origins and subsequent legitimation, one should beware of falling into the trap of assuming that the two are necessarily mutually exclusive. Modern American nursing theory is acknowledging this by identifying both the curative aspects of care, and the carative features of cure.

In looking at the literature on caring, both within nursing and beyond, we have noted certain important distinctions:- that caring can be separated into a number of components, caring about or caring for; that caring incorporates elements of both labour (service e.g. the physical/technical features of nursing) and love (emotional/affective). The components of caring can sometimes be symmetrical and/or reciprocal. The literature, supported by data in this study underlines the complexity of "caring", that it is not just what one feels about people, but what one does about it.

The strength of caring as an ideology embraced by nurses (in this and other studies) may lie in two factors. Firstly, as Graham (1983b) and others show, it is about the ways in which women see

themselves and relate to the world about them (for example, the emotionality with its gender associations). Secondly, precisely because of the complexities and ambiguities associated with "caring", it can be appealed to and used as a rallying call by women in a number of situations (e.g. nursing).

It is no co-incidence that nurses have embraced the nursing process (as a method?) and "caring" (as an ideology?) during a resurgence of women's consciousness. Only with women's increased confidence to state their position, separate from men's, have they been able to claim "caring" as an ideology. On the other hand, it is significant that Larson's findings, like findings from this study, emanate from nurses working with dying patients, where as we shall see in the next section, "caring" as a method and as an ideology have become legitimated in the absence of the certainty of cure.

Section Three thus explores how cancer and dying have been conceptualised in medicine and in nursing. The settings and contexts in which cancer patients and the terminally ill are nursed will be discussed in Section Four.

Introduction

We have seen that nursing care includes elements of nursing service and of emotional work. Views of the relative importance of these have changed over time and may differ between doctors, nurses and patients and possibly also between different groups of patients.

Armstrong (1983) in a review of nursing literature argues that until the early seventies the caring role of the nurse was restricted primarily to the biological functioning of the dying patient. In 1977, it was argued that basic nursing care of the dying should concentrate on ensuring comfort and relieving symptoms. Armstrong (1983) detected a change in nursing rhetoric shortly thereafter when nursing textbooks emphasised the need for a trusting atmosphere in which patients could express their fears to nurses who would listen with compassion and understanding.

A conceptualisation of caring within nursing presupposes a congruence of views between carers and cared for (Dunlop 1986). Larson (1986) studied perceptions of "caring behaviours" of patients and nurses in a cancer ward in the USA (the methodology was described in Section Two). Nurses in her study gave a higher ranking to certain caring behaviours than patients - these were touching the patient when comforting is needed, allowing the patient to express feelings about disease and treatment and treating the information as confidential, getting to know the patient as an individual, realising that the patient knows him/herself best and including the patient in planning and

management of care, and being perceptive to patient's needs. Thus nurses saw trusting and comforting behaviours as those likely to make patients feel looked after. In contrast patients prioritised the following behaviours:- knowing how to give injections and manage equipment, knowing when to call the doctor, administering drugs on time, being well organised, checking frequently on the patient. Patients

perceived nursing behaviours that demonstrate being accessible, monitoring, and following through as more caring (Larson 1987 p 191)

Hence patients valued those carative behaviours which facilitated cure as well as comfort.

Larson's statistical analysis demonstrated that cancer patients and nurses had significantly different perceptions of the importance of nearly 40% of the CARE-Q items. Only one item, "Puts the patients first, no matter what else happens" was given a high rating by both groups. Larson reports that her results were replicated by Meyer (Larson 1987). These studies used quantitative methodology to construct a model of caring behaviour. Unlike studies using an interactionist approach such as that reported in this thesis, quantitative studies do not explore feelings per se. Nevertheless, there are a number of implications for practice arising out of Larson's findings. These suggest that nurses should not assume that patients concur with their ranking of important caring behaviours (which was raised by Dunlop 1986). Larson found that patients most valued nurse behaviours that demonstrated competence in the technical aspects of cancer nursing. This can be seen as congruent with Weisman's claim (quoted in Larson 1986) that the priority of cancer patients is to get better.

Although it is possible that Larson's findings are culturally specific, having taken place in the USA where the lay population might embrace curative ideology more than in the UK, one should not lose sight of the value of life to individuals and groups. When the quest for extending life is the goal for cancer patients, particularly in the throes of initial treatment, it is reasonable to assume that patients expect nurses to comprehend and facilitate their priorities.

The discrepancy between the patient's goal (cure) and that of nurses (care) is one which nurses have not adequately addressed. Larson (1986, 1987) expresses concern that patients did not share nurses' conceptualisation of nursing (that the affective outweighed the physical aspects). Yet the central issue to be thrashed out is which aspects of caring behaviour are the most important and is this the same for all patients? Although cancer patients and terminal patients are often nursed in the same ward, it is possible that these different groups, where one can separate them, might have totally different perceptions of appropriate nurse behaviours. Treatment patients may therefore see the emotional work component of care in conjunction with cure, but when asked to prioritise these, see emotional work as secondary to nursing service which might achieve cure. Hence when nursing patients, nurses should operationalise their ideology of individualised nursing care, and not impose their own priorities on patients, but provide a flexible service pertinent to the patient's stage of illness and frame of mind. In certain circumstances truly individualised care might include a high priority of "cure".

Attempts to analyse caring behaviours highlight different features of care, that it can be viewed as a method, an ideology and a behaviour. Care can incorporate cure as one of many aims, which under certain circumstances could conflict with caring behaviours. At the same time, cure can be achieved in a caring way. Hence patients undergoing cancer treatment might prefer physical care (e.g. drugs on time) to "psycho-social care" but probably not value physical care of a predetermined kind such as task allocation. Psycho-social skills can thus be viewed as necessary to elicit symptoms (physical care needs) from patients. These symptoms might have implications for current or future treatment. Thus cure can be seen to be one of the aims of caring behaviours, and not necessarily in conflict with care.

Training for terminal care

The question of educating doctors or training nurses to deal with cancer or terminal patients has received much attention in the literature (Lasagna 1970). The technical aspects of cancer / terminal care, are emphasised during training whereas psycho-social issues are regarded as less important. Medical students are taught to communicate with dying patients as if they were going to survive (Duff and Hollingshead 1963) and advised not to raise topics with patients which might induce psychopathology. More recently "care of the dying" courses have been introduced into medical training to make medical students aware of the psycho-social implications of cancer for the patient and his/her family. Even these are deemed inadequate, not providing a comprehensive overview of the implications for treatment and guidelines how to

communicate with dying patients and their relatives (Bloch 1976; Souhami 1978).

How does cancer fit into the prevailing medical model?

Medical ideology promotes cure as the ultimate goal of medicine. Many nurses viewed this approach as inappropriate for the terminal patients on Taylor ward. **Nurses repeatedly referred to "caring" as the crucial component of nursing**, implying a rejection of medical ideology which they equated with cure. Nurses questioned the curative stance of the doctors who prescribed radiotherapy and chemotherapy in order to prolong life. As nurses they did not sanction the use of heroic measures as an alternative to supportive care (Castles and Murray 1979).

Chapter Two reviewed studies which found that medical personnel experienced difficulties in dealing with death or the dying. Parsons, Fox and Lidz (1972) explain this by suggesting that contemporary medical ethics place primary importance on life saving activities. The doctor is "commanded" to combat a patient's death. This absolute commitment to preserve life, irrespective of the quality thereof, has protected medical ethics from encroachment by any other ethical system and kept it autonomous. Death is therefore structured as a defeat both for the individual doctor and for medicine itself. Doctors therefore find it unacceptable to facilitate death ; in this they have been aided by technological advances.

Ethical dilemmas are integral to cancer treatment. These issues accompany decisions not to treat as well as decisions to treat. Nurses in this study, as we have seen, were angry when treatment

decisions were based on doctors' perceptions of patients' social, economic and domestic status (as well as medical considerations). They believed that patients should be aware of the implications of a course of radiotherapy or chemotherapy neither of which may be life prolonging. Treatment can have consequences for patients in terms of health, projected short and long term quality of life, potential incapacities or disabilities (including physical and emotional responses to treatment) each of which might affect social or occupational roles.

The predominant view is that, within medicine death is synonymous with failure (e.g. Maclean 1971). The ideology of cure is applied to all medical conditions, regardless whether they respond to medical intervention. Within this prevailing medical model, treatment procedures are used to "attack" malignant cells. "Fights" against cancer, are always perceived as either won or lost (e.g. Relman 1980 Obituary to Franz Ingelfinger). Patients who have been treated unsuccessfully are constant reminders of medicine's inadequacies. Yet cancer treatment still has a low success rate. Why has medical ideology not acknowledged medicine's limitations nor reconceptualised its role vis a vis dying patients. Non-specialist journals are slowly redefining medicine's role in terminal care. An editorial in the Journal of the Royal College of General Practitioners (1980) pointed out that death should only be viewed as a failure if the patient died lonely, in pain or in discomfort. This stance is very similar to the views expressed by nurses in this study.

How does cancer fit into the "traditional" nursing and more recent nursing models?

Traditional nurse training, like medical education emphasised physical rather than emotional care of cancer/terminal patients. Nurses have been found to identify with a curative life prolonging culture. Benoliel (1974) suggested that

Given that the medical and nursing subcultures attach primary value to lifesaving activity and secondary value to palliation and symptomatic therapy, the performance of tasks associated with the preservation of life carries greater weight in the allocation of professional and social rewards than does the provision of comfort one can conjecture that any activity or situation which negates the capacity to save lives can be conceived (and experienced) as a loss of an important relationship - professional competence ... the dying patient provides opportunity for several kinds of professional loss which can be analytically distinguished from personal and social loss shared in common with the society at large (Benoliel 1974 p 220-221)

Over the past ten years a number of textbooks on nursing the dying in a number of settings, have been published (e.g. Hector and Whitfield 1982; Charles-Edwards 1983; Copperman 1983). These have concentrated primarily on needs of dying patients (including emotional/affective) and how nurses might meet these, and not tackled ideological issues concerning nursing the dying.

Conclusion

Despite the introduction of cancer nursing as a nursing specialty thirty years ago, until recently nurses continued to identify with the medical goal of cure. Although cancer patients are frequently not cured, they require considerable medical and nursing attention during their illness (and dying trajectories). Except within

hospice ideology (see next section), medicine does not conceptualise palliation as a legitimate goal ; in contrast nursing recently put out feelers towards a new ideology, that of caring, which embraces all kinds of medical conditions, regardless of whether patients are likely to survive. In their zeal to operationalise this caring ideology with caring behaviours, nurses may ignore the agenda of patients; this action conflicts with the anchor of new nursing ideology, that nurses should respect patients' agenda and not replace that of the doctors with their (nurses') own. There need not be a contradiction between nurse caring behaviours (for example checking whether a patient is comfortable or needs a bed pan) and a patient's desire for curative behaviours (to receive drugs on time, physiotherapy etc). Caring behaviours can include a recognition of a cure aim where the cure aim is seen as appropriate.

Data emerging from this study has indicated the importance of the context in which nursing cancer and terminal patients takes place. I argue that where ward practices reflect the traditional view that dying patients are a nursing failure, nurses are most likely to experience anxiety and conflict. Contexts for caring for cancer patients and the dying will now be explored.

SECTION FOUR : CONTEXTS OF NURSING THE DYING

The context in which dying takes place is an important determinant of how nurses experience looking after dying patients (Field 1987). Context, like care, can be interpreted in a number of ways - we have already looked briefly at the historical context of the delivery of nursing. Social and institutional contexts of nursing the dying have been explored in American (Sudnow 1967) and British literature, particularly in acute ward settings. Chapters One and Two described reactions of healthworkers, especially nurses, to looking after dying patients in acute medical settings. I argue that the context of nursing the dying (i.e. the inter-action of the setting with the ideology represented in the setting) influences nurses' experiences of nursing the dying.

As set down in Chapter One, most references in this thesis to context (unless otherwise stated) refer to the structure of nurses' work. This structure is composed of a number of factors: the physical setting of nursing work, the general environment, the ward atmosphere, nursing management styles, ward culture and the organisation of nursing work (e.g. staffing levels, use of the nursing process, rules of behaviour). These are underlined in the text for easy reference and / or emphasis.

Chapter Two demonstrated that until recently, dying patients were studied primarily in acute hospital wards, a field pioneered by Glaser and Strauss (1965, 1968) and Sudnow (1969) in the USA and replicated by McIntosh (1979) Bond (1978) and Field (1987) in the UK. These studies generated data relating to communication practices and the way nursing staff use routines to cope with

stressful situations and rationalise their work. Most of these studies did not juxtapose ideology and context nor explore whether or how nurses made sense of difficult tasks within specific settings.

Recent American studies have demonstrated how interpretations of the nursing process have led to a devaluation of technical skills and nursing tasks and resulted in minimising the importance of the body and its physical requirements (Dunlop 1986). Section One looked at reconceptualisations of nursing in response to the nursing process in Britain. Despite the positive response to elements of the nursing process in nursing rhetoric it must be re-emphasised that the change to individualised as opposed to task oriented care is not universal in the UK and even where individualised whole person care has been implemented, interpretations vary (Fretwell 1982; Field 1987; Smith 1988b etc). Hence experiences of dying patients may still resemble accounts of the 70's (McIntosh 1977; Bond 1978) especially where changes in nursing practice are minimal.

Despite a sustained emphasis on routines and tasks in many hospitals, Field (1987) argues that there has been an attitudinal shift amongst professionals caring for the dying. He compared nurses working in three wards of the same hospital and in the community to ascertain differential responses to the care of the dying. He detects a change in attitudes towards the care of the dying. He partly attributes this shift in attitude to practical changes in the care of the dying, especially control of pain and discomfort. In addition, he feels that the introduction of behavioural science teaching into nurse and medical training has

facilitated better inter-personal skills and understandings relating to the effect of cultural differences on illness behaviour.

In the UK most cancer patients die in acute medical settings. Separate cancer or terminal wards ~~per se~~ are rare consequently many cancer patients are nursed alongside curable patients. Notwithstanding changes in attitude towards disclosure and better knowledge about pain control, patients are still reported to die in isolation, without dignity and in excruciating pain (Saunders et al. 1978).

Many factors influence how dying patients are nursed in general hospitals. Following Glaser and Strauss (1985), Field (1987) looks at work settings to explain variations between the ways nurses cared for dying patients on different wards. He suggests that the experience of dying patients is determined by the nature of the profile of a "normal" patient in a particular setting (p145). If the norm required is physical or technical nursing, a dying patient requiring a psycho-social focus to nursing work challenges normal work routines. He found, however, that on long stay medical wards, with slower turnover of patients, nurses were accustomed to having extended contact with individual patients and hence dying was not in sharp contrast with the expected nature of nursing work.

The nature and level of staffing is a pertinent feature of work settings (Field 1987; Melia 1987). My data supports this contention. Field suggests that the

pace and intensity of work for nurses is not simply determined by patient characteristics, but is also greatly influenced by the number and training of nursing staff available to deliver such care. At its simplest this can be viewed in terms of the time which is available for nursing work. (Field 1987 p146)

Fretwell (1982), Field (1987) and Smith (1988a) suggest that where student nurses constitute the bulk of the work force the conflicts experienced between learning and working may influence the care of the dying (This is elaborated in Chapter Seven).

Field (1987) citing Walker (1982) postulates that the nature of nurse / patient contact is influenced by the physical environment. Isolation in single rooms might further limit contact. (Accounts of nurses in this study did not substantiate this contention). Field suggests that the starchiness and formality of certain settings might also inhibit patients and relatives from seeking help or simply "chatting" with staff.

The way in which nursing work was organised emerged in this study as a crucial determinant of how nurses experienced working on Taylor ward. James (1986), Field (1987) and Smith (1988a) had similar findings, the latter two in acute settings. Field suggests that nursing work involves some "role making" by the nurses themselves (p148). This concept is similar to that of Strauss et al (1963) who described the negotiated order of hospitals, where hospital staff "strike bargains" in order to bend the rules. They summarise their position:-

there is a patterned variability of negotiation in the hospital pertaining to who contracts with whom, about what, as well as when these agreements are made. Influencing this variability are hierarchical position and ideological commitments, as well as periodicities in the structure of ward relationships (Strauss et al 1963 p162-163)

Strauss et al (1963) emphasise the temporal aspects of these negotiated agreements, suggesting that end times are "written in". Smith (1988a) describes how nurses in her study "volunteered" or "requested" certain patient allocations and that these negotiations between sister and junior nurses took place daily for the duration of that shift and that shift only. Thus nursing work can be seen as somewhat negotiable, not only the nature of the work, but for how long.

Field (1987) suggests that different nursing methods explain the variation in terminal care in a medical ward, surgical ward and coronary care unit. He proposes that the

individualized system of patient allocation combined with the use of the nursing process on ward 6 and CCU meant that nurses could obtain the satisfaction accruing from seeing the direct effects of the nursing work, something which would be harder to do under the more traditional system of fragmented task allocation which was used on ward 7 (Field 1987 p150).

The way in which the nursing process has altered individual nurses' accountability is debated in the literature (Smith 1988a). Field (1987) found that where the patient allocation was combined with the nursing process, patients were clearly the responsibility of individual nurses, rather than collectively. This meant that nurses were less likely to distance themselves from "their" patients; familiarity, rather than breeding contempt, created the circumstances where nurses could become less fearful of death and even acknowledge the rewards of nursing the terminally ill.

Management styles of wardsisters, particularly how the nursing process is implemented, influence the ward climate (Field 1987) and the organisation of nursing work (Fretwell 1982; Melia 1984; Field 1987; and Smith 1988a). Relationships between the ward sister and her medical colleagues (or as Freidson would construe, superiors), determine the degree of nursing "autonomy" on the ward. Runciman (1983 quoted in Field 1987) found that although wardsisters often disagreed with doctors regarding management of the terminally ill they rarely challenged decisions.

Fretwell (1982) identifies three categories of management style:- doctor orientation, patient orientation or administration orientation. Fretwell suggests that the sister's style of leadership signals her expectations of nurses.

Smith (1988a) viewed the interpretation of the nursing process as an indicator of ward management styles. She found that:-

An explicit commitment to the practice of the nursing process appeared to be associated with sisters who valued interpersonal communication with patients and nurses, interpreted as the recognition of patients' affective needs and doing emotional labour. Participant observation confirmed interview findings that ward sisters adapted the nursing process to their own work realities and work preferences. (Smith 1988a p 383)

Smith (1988a) found that wardsisters in her study, in contrast to those in Pembrey's (1980 quoted in Smith 1988a) did not go on daily nursing rounds of patients. They managed the ward by allocating work at the beginning of each shift, requesting report backs from nurses and providing information about patients themselves. Sisters in Smith's study (1988a) varied in the extent to which they allowed nurses to share verbal and written information, and indicated their priorities regarding patient care

through their strategies for controlling patient handovers and reports (The way in which wardsisters on Taylor Ward managed information has already been discussed in Chapter Five. Chapter Seven examines how ward report conveyed ward culture).

In contrast to findings in this study, long term patient allocation was not practised in the wards studied by Smith:-

Long term patient allocation was not practised, even on wards where sisters were committed to the nursing process. Frequent change of patient was seen as desirable by the more senior students in order to satisfy their learning needs. Junior students were more likely to choose and/ or be allocated to look after patients on a long term basis, especially if they required physical and emotional rather than technical labour. Some ward sisters and students, on the other hand, saw changing patients regularly as an important way of preventing overexposure of nurses to patients who might be 'difficult'. Consequently, students were observed to choose the amount of emotional labour they undertook, through a system of patient allocation that allowed them to change their patients daily. (Smith 1988a p 384-385)

Smith (1988a) suggests that a possible explanation for this kind of fragmentation of care might be that this protected nurses from becoming too involved with individual patients, "by continuing to undertake patient centred tasks rather than individualised patient care". (Smith 1988 p386.) Smith (1988a) proposes that this ties in with Menzies' thesis (1959) that nurses develop social defense mechanisms to protect them from anxiety and distress.

In summary a number of factors influence the way nurses experience caring for the dying in acute settings. Those discussed above relate to the way in which nursing work was organised, the physical environments of the ward, ward sister's management styles and the nature of the work setting. This study confirms the

importance of these factors. Chapter Seven will explore additional factors e.g. ward atmosphere, which also influenced the way in which nurses perceived their work.

Alternative models of care for the terminally ill

During the 1960's, terminal care movements raised the question of euthanasia and palliative care of the dying (James 1986). James (1986) suggests that these movements arose in response to a fear of dying in inhospitable institutions. The terminal care movement proposed alternatives to dying in allopathic settings.

The fate of patients dying lonely and in pain was publicised largely through the initiatives of Cecily Saunders who founded St. Christopher's Hospice in Kent. Hospice leaders, such as Saunders, exposed the lack of emotion and sentiment in the care of the dying in hospital wards, and how this resulted in a lack of dignity for dying patients denying them choice regarding their preferred place of care (James 1986). The terminal care movement offered dying patients something different:

Instead the outline of patient-centred care, social, spiritual and psychological, together with the best of physical care, were legitimised as being the proper concerns of health staff involved in terminal care. Emotion, far from the norm of being contrasted with rationality, and therefore thought of as irrational, was considered a realistic response to dying. (James 1986 p 411)

The terminal care movement became known as "hospice" which in the USA implies the non-hospitalisation of the dying (i.e. patients die either in purpose built units or at home). In the UK hospice means purpose built homes for the dying; terminal care teams, continuing care teams and home care teams are the terms used for

multidisciplinary teams supervising the care of the dying at home.

Hospice philosophy differs fundamentally from traditional medical ideology in that no effort is made to sustain life. Heroic treatments are not used to cure but to palliate. Hospice accepts that death is an inevitable consequence of terminal illness, and aims at maintaining a quality of life whilst dying (James 1986) rather than prolonging life. James (1986) suggests that in the hospice view death is seen as a success if patients can retain control and dignity and die according to their wishes.

The focus of hospice ideology is thus to enable patients to remain pain-free, dignified, comfortable and lucid during the terminal phase of illness. This approach aims to avoid inappropriate treatment, control pain, treat the patient as a person, rather than as a disease or bed number, care for the relatives and support the bereaved. Patients are viewed within their domestic contexts rather than as isolated individuals. Hospice is based on the premise that patients should be free from physical pain even if this means prescribing addictive drugs. Different sorts of pain are acknowledged and addressed:-

Since physical pain influences, and is influenced by, the other aspects of pain, a careful assessment is made which involves the following: (a) all members of the health care team (physician, nurse, clergy, social worker, volunteer), (b) the selection of the appropriate drugs at an optimum dosage, and (c) appreciation that the patient's needs may change rapidly, necessitating frequent readjustment in the medication regimen. Addiction is not a consideration, since dying patients are seldom emotionally dependent on drugs (Campbell 1986).

In theory hospice care is provided by a multidisciplinary team (Lack 1983) which includes medical, nursing, ancillary and volunteer staff. Team members are encouraged to value the skills of one another and not constitute a hierarchical system, although the doctor usually has to take legal responsibility for the prescription of drugs. The patient and his/her family are centrally involved in decisions relating to patient care. Each patient's care is planned through consultation between the primary care-givers (spouse, doctor, nurse etc.). Back-up is provided by an in-patient unit from which services are co-ordinated and nursing and medical care are often available around the clock.

Hospice care is therefore based on physical care and symptom control within the personalised model. Hospice ideology should not be viewed as synonymous with any of the nursing models described in this thesis. It differs from the psycho-social nursing model now common in the USA (Larson 1986) and the traditional task or patient-centred task orientation (Smith 1988a) models of British acute nursing.

The British medical establishment has cautiously embraced the concept of hospice. The Wilkes Committee reviewed the provision of care for the terminally ill in 1979 and suggested that instead of increasing the number of in-patient hospices, the hospice ideology should be disseminated through the health service (Ward 1987). It recommended that care should be co-ordinated around the needs of the patient and his/her family in their own home.

Ward (1987) studied home care services, operating independently of in-patient hospices. Contrary to the expectations of the

Wilkes report, she found that home care services do not replace the advantages of the in-patient hospice, but do provide some of the benefits of the hospice movement to an increasing number of patients.

Section Three explored conceptualisations of caring within British nursing. In a thesis recording her participant observation study of a Scottish Health Service Continuing Care Unit (hospice) James (1986) makes a substantial contribution to an understanding of caring for the dying, in particular understanding concepts of care amongst hospice nurses. Despite the different setting, James (1986) noted similarities in emphasis between this unit and other Health Service facilities:-

Byresfold Continuing Care Unit had been set up to be an example of good terminal care, but it was observed that physical care tended to have greater priority than 'emotional care' as the Unit was integrated into mainstream National Health Service Provision (James 1986 p i)

In order to ascertain how nurses made sense of nursing the dying, James (1986) separates their views of "care" from their views of "work". The nurses found that the tension between care and work prevented them from operationalising their nursing ideology. James (1986) collapses "care" and "work" into the concept of "carework", a combination of emotional labour (emotional work), physical labour (nursing service) and organisation. She explains how the "carework" carried out by nurses in her study is the practical implementation of the total care ideology of the hospice movement.

The term "carework" was coined in an attempt to explain the articulation between the ideals of "care" and the pressures of "work". It was noted that at times of strain, such as when there were many heavy (literally)

ill patients, there seemed an urgency to complete the physical tasks and physical care at the expense of other kinds of "care". For the latter there "just wasn't enough time". Thus 'carework' was designated a flexible framework which was expected to explain the practical outcome of 'care' and 'work' and accommodate the influences of both the ideals and the tasks in different circumstances. (James 1986 p 417)

Carework (James 1986) as an explanatory tool had both descriptive and analytic uses. As a descriptive device it is

the product of the ambiguities and interests with both 'care' and 'work' are invested. In its second analytic form, 'carework' can be used as a means of connecting together two frameworks, which are usually distinct, with their own separate social histories, but which are joined together in a wide range of circumstances as 'caring work' (James 1986 p423)

Care and work were connected in carework through routines and rituals. This implied that work was accompanied by affect in a way that moved work beyond repeating routines towards a ritualistic approach. James uses laying out as an extreme example of affect in routine, where attachments to patients were shown after death as well as during life. The similarities between the ways in which nurses responded to laying out in this study (see Chapter Four) and in the hospice she studied are quite striking. Despite superficial differences in setting, the world view espoused by her self-selected sample of hospice nurses is extremely similar to that of "ordinary" nurses in this study.

The hospice movement has gained strength in Western societies. The way in which symptom control has affected the quality of life for dying patients is universally praised. The hospice ideal is not always met, however, as it too is subject to financial and other constraints. In addition, criticisms have been directed at the non-impletation of basic hospice tenets. Wright (1981) argues that even in hospice patients are isolated and staff adopt

"distancing" strategies. He suggests that although hospice ideology espouses individualised treatment and "tender loving care", the only way in which staff can carry out their work with the dying is to make it as ordered as possible. Wright's account more resembles care of the dying in acute settings (e.g McIntosh 1977) than accounts of hospice care. Wright suggests that hospice staff acquire strategies to enable them to care for the dying - the skill to predict the dying trajectory (Glaser and Strauss 1968) and expertise in medical nursing, pastoral skills and pain control.

James (1986 see above) acknowledges the importance for hospice nurses of routines and rituals and explains how affect can be introduced into both. Thus both labour and love (Graham 1983) can be seen to be integrated into James's carework. Nurses in James's study can be viewed as responding to the philosophy of hospice, "the team development of attitudes and skills to enhance the quality of life remaining" (Saunders in introduction to Copperman 1983).

A central feature of hospice staff is that they are self-selected. Despite different settings, different ways in which nursing work was organised and the fact that nurses in James' study are self-selected, there are striking similarities between nurses' accounts of nursing the dying in her study and the study reported in this thesis. Nurses in both studies provided accounts of how their worldviews interacted with the context in which they were nursing the dying. The congruence between the ideology of the context with that of the workers is therefore a crucial determinant of how those workers experience the job.

The hospice nurses in James' (1986) study, like nurses in this study, were enabled to make sense of personal stress within their role (see discussion of Antonovsky in Chapter Two). Their expectations of work with the dying incorporated elements of stress as part of the job. This was manageable as long as they perceived that their conceptions of care were congruent with that of the context. Chapter Seven will demonstrate how nurses in this study experienced stress when they perceived a conflict between their worldview and that of the context.

Conclusion

This study explored nurses' accounts of nursing cancer/dying patients in an acute setting in a teaching hospital. Certain features of nurses' conceptualisations of "nursing care" resembled the hospice view of "care". The opportunity to put into practice this ideology depends on the setting and the context.

The setting and the context shape the experience of dying for both patients and nurses. The physical environment, the ways in which nursing work is organised, and management styles of ward sisters are some of the variables which influence this experience. Chapter Five demonstrated that nursing management on Taylor Ward was relatively autonomous. Within certain constraints nursing management could practise their own version of nursing. This was congruent with the worldview of the nursing workforce, in that nursing management had adapted certain features of the nursing process and operationalised them on this ward. These features resemble some aspects of total patient care, the ideology of the

hospice movement. Both the hospice view of care and individualised care as epitomised by the nursing process, can be seen as challenging medical ideology with regard to terminal patients. Yet even where it has its own separate setting, the practice of hospice care differs somewhat from the ideology. One assumes that terminal care teams, operating out of traditional medical settings, also make similar compromises.

CONCLUSION

Nursing as a semi-profession (Etzioni) or aspiring profession (Oakley 1984), has in recent years made a concerted attempt to define what it does, and in particular has taken the concept of caring as its flagship. Caring as a term, both within and without the nursing arena, has been identified primarily with women and with low status occupations. Within nursing, "basic" care until recently was devalued as a unskilled task, whereas higher status work related to technical tasks requiring specialised training. With the introduction of the nursing process and its emphasis on patient allocation and individualised care, the affective / emotional aspects of caring are emerging as the cornerstone of nursing.

Caring as a concept has been analysed within feminist literature as having the elements of both labour and love. Labour is often associated with the public domain, is commended and financially rewarded. Love is usually associated with the private domain, where caring entails labour but is devalued and not remunerated. Love is legitimated in the private but is seen as problematic in the public domain. Nurses in acute settings traditionally have been reported to separate labour and love (e.g. Conboy- Hill 1986) suggesting that labour components of nursing (nursing service) were valued whereas love (emotional work) was not seen as "real nursing". This reflects the low value society places on women's unpaid work which women, too, accept as given.

More recent analyses are suggesting that a reconceptualisation of nursing would view as legitimate those affective/emotional aspects

of the job. For example James (1986) illustrates how feeding a dying patient can be construed as a routine, unskilled task, or one filled with affect approaching the ritualistic.

This chapter has explored how caring as a concept can be seen as having been incorporated into nursing ideology and practice. Nurses in this study derived their worldview, in particular their conceptualisation of nursing care, from their training. Similarities can be found between the worldview of nurses in this study and the hospice notion of total patient care. The existence of a terminal care team at Suburban Teaching might indicate that hospital management too shared aspects of this approach.

Nurses are likely to experience stress when their ideological basis conflicts with that of their work setting. On the other hand, they are likely to feel supported if the context reflects the ideology. Nursing the terminally ill can be one area where nurses are able to provide a service to patients "independent" of other disciplines. Within the context of nursing the terminally ill, nurses can make a statement regarding their distinctly different ideology from that of their medical colleagues, that nursing the dying should not be regarded as a nursing failure but as a nursing strength. As nursing does not operate independently of other disciplines, however, certain conditions are needed for nurses to be able to provide "ideal nursing care".

The following chapter looks once again at the accounts of nurses in this study. It analyses the interaction between the 'nurses' worldview and the context in which they work. This interaction explains why nurses in this study experienced less stress than

those reported in other studies. These nurses differed from other nurses (described in the literature) who have worked with dying patients in acute settings, in that they did not perceive the same issues to be causes of stress. Similarities will be identified between the accounts of nurses working in a hospice (James 1986) and these nurses working on a cancer ward. The argument of this thesis will be substantiated by illustrating how traditional stressors appeared when either the ideology or ward practices seemed to flag, but disappeared when an equilibrium was re-established.

CHAPTER SEVEN

A GOOD WARD FACILITATES GOOD NURSING

INTRODUCTION

Chapters Four and Five presented nurses' views of stress and support. To recap briefly, nurses in this study did not view patients' conditions as a source of stress, but perceived stress as resulting from being prevented from practising "good nursing care". The nurses' worldview related to their professional identity, their ability to provide "total care" for patients. Certain conditions had to prevail for nurses to be able to provide this optimal care. These related primarily to the way in which the ward was managed and whether there was congruence between the agenda of ward management and nursing staff. In addition, nurses required clear boundaries within which they could practise "good nursing" which protected the patients interests as well as their own. The implicit and explicit Rules of Behaviour obviated the necessity of additional support measures for nurses working on this oncology ward. In presenting literature on concepts of care, nursing and nursing the dying, Chapter Six sought to highlight the dichotomy facing nurses between conceptualising nursing as carative (their own discreet ideology) or curative (in line with the doctors). It demonstrated that caring for the dying raises particular sorts of nursing issues, many of which will be discussed in this chapter.

This chapter presents further findings from the data. It will examine the interaction between the ideology of the nurses and ward management emphasising those factors which maintained or disturbed ward equilibrium. The chapter is divided into four sections.

Section One will look at the ways in which activities in the ward sisters' office conveyed the ward culture to nurses. One of these activities (ward report) will be used to illustrate this contention. Section Two will examine causes of disequilibrium on the ward - i.e. when nurses reported experiencing stress. Particular emphasis will be placed on the effect on the ward of changes in nursing management. The discussion will focus on the balance between ideology and ward management to ascertain which conditions put the system at risk. Section Three explores the fundamental issue of working and learning by examining the priorities of student nurses :- to provide good nursing care to patients, to meet the expectations of their teachers in the nursing school and to be accepted by colleagues on the ward. This section relates these priorities to ward management and to ward ideology. The way in which nurses themselves participated in restoring the equilibrium will be described. The conclusion will argue the importance of context for nurses and how a well functioning ward with an ideology congruent to that of the nurses can create a safe environment which reduces nurses' experience of stress and distress and contains the expression thereof.

SECTION ONE : THE CONTEXT OF NURSING : MAINTAINING A GOOD WARD
ATMOSPHERE

During the stable ward management periods (first and third) nurses' accounts of how Taylor Ward facilitated good nursing referred specifically to what they saw as unusual uses of the sisters' office. This office was used in the normal way for managing the ward, yet both the use of the office and Ward Report on Taylor Ward were distinctive. In addition the office provided nurses, of all ranks, with a place to put their personal belongings, to drink coffee and a bolt-hole when they felt distressed. Nurses accounts' as well as my observations, indicated that the way in which the office was used expedited nurses' integration onto this ward.

The office as sanctuary

Nurses used the office as a "bolt-hole" whenever they needed to flee from the ward. A sister illustrates how management encouraged this use of the office:-

Sr I think you should feel that you are allowed not to cope if you don't feel capable - if you've had two patients that have been talking about death and dying then perhaps you ought to go to the office and sit down and have a cup of coffee or read a magazine.
(Sister; second (individual) interview)

In addition to using the office as a sanctuary, nurses of most ranks used it (within strict time limitations) as their "common room", to relax, for tea breaks and for social contact with other wardstaff. Before ward report, nurses reporting for a "late" shift made the office their first stop, they changed their

shoes there, hung up their coats and glanced through magazines (not only nursing journals!) as they waited for ward report to begin. Nurses spoke about their off-duty activities as well as nursing issues whilst preparing for the day's work.

The office was also a venue for "mutual support" amongst qualified and student nurses. On occasion, colleagues who had been off duty when certain patients had died were expected to be distressed on hearing the news. Consequently when the afternoon shift was arriving for work they were met in the sister's office by one or more colleagues who would break the news in semi-private before the remainder of the nursing staff assembled for ward report. The nurses who had been present at the death, or received the news from the night staff, recounted how the patient had died, whether the nurses involved had described it as a "good death" (i.e. painfree, without convulsions etc.) and the patient's last actions and words. Even when patients died in the middle of a shift, where possible, nurses retreated into the office to conduct their own nursing "post-mortem" as well as share memories, and / or grief with colleagues.

Certain patients on the ward were "adopted" by nurses who substituted themselves for absent family. James (1986) found that hospice nurses (in her study) saw themselves as providing patients with the love and care of family members. The patients "adopted" by nursing staff on Taylor Ward were usually "little old ladies" reminiscent of nurses' grandmothers. When these patients died, their status as family members precipitated communal grief which was expressed in the sister's office.

Nurses viewed these expressions of shared grief as quite legitimate within the context of their job. The caring dimension of their job included expressing sadness. The professional component was never forgotten. Nurses spoke at length about nursing issues relating to the patient's death. Was the death pain-free, was the patient anxious, were there any nursing problems that might have been handled better? The shared grief was time-limited. Discussions in the office were restricted to nurses perceptions of how long they could be away from their work.

The ward sisters' office as the focus of ward management

The ward sister's office was situated next to the doctor's office in a central corridor of the ward, out of sight from patients' beds. In this small room a desk was placed at an angle and positioned next to a table upon which were a kettle, cups and saucers, coffee and tea. Behind the door were a set of hooks where nurses hung up their coats, and behind the desk, a cupboard where nurses stored changes of shoes. A mixture of nursing charts and aesthetic pictures, cards etc. decorated the walls. In contrast to the doctor's office which was rarely used, the sister's office was in constant use and can be viewed as the central focus of nursing work.

Although superficially the nurses' station (opposite the high dependency beds) appeared to be the hub of nursing work, nursing work was managed from the office. Nurses' duty rotas were compiled and displayed there. The more senior students were delegated the responsibility for patients' medication on a daily basis; this task necessitated frequent trips to and from the office to collect the keys for the drug cupboard.

The management uses of the office will now be explored - these included dealing with students and relatives and holding all the ward meetings.

a) Dealing with students : counselling and disciplining

On starting their placements student nurses expected to have a private session with the sisters during which they could discuss or negotiate (Strauss 1963) their objectives for working on Taylor Ward. Students assessed these sessions as helpful during the first and third management periods; to the students' chagrin these were usually postponed indefinitely during the second management period.

For nurses joining Taylor Ward, ward practices were clarified and acceptable behaviour identified during sessions with trained nurses in the office:-

- N I thought we were supposed to keep a stiff upper lip but they're very sweet actually - the staff take you into the office and make a cup of tea for you and don't let you go out till you feel better
- JK How did you discover that they don't expect the stiff upper lip?
- N1 Well I got called into the office. Well, you discover what the staff are like - the new sister is very sweet, she's very helpful, I had a very very long talk with her the other evening and she said, "at half past eight we're going in to the office and we're going to spend half an hour there until the night staff come on because I think you need me to talk to you". And we had a long chat and I got things straight with her and it was very helpful really. I was really at my wits end that evening.
- N's She's very helpful - she's ever so good
(Second year; second (group) interview)

Another student described her experience of counselling in the office:-

- N2 I thought I pulled myself together in the loos but I hadn't and I went in (to the office) to get the keys and started crying, and then I just couldn't stop crying, I just felt terrible
- JK Was anyone in the office?
- N2 Oh, yes, the staff were brilliant, really good, couldn't have been nicer. Because they told me things like well, at least you still can cry and they were saying about times when they'd gone home and cried. The staff nurse told me that when A died, she'd gone home and cried until one in the morning. I thought I was really strange, I couldn't stop crying, and I thought I'd had a nervous breakdown or something. No, I didn't really, but you know, I couldn't understand why I got into such a state because of it - it never happened before, I mean I've never cried on a ward before
- N3 not to the point you couldn't control yourself
- N2 No, never to the point where I couldn't control it - I'd always go into a loo, have a cry, come back and be fine. And they were just telling me how they were the same
- N3 which makes you feel as if everything is ok
- N2 Yes yes, they couldn't have been better.
(Third years; second (group) interview)

Students contrasted these experiences of support with breaking down on other wards:-

- N On Malcolm Ward, I got attached to a patient who got very ill and I got very upset about it and I told the sister on the ward and her attitude was not really sympathetic, was more, you shouldn't get so involved and when I left the ward, she wrote a great deal about it in my report and I had to go and see the nursing officer and discuss it and go through again what happened, and she wanted to know if there was someone I could go and talk to. Then I had to go and see my tutor, all three tutors, and discuss it again and they all said, you need counselling, but they never actually suggested I go anywhere or see anybody.
(Second year; third (individual) interview)

At the end of students' placements, the sisters compiled individual reports on their performance on the ward. The sisters tended to discuss these with the other trained nurses in order to attempt to achieve a balanced view of the nurse's performance :-

- Sr We sit together on the reports, all of us on the shift, staff nurses, or just the other sister and I. And you'd be surprised that out of the five of us in the room, two

will differ from the other three - two will say they get on well with the nurse and three will say they have great difficulties or vice versa. So you will have to compromise. You have to back up your ideas with the occasions when things have happened - 'cos that's the fairest way to do it.

(Sister; second (individual) interview)

When these reports were completed, the student in question was taken through all the aspects of this report by the sister. This provided an opportunity for the student to query any comments.

Students who behaved unacceptably were sanctioned in the office. This was only reported once during this study.

b) Dealing with relatives

When a patient was dying or had died the nurse in charge was delegated the job of notifying relatives (See Chapter Five, Section Two) . Trained nurses assessed this responsibility as being one of the most taxing in their jobs. The privacy of the office enabled them to face a difficult task:-

JK Is it difficult for you to phone someone up and say the patient is dying?

SN I don't like doing it; I have to sort of go somewhere and be by myself in the sister's office or the doctors' office; I have to be by myself; I don't like people listening, I don't know why, because I never think of what I'm going to say. I usually say "your husband's condition has suddenly deteriorated, he's very ill, I think you ought to come in"

(Staff nurse; second (individual) interview)

A sister agreed that breaking news over the phone was a difficult task:-

Sr If you're talking to another person, do you want someone sitting listening to you? I know if I have to talk to a relative and tell her bad news, I don't know that I would

want someone else in the room - I think I'd find it difficult. If I have to phone a relative to say that their relative has deteriorated in condition, I go into a room on my own, it's easier, otherwise you feel terribly self-conscious and things come out... your voice sounds ugly to yourself, because you're saying horrible things, and you sound self-conscious - it's giving bad news so it's better if you're on your own and also you can be slightly more human to some one on the other end of the phone, if you haven't got people sitting around you. I find telephones embarrassing, you see - I'm much better on the telephone if I'm on my own.
(Sister; second (individual) interview)

When relatives became very distressed, the trained nurses accompanied them to the office where they were given something to drink and the privacy in which to express their feelings.

c) Holding meetings

i) **Meetings with doctors**

Several times a week the three consultants held grand rounds. The consultant and the junior doctors first congregated in the sisters' office where they were joined by the most senior nurse on duty (if the ward was well staffed other trained nurses accompanied the ward round). Both the houseman and the sister presented their versions of the condition of the consultant's patients. The consultant followed by the entourage of junior doctors and sister then moved through the ward, seeing all his/her patients in turn. This entailed a short talk with the patient, usually from the end of the bed, followed by a huddled discussion with colleagues in the corridor, when x-ray plates were sometimes viewed. At the end of the round all those present withdrew to the sisters' office for tea and cake and a review of the patients' management. The sisters usually made the tea whilst contributing substantially to discussions. Issues such as discharge or extended treatment plans were often challenged by the sisters;

frequent negotiation between the sisters and the consultants took place regarding the latter's wish to empty beds. The relations between sisters, staff nurses, consultants and junior doctors were assessed by all as excellent. This was one factor which attracted one of the staff nurses to return to this ward where she had worked as a student:-

SN I worked here as a student for some time, I got on well with the staff. I thought that the relationship between the medical and the nursing staff was excellent.
(Staff nurse; first (individual) interview)

The sister's office was also used for regular formal twice - weekly meetings of trained nurses and junior doctors as well as daily informal meetings which took place in the afternoon, before the early nursing shift left the ward. The latter had a "social" air in that both junior doctors and trained staff tended to relax, smoke cigarettes, have tea and cake, and talk about issues which included personal and professional topics. The staff nurses, in particular, valued these meetings:-

SN The trained staff tend to discuss things with the doctors because we'll have tea together at about 4 o'clock in an afternoon but the students don't have so much opportunity because they don't come in for tea in the afternoon. That's an advantage of being a trained member of staff in that we do get this tea break - the students are working from after lunch till 4.30 without a tea break, at least not an official one. I suppose that's how we cope with being here full time - that's how I imagine we cope in that we manage to ventilate what's been going on during the day, what still needs to be done and actually air our views. I think I need that teabreak from 4 o'clock onwards - I don't like leaving at 4.30 without having had a chat.
(Staff nurse; third (individual) interview)

Thus some trained staff on Taylor Ward saw their afternoon tea breaks with junior doctors as constituting a debriefing session. Hence both formal and informal meetings sometimes presented an

opportunity for mutual received interdisciplinary support. It should be emphasised that these meetings always excluded consultants and student nurses.

ii) Meetings with the social worker

The "social" meeting took place once a week in the sister's office. The social work team leader responsible for patients on Taylor Ward chaired this meeting which was attended by the trained staff, the out-patient sisters, junior doctors and occasionally physiotherapists and occupational therapists. Patients with practical problems were referred to the social workers; rarely were they referred for social casework (counselling). The social meeting can be seen as an opportunity for trained nurses to discuss and debate management problems with other professionals. Although the official agenda of this meeting was to refer patients to the social worker, some trained nurses perceived that to some extent it provided mutual support across disciplines. Student nurses fantasised about topics discussed during the social meetings (See Chapter Five Section Three) and felt excluded from the opportunity to discuss "social" issues with a multi-disciplinary broader team.

In some respects these "routine" meetings with junior doctors and the social meeting resemble support groups described in the literature (e.g. Klagsbrun 1970); but this should be viewed as a hidden agenda, albeit mutually agreed, the only requirement of the social meeting and regular sessions with the junior doctors was the exchange of "medical" or "social" information relevant

for patient management. That some of the trained staff chose to discuss personal responses to patients or general nursing management issues with other disciplines must be seen as purely voluntary, and yet reflects the ward culture which encouraged cross rank dialogue and support.

iii) Meetings with nurses

Patients were handed over to the incoming shift of nurses during meetings in the sister's office three times a day: from the night shift to the early shift at about 8 a.m.; then at 12.30 from the early shift to the late shift (the main **ward report**) and finally at 9 p.m. from the late shift to the night shift.

Nursing work was centralised in the midday ward report which took place in the sister's office. Ostensibly ward report was used for delimiting nurses' work but it served a number of functions, some of which will be described.

Ward Report as a forum for conveying expected behaviour to nurses

Nurses joining the ward expressed surprise at the way in which ward report was managed on Taylor Ward. Several aspects of ward report differed from other wards in the hospital.

On other wards, firstwarders and often second year students were not required to "present" their patients at ward report. First warders and second year students were only expected to attend discussions relating directly to their own patients; these were usually very brief. Nurses suggested that the purpose of ward reports on other wards was to assign nurses work, transmit

"doctor's orders" relating to technical procedures required and provide qualified staff with succinct information about patient's conditions. In short, ward report on other wards was simply a communication exercise providing the next nursing shift with depersonalised accounts of patients. In order to remember instructions, students had learned to write down as many details as possible in notebooks which became invaluable because nurses were not forced to consign rather disembodied information to memory. The more detailed their notes, the less likely it became that they would reveal their inefficiency by looking up information in the kardex or worse, by requesting trained staff to repeat instructions.

Nurses' accounts of ward report on other wards resembled those described by Melia (1982) who described ward report as a tense meeting where nursing management emphasised the priority of getting the work done. In her study of nursing in a continuing care unit James (1986) describes ward report as follows:-

The lunch-time report, although it was the most important gathering of nurses, remained a routine event. Unlike the weekly unit meeting, with the doctors, social worker and others, which was accompanied by tea and cake, the lunchtime report was a fragile structure, altered by the conditions on the unit. It was the opportunity to talk about the patients as people, and consider their 'total care' in detail, but the quality of information varied enormously with the length of the report, who was running it, and the pressure to do other 'tasks'. If patients' buzzers went during report, someone had to go and it was nearly always the auxiliary.

As the workload increased, 'tasks' had greater priority (you cannot reasonably tell someone they cannot use the commode until the end of report), and the quality of the report as a pooling of information altered as key informants had to do other things. Thus, although report was considered important its effect on the consideration and planning necessary for good care could be circumscribed by pressures to 'do' things. There were occasions when, with a shortage of staff, it was missed out completely, and on those days, it felt as if a

central hub had been taken away, and left everything feeling disconnected. At its best the report was the fullest exchange of the day, and at its least effective was a dislocating series of interruptions.

(James 1986 page 230)

In contrast to James' (1986) account, **ward report on Taylor ward was the most important nursing event of the day.** It epitomised "nursing" for nursing management and eventually for student nurses as it conveyed the principle characteristics of nursing ideology on Taylor ward - good nursing practice and nursing education. The way in which ward report was structured reflected nursing management's approach to students. Student nurses were not only expected to attend, present their patients' problems but also enabled to learn about good nursing practice through listening to the way in which trained staff and other students presented their work. The high staff-patient ratio on the ward, and the expectations that students would complete their work in good time to ensure attendance at ward report, facilitated a large turnout at ward report with a skeleton staff running the ward. Students would rotate so that each student could be present for the maximum period.

a) The approach to nursing conveyed by ward report

During ward report trained staff indicated that student nurses were expected to provide optimal care for their patients. In order to do this they required diligent and carefully planned teaching. Nursing management encouraged nurses on Taylor Ward to respond imaginatively and creatively to their patients' needs, and not behave in a stereotypical fashion. To persuade nurses to do this, ward management had to create an atmosphere where nurses felt safe to make mistakes and seek help from their nursing

superiors. Ward report with its emphasis on dialogue and teaching indicated that nursing management ratified the students "learner" status and consequently student nurses were not expected to "know nursing". At the same time, patients needed protection from students' errors. Hence clear directives about information disclosure created parameters within which nurses could safely talk to patients, and also request information, (which they may not receive in full) from superiors. By virtue of their student status, students learned that they were protected by, yet accountable to the trained staff. At the same time, they were responsible for the patients allocated to them. If they neglected their duties, or abused the privilege of being a member of a team they could be sanctioned.

b) Ward report as a learning environment

As we have seen above, an unusual feature of Taylor Ward was that all student nurses were required to attend ward report and present "their" patients' problems. At first students were concerned that mistakes or misunderstandings might affect their own reports at the end of their placements, but were quickly reassured by the conduct of their peers, whose agenda was clearly to learn and be taught. With regard to the content of their "presentations" those new to the ward and unaccustomed to this practice were guided by the trained staff who through questioning students, indicated the range of information students were expected to elicit from patients and the importance of establishing the precise nature of patients' concerns. The manner in which trained staff prodded students was "constructive" in that emphasis was placed on the "nurse who knows the patient best". This approach consequently bolstered the nurses' self esteem. In other words, the opinion of

the nurse looking after a particular patient was valued, irrespective of her rank or experience and students were encouraged to suggest ways of solving problems. This was in contrast to Menzies' (1959) study where she suggested that the

student nurse is actively discouraged from using her own discretion and initiative to plan her work realistically in relation to the objective situation (p104)

The qualified staff encouraged students to ask questions during ward report about any aspect of patient care that concerned them. Students new to the ward observed other students inquiring about a range of topics and imitated this. If the qualified staff regarded the information requested as inappropriate for the student nurse, they either skirted over the question or indicated that the details requested were not essential to practise good nursing. Thus control over information and over students was subtly effected without students perceiving that they were demeaned.

Students, recognising that they could "learn" during ward report, seized the chance to question nursing practices; ward report enabled them to engage in dialogue with their nursing superiors and request explanations for management decisions. Nurses spoke about wanting to make sense of the treatments patients received or the manner in which they died. A student nurse described how she purposefully used ward report to pose her questions about a patient's deteriorating condition and express her anger towards the medical staff for not investigating the causality:-

N Since our (last) interview we've had quite a few discussions about the patients - a few of them have died now - about why basically they died, the nurses never know

JK How have you had these discussions?
N In ward reports, actually, because I just brought it up on report
JK You've asked how somebody died or why they died?
N Yeah or why we didn't know at the time say Mrs T why did she die - but nobody ever knew why she died, what it was. So I said to sister, first of all they said septicaemia, she's already got lymphoma, the underlying disease, but why has her breathing gone up the spout, but why is she suddenly dying, is it due to the disease, is it due to the septicaemia, or what it was hard for us to know. And so I asked and she (sister) said that they had not done anything to try to find out because they thought that the investigations might kill her in the process so she would have to have a post-mortem and then they'd know why she died. At least we discussed it and I found out why they had not done any investigations - it is important to ask
(Second year; second (individual) interview)

Melia (1984) has described the "nursing in the dark" syndrome. Nurses on Taylor Ward were familiar with this concept and found it unacceptable:-

N Its difficult nursing someone if you don't know why you're doing it, you know. You need to have a sense of purpose.
(Third year; second (group) interview)

During the stable management periods discussions during ward report were purposive and business-like. At the same time, nurses did not feel inhibited nor rushed.

c) The atmosphere of ward report

Ward report on Taylor Ward was unrushed. Nurses did not sense an urgency to return to the ward. It is important to emphasise that patients were not neglected during ward report; the nurse/patient ratio was sufficiently high (cf. James 1986) to enable most students to be present for at least half the session. There were always enough qualified staff on a shift for one or two to absent themselves from the meeting if they were needed on the ward. Ward report always ran overtime, and although this meant that nurses'

lunch breaks were often late this was not a cause for complaint. Ward report continued until the trained staff were satisfied that all nursing issues were adequately resolved.

Nurses felt that ward report and other handovers to the incoming shifts reflected the atmosphere on the ward, the absence of work pressure characteristic of many other wards. This quote described the first handover of the day:-

N We come in and we'd have a good long report then we'd go and have (eat) breakfast whereas on other wards they'd have given a bath to one or two people before breakfast even starts whereas for us we'd be going around chatting and getting to know people; everything was very spaced
(Firstwarder; third (individual) interview)

Although ward report was clearly part of the business of Taylor ward, where handover to the "late" shift took place, it was permissible to be humorous and recount anecdotes regarding patients. The "business of nursing" was the primary purpose of ward report, but the human aspect of nursing "people" implied incorporating the personal component.

Conclusion

Nurses' accounts of working on Taylor Ward during the stable management periods emphasised events taking place in the sisters' office. They commended the qualified staff for smooth nursing management and their welcoming and integrating approach to students was indicated by sharing their office with students. Nurses' accounts of the second management period were very different. Section Two will examine these.

SECTION TWO : NURSING AND CONTEXT IN CONFLICT

Nurses provided two conflicting accounts of the experience of working on Taylor Ward. This discrepancy can primarily be explained by the effect on the ward of changes in management teams (referred to as management periods in this thesis). This is consistent with Nicklin (1982 - see Chapter Two) who argues that organisational changes cause nurses stress.

Six weeks into the study almost all the trained staff left the ward and were replaced by newly qualified staff nurses and a relief sister. For a period of about two months (the second management period, also referred to as the unstable management period) those positive features which had identified Taylor as a good ward facilitating good nursing became obscured.

Nurses became confused by the apparent discrepancy between the reputation of Taylor Ward and what they observed. During this second management period, nurses saw Taylor Ward as no different from other wards in the hospital:-

N I asked people who had worked here what the ward was like and it was "Oh, it's a lovely ward to work in, it's such a lovely atmosphere, everything is really well organised, the students are really kept in touch with everything that goes on, the trained staff go through everything that's wrong with patient, if anything happens with the doctor they tell you, and you know what patients know"; they really had a high opinion of the ward; you know it was run so efficiently and everything and we came here and it was just pandemonium; we didn't get any special introduction to this ward than any other ward, we came on and started work. We got an interview after about a week, to ask if there was anything worrying you or if there was anything special you wanted to learn, but there was no talk about what you think of the nursing, nothing.
(Second year; first (group) interview)

Towards the end of the unstable management period, the newly appointed, oncology trained permanent sister took up her post and asserted her authority. (The time subsequent to this is called the third management period). The following quote comes from the final interview with a second year nurse whose entire ward allocation had taken place during the third management period. Her account of the congruence between her expectations of and her experiences on the ward provide evidence that "Good Nursing" had been reasserted on Taylor Ward:

N I was really looking forward to coming onto the ward and it's lived up to my expectations - it's even surpassed them actually because I was thinking a lot of people have enjoyed the ward and I thought, well, it's a really good ward to do before your exams and you revise your total nursing care - you put everything into it, psychiatry comes into it because cerebral metastases affect the personality.
(Second year ; second (individual) interview)

The second (unstable) management period is the focus of this section. As already stated, all but one of the trained staff had left Taylor Ward at the end of the first management period and were replaced by three newly qualified staff nurses and a newly promoted relief sister, who was new to the hospital.

The influence of sisters' management styles on ward atmosphere and quality of nursing are debated in the literature (Fretwell 1982; Field 1987; Smith 1988a; Whelan 1988). Although both Smith (1988a) and Whelan (1988) explored how nurses perceived ward management styles to influence quality of care, neither of them investigated *per se* how ward management styles affected nurses' perception of their own stress. Some studies focussed on ward

learning climates (Field 1987) and on social relations of trained staff to students and patients (Smith 1988a). Orton (1981 quoted in Field 1987) identifies individual autonomy, the degree of structure imposed, rewards, consideration, warmth and support as key variables indicative of leadership style (Field 1987 p156).

Whelan (1988) defines ward management style as a:-

composite of the ward sister's task orientation, socio-emotional orientation and pattern of decision making (Whelan 1988 p 126)

Field, comparing three wards, found in two that an:-

'employee-oriented style' enhanced individual autonomy within a well focussed and supportive structure. This allowed nurses to gain satisfaction and reward from their nursing work with patients, and to be confident that when they experienced problems, e.g. in nursing a dying patient, then more senior staff would be on hand to help. The Sister's strong belief in the nursing process was another important element in the ethos of nursing care found on the ward. A similar situation was found on CCU where the structuring of work was to a much larger extent shaped by the medico-technical task of patient care. The apparently very high level of nurse morale and satisfaction in these settings seemed to be directly related to these factors (Field 1987 p156).

Field (1987) links morale and ward climate, suggesting that nurses' work satisfaction and rewards were reduced when work was fragmented and nurses perceived themselves as unsupported by seniors. Similarly on Taylor Ward, nurses' work satisfaction was reduced when they felt unsupported by their superiors during the unstable management period.

Smith (1988a) in assessing ward management styles describes the ways in which ward sisters interpret the nursing process for handling information and feedback among nurses and setting priorities for technical, basic and affective care (Smith 1988a

p308). She argues that ward sisters in her sample created the ward atmosphere and staff relations through their personal management styles (p382).

Nurses on Taylor Ward noticed that following the departure of the senior sister, Anne, the ward atmosphere changed and the allocation of nursing work became disorganised. Other than Melia (1982), who emphasises the influence of untrained, yet long staying, nurses, much research in this area focuses on the management style of the senior sister as influencing nurses' perceptions of work, and minimises the importance of other trained staff. Smith (1988a) found that although staff nurses contributed to ward atmosphere and staff relations, their influence depended on the sister's management style. This assumption suggests that nursing staff in situ abandon well established nursing patterns in response to each change of senior sister. This suggests a rigid hierarchical system, which does not accommodate a more democratic process of authority which I contend prevailed on Taylor Ward. There was almost a total changeover of trained staff on Taylor Ward which was accompanied by a perceived change in the approach to nursing, yet basic assumptions such as adherence to the nursing process remained fundamental. In order to support my contention that the worldview of nurses on Taylor Ward related to something more than simply the sister's management style it is important to examine why and how changes in staffing influenced different experiences of nursing. The first and most important factor relates to the conflict experienced by qualified nurses between their management responsibilities and their view of good nursing.

Management versus good nursing

Most of the newly trained staff nurses had spent time on Taylor Ward as students and requested staffing jobs there precisely because they valued Taylor's style of nursing.

SN I enjoy this sort of nursing - I don't like to be under too much pressure - I can cope with pressure, you know the acutely ill patients, looking after post operative patients for instance, really rushing off my feet. I didn't find it any sort of trouble during my training but I did like the aspect where you can have time to get to know people as people and not as bodies - you've got too many things to do in some cases on the surgical wards - you almost begin to lose - you don't tend to look at the patient as a person as a whole - in some cases I began to get myself totally wrapped up in just the technical side of what I had to do to people rather than being able to treat them like people and talk to them - that's why I like this ward especially - you get to know people better and get to know their families.
(Staff nurse ; second (individual) interview)

The new night staff nurse had not worked on Taylor but knew of its reputation:-

JK Why did you choose this ward and not the others?
SN Because it sounded like, from the feedback I got from other people who'd worked here, this sounded like a good ward to work on, it sounded as if they really cared about the patients; they really did their utmost to keep them comfortable and painfree, and everything else, and it was well organised and that appealed to me rather than the other wards where I'd worked before and I didn't really fancy them - but I've since been disillusioned unfortunately
(Night staff nurse; only interview)

One can therefore assume that these staff nurses all subscribed to the way in which nursing had been practised on Taylor Ward and wished to continue in this vein. Starting their first jobs as qualified nurses they became aware (like nurses in Fretwell's study), however, that their training had not adequately prepared them for management responsibilities (Binnie 1988). They found the

"leap" to responsibility all-consuming and became obsessed with the need to prove to themselves and their superiors that they were fit for the job. Newly qualified staff nurses noted how other professionals responded differently to them now that they had changed their uniform:-

SN I think you do get slightly more respect in this uniform than you do in a student uniform even though I'm no different now than I was a few months ago. They do treat you very differently in a blue uniform.
(Staff nurse; first (individual) interview)

Without clear guidance and leadership, newly qualified staff nurses were unable to both manage the ward and promote the ideology. Students observed changes in the priorities of the trained staff:-

N The staff have changed as well - it's affected the ward, I think, it's not the really kind ward it used to be - I think the staff that were here before were just brilliant - they were really nice. They had been here so long, they were more involved with the patients really, but these because they're all new, they just want to get to know the ward and what to do.
(Firstwarder; third (individual) interview)

The previous section demonstrated how the priorities of nursing management could be gauged by the way in which the sister's office was utilised by nurses, in particular, the style of ward report. During this "unstable management period" these began to resemble practices on other wards.

a) Changes in uses of sisters' office

During the first management period, other than during meetings, the door to sister's office had been left open and nurses felt comfortable going in to ask for help, collect the keys etc. Now,

nurses observed that the door was always closed and felt as if they were intruding on private tea parties whenever they knocked on the door:-

N A lot of the time they (the trained staff) go into the office in the afternoon and have tea and cakes and that sort of thing - my mum says I'm too sensitive, she says I'm perceptive, I'm too perceptive maybe I read into things that aren't really there - but I get the feeling sometimes when you knock on the door and say, "Can I have the drug keys or would you come out and check this, or would you mind looking at this lady?" they resent me going in and disturbing them. I don't know how they feel, it seems to be quite cliquey. If they're talking in the drugs room and you go in they seem to be reluctant - maybe it's just me being thinskinny, I don't know - I always feel I had to tread carefully with staff - sometimes I feel resentment towards them that they're not doing enough work, we're busy and they're just sitting around.

(Third year; third (individual) interview)

In addition to criticising trained staff for spending excessive time in the office, students expressed uncertainty whether or how they could use the office. They may be seen as having lost rights to their "home", their "base".

b) Changes in ward report

Ward report which hitherto had been comprehensive and unrushed, concentrating on projecting the ideals of good nursing practice and teaching, now reflected the personal priorities of the trained staff, to get through the work (Melia 1982).

Delegation of work, one of the tasks of ward report, became somewhat haphazard and student nurses felt that their roles were primarily that of workers, rather than learners (See Section Three). In particular third year students, about to take their hospital finals felt burdened with the most time-consuming and

difficult tasks:-

- N As a third year you're given all the responsibility - "there the keys , you're in charge". You've got all the management problems plus which is the most difficult patient to nurse. Oh you're the most senior student, they give you the most difficult patient also the heaviest patients, so you've got the most workload plus sometimes a lot of responsibility... you've got everything - I find that sometimes quite a strain actually trying to cope with heavy patients plus you seem to get everything put on you because you're a third year.
(Third year; second (group) interview)

Another third year suggested that the trained staff exploited their relatively greater experience without acknowledging their personal agenda or pressures:-

- N They tended to see the three stripes and say, right you have the heaviest, that did happen.
JK Did this happen to your setmates on other wards?
N Yes, this was something else for us to get stressed about...
The sister once, in report, asked the staff which is the heaviest side, and looked straight at me and said, "right you can have that"
JK So it was really blatant
N You couldn't get more blatant than that.
(Third year; second (group) interview)

The staff nurses also observed that the atmosphere and content of ward report differed from their student days. They acknowledged that ward report was no longer a forum for discussion and learning:-

- SN I think sometimes communication on the ward is rather bad, really because of the time factor - we don't always have time to sit down and talk to people and find out little things about the patient. Even report time, obviously the nurses are sitting down and they're discussing the patients with us, what progress the patient's made, but they don't really have time to ask us questions or discuss how they feel about certain patients.
(Staff nurse; second (group) interview)

Other factors contributing to disequilibrium on the ward

Although nurses attributed the disequilibrium they experienced on Taylor Ward during the unstable management period to changeover in trained staff, certain factors which were accommodated within normal functioning during the stable management periods (one and three) can be seen as exacerbating these experiences of disequilibrium. These variables stressed the system causing a number of responses in nurses similar to those described in the literature reviewed in Chapter Two. When these factors occurred in combination with uncertainty in management, the system appeared to break down:-

- a) Pressure of work
- b) An unexpected run of deaths
- c) When certain rules were used as measures of power and control

a) Pressure of work

Taylor Ward had an exceptionally high staff/patient ratio so that nurses would be able to work on a cancer ward unburdened by pressures relating to completing tasks. On occasion, when a number of nurses were off sick, these pressures surfaced. This occurred with some regularity during the unstable management period and can be related to the absence of teamwork, one of the hallmarks of Taylor Ward. A third year student describes these pressures:-

N the bells are ringing all the time and you can't do anything properly.... She (sister) called me in to the office and said that staff nurse noticed that I'd been a bit aggressive. I said, "I'm really sorry that that's how it comes out." She said, "are you not managing your

work?" and I said, "I am managing my work, it's just that I wasn't able to manage everybody else's on my own", and I said that I was annoyed because everybody was in the office..... I can't cope with a ward on my own at 10.30 in the morning and half the people haven't been washed, the beds haven't been made and everybody wants bedpans at the same time.

(Third year ; third (individual) interview)

During this period nurses were particularly sensitive to criticisms of inefficiency from patients' relatives especially if they viewed these criticisms as unjustified:-

N Just after about five patients died in that week or the weekend, even it was quite heavygoing, I think about four or five people died around that time anyway, it was just the relatives, I think, the pressure from them made it difficult - the relevant thing for me was the way relatives just don't seem to think you're doing anything for the patient and sometimes you go off the ward and you've done what you think is your level best given the circumstances and you go off the ward and you hear relatives saying, "The nurses on here don't look after the patients, neglected them", and you think, "Oh no, what have I been doing all day" but I don't let that get me down.

(Second year; second (individual) interview)

This contrasts with nurses' accounts of the appreciation and gratitude shown towards them by relatives during management periods one and three. Nurses' maintained that grateful relatives provided their main source of work satisfaction. Waitresses in Whyte's study (1946) cited ungrateful customers as a source of work dissatisfaction and a cause of stress. (An interesting semantic similarity between the study of waitresses and those caring for dying patients, is the use of the term stiff - in Whyte's study, customers who did not tip were called "stiffs"; this word is used frequently (but not by nurses in this study) by healthworkers to refer to dead patients who obviously do not respond to healthworkers efforts.)

b) Unusual number of deaths

Unexpected deaths, a run of deaths or deaths of particularly important patients could upset the ward equilibrium. Glaser and Strauss in Time for Dying (1968), describe how health workers learned to predict deterioration or time of death in patients (see Chapter Five section Two). Nurses in this study made similar forecasts and experienced stress when patients died unexpectedly or from unanticipated causes. Nurses planned their interactions with patients around these temporal projections and when patients died earlier than predicted their routines were disturbed which prevented them from completing their planned work. Despite the fact that these were all cancer patients, nurses expressed shock when patients died unexpectedly (see discussion on anticipated deaths in Chapter Five Section Two); for example most nurses on the ward at the time expressed their disbelief at the sudden death of Mr W. This is sister's version:-

Sr The thing is with Mr W, it was worse because they didn't expect him to die. He suddenly collapsed, he had a heart attack, and that is worse than somebody who you know is going to die, because you prepare yourself for it. He was going home the next day, and that's worse and that's why working say, on a ward where most people get better, and then suddenly you have a death, is worse than working on a ward where everybody is fairly ill and you can like plan, you don't know the date or time, and you've given time to prepare yourself.Mr W was very well and had a family party and a lot of girls were very shocked.
(Sister; second (individual) interview)

A large number of deteriorating patients or a run of deaths, with the additional work involved, both technical and emotional, was often the trigger, rather than the cause of nurses "losing control":-

N3 We always say to each other that we're fed up with people dying and all that stuff - you (N2) really got upset that day didn't you?

N2 The reason that I got upset was because as well as the fact that a lot of people have been dying, but honestly I don't like to see the deterioration more, I can cope with the death but I can't cope with the deterioration - someone who is in a real lot of pain, I couldn't stand to see them in pain, it was a relief when they died, it's just the deterioration - at this point I just felt that everyone was going downhill and it was that that got me upset

(Third years; second (group) interview)

A staff nurse describes the impact an unusually high number of deaths has on the nurses:-

SN I think they go hyperactive actually, they tend to talk a lot, you can't stop them talking and when we get to report, they'll go on and on about patients, a tremendous amount of feedback and report goes on for well over an hour sometimes, because they're relaying everything they can remember about the patient they just nursed - it does affect the morale, I find particularly the third years who are about to sit their hospital finals and they can't cope with too many deaths and dying patients as well is an added pressure and they suffer and also the first warders, they've never perhaps come across death before and they find it hard

(Staff nurse; third (individual) interview)

The above quote suggests that some nurses found frequent deaths stressful during this management period. At this time, the type of patient did affect how nurses coped. In addition, personal and educational pressures contributed to nurses' losing their grip. Nurses repeatedly referred to the reputation of the ward (or their previous experiences there) in a quest to re-instate "good nursing". This will be explored in Section Three.

c) When certain rules were used as measures of power and control

When the tension between ward ideology and nurses' own worldview arose, it was often because management was not consistent in conveying the rules of behaviour to nurses and did not provide an example of how these rules worked. The principle behind these rules related somewhat to nurses being professionals and being responsible for their work.

During the first management period nurses had perceived that the tight rein on information was for their own protection, to enable them to do all aspects of their work properly whilst protecting them from over-involvement with individual patients. During the unstable management period student nurses perceived that qualified staff were not sharing relevant information about patients with them. This did not apply only to the disclosure issue:-

N More often than not we weren't actually told, not what was wrong with them but what was going to happen to them - I know it's possible to find out and like when I did say something like that and they said "well you can look in the doctor's office". It wouldn't take long for somebody to come round and say to us, well the doctor said this and the doctor said that. I think if I were expected to do all the care for someone in the day and expected to really care about them then I should know what's happening as well - they seemed to sort of think you're just there to do the cleaning up and everything else that they need doing for them and then you're not supposed to care that much that you want to know what's going to happen the following day. That did bother me a bit. I felt we weren't given enough. Sister was quite good with it, she used to come round and tell you what happened with your patients on the doctor's rounds so that you could tell everybody in report. But the others, you'd be sitting there in report and you'd be saying what happened this day that she'd been sick at 10 o'clock but she felt better now and everything like that and then somebody would turn round and say, "oh by the way the results of her tests were so and so" and they wouldn't say it to me who had been looking after her all day and would be tomorrow and had been all yesterday, they would

say it to the sister, not that the sister is not important but I think I should be the one it's directed at if I've been looking after her..... they want you to care so that you look after the patient all but they want you to stop caring when it comes to knowing what's wrong with them or the results of the tests.
(Firstwarder; third (individual) interview)

This view that information essential for providing "total care" for patients was withheld deliberately and unnecessarily was confirmed by the relief sister who perceived that the other qualified staff were being highhanded and unreasonable regarding sharing of information. It is possible that the newly trained staff nurses were probably uncertain, as they felt leaderless (the sister being temporary and not experienced in oncology) , what information could be shared with students and did not feel confident enough to take responsibility for these decisions. Their inability to find time to "teach" the students, probably aggravated the situation, as such a forum might have facilitated sharing information.

The outcome of this **shared** negative assessment of nursing on Taylor Ward was an insistence that trained staff fulfilled their obligations to teach students. This can be seen as a demand to re-institute ward values and was to have the effect of restoring equilibrium.

SECTION THREE : THE WORKER - LEARNER CONFLICT

Introduction

Nurse training in the United Kingdom has been the subject of a number of research projects and public commissions during the past twenty years (e.g. UKCC 1986). Reports have challenged the concept of nurses working whilst being trained, pointing out the disadvantages financially to the National Health Service, the quality of patient care and to the education of the nurses. Recent research has looked at the quality of nurse training in the UK and relationships between wards as learning environments and quality of nursing (Smith 1988a) and wardsisters as teachers (Fretwell 1982; 1985).

From nurses' accounts it is possible to suggest that student nurses on Taylor Ward prioritised their work in the following order:-

- (a) to provide "good nursing care" to patients
- (b) to meet the expectations of their teachers in the nursing school
- (c) to be accepted by colleagues on the ward (Melia's category of "fitting in" (1984).

Chapters Four and Five have described what nurses meant by good nursing care, and how Taylor Ward (in principle) enabled them to practise Good Nursing (criterion a). This Section looks at working and learning on Taylor Ward (criterion b) and at teamwork in nursing (criterion c).

Working and learning on Taylor Ward

Was Taylor Ward, an oncology ward, a good ward for learners? First, I shall explore nurses' accounts of Taylor Ward as a suitable ward for learners using contemporary worker / learner debates. Trained nurses and students alike differentiated between the quality of teaching/learning during the different management periods. This is followed by looking at how different management periods influenced nurses' experiences of learning. It is proposed that through appealing to an ideology shared by nurses of all ranks, quality learning was re-instated on Taylor Ward.

The worker/learner issue has been the subject of a number of debates in British nurse training. Melia (1984) suggests that students see a gulf between the education and service segments of nursing:-

The education segment, through the college of nursing, puts forward what we might call the 'professional' version of nursing. This version represents, too, the official aims of the three-year training programme; that is the production of a competent registered nurse capable of independent practice and professional judgement, insofar as this is possible given nursing's relationship to medicine. The managers of the service segment, on the other hand, are far more concerned with 'getting the work done', and are therefore interested in having students who are competent, but compliant.

(Melia 1984 p135)

Students are subject to both versions of nursing, having two sets of expectations to meet (Melia *ibid*). Students at Suburban Teaching reflected this, by expressing concern about the end of placement reports (compiled by the wardstaff - See Section One) as well as their performance on examination. Like the students in

Melia's study, learners at Suburban Teaching were transients, having to readapt to their student status as soon as they left the ward, re-entering the school of nursing, out of uniform, for another block of academic study, followed by commencing a new allocation and so the cycle continued. Student nurses in Melia's (1984) study saw their nursing training as a series of hurdles over which they had to jump. Student nurses in this study expressed similar views but continually appraised their "education" in a highly critical manner.

As Chapter Four indicated, student nurses perceived that the Nursing School was in flux. A number of "sets" had been shifted amongst tutorial teams there, consequently students experienced a lack of continuity in teaching:-

N Sometimes in the past I've felt we've been left to our own devices at times, I think you need a little more supervision from them for working. Once you're on the wards you have some written work which has to be finished before you go on to the next block, but that's all really. They don't supervise your work at all - even when we have been in school there has been a lack of tutors so the majority of time has been spent in private study which I think is really dumb. They could do a bit more teaching in the school of nursing - they don't do enough for us.

(Second year; third (individual) interview)

Students were equally critical of the quality of teaching on the wards. Students' opinions of teaching contributed to reputations enjoyed by different wards in the nursing school. Wardsisters, clinical teachers (on the ward) and tutors were assessed by them on the basis of their willingness and ability to teach.

Fretwell (1978) challenged widely held beliefs that student nurses learned as they worked and were taught by wardsisters (quoted in Fretwell 1982). She suggested that responsibility for teaching

student nurses on wards was not clearly defined. Wardsisters are traditionally ascribed the role of pedagogues with no teacher training, and few guidelines.

Wards (and hence wardsisters) were selected by the nursing school attached to Suburban Teaching Hospital as appropriate training grounds for their students. All the wardsisters, however, did not share similar approaches to student training nor to the nursing process as taught in the school.

Most tutors in the nursing school provided students with minimal preparation for their ward placements, other than written guidelines relating to training expectations (Exceptions to this were referred to in Chapter Three). Students felt that the nursing school did not prepare them for their next hospital placement:-

JK You got information about the ward from people who'd been here before rather than from the school?

N1 Yes, they (tutors in the nursing school) don't really know

N2 They don't have any contact - they just give us forms that tell us our aims, our objectives

JK Are they different from other wards?

N's Yes

JK But they didn't say what the ward would be like

N2 The school of nursing has hardly any contact with the wards

JK Is that a good thing?

N's No

N1 Sometimes you need to see someone about how you're getting on - you can't always see the sisters

N2 It would be handy if you could go to the School of Nursing and say I feel this and have some back up.

(Third years; first (group) interview)

Some nurses were apprehensive about working on a cancer ward; the majority were guided by the ward's reputation for good nursing care and good teaching (See discussion in Chapter Five).

Students assessed the ward as an educationally positive experience if they mastered the required tasks. Firstwarders were concerned that the nature of nursing work on Taylor did not provide sufficient opportunities to practise certain basic skills:-

N I think we miss out on doing things rather than doing extra things - we never do dressings - it doesn't bother me at the moment that I'm not doing dressings but when we go back to school and I've never done a dressing and we go to our surgical ward it's going to be a bit (difficult)
(Firstwarder; second (group) interview)

Several firstwarders had other reasons for alleging that Taylor Ward was an inappropriate placement:-

N At the moment I'm just trying to learn the very basics of nursing care - just learning to care for a patient, this ward is too complicated, it's too specialised. I really found it interesting but not a lot meant much to me, it was so specialised, I didn't really understand it.
(Firstwarder; third (individual) interview)

Learning the basics in nursing care, however, was fundamental to the nursing school programme; the nursing school tutor in charge of student allocations had assessed Taylor Ward as suitable for learning the principles of basic nursing care. Basic nursing care is often devalued (Smith 1988a) by more advanced students, who regard the technical skills as more important and indicative of training. Although firstwarders were anxious that they would not learn specific skills, second and third year nurses on this ward, in contrast to nurses in Smith's (1988a) study expressed the view that working on Taylor Ward provided them with the opportunity to **consolidate** their basic nursing skills.

As most firstwarders had not worked in hospitals before, hence had no basis for comparison between wards, they assessed the ward on two criteria - could they acquire the prescribed skills on the ward, and was nursing practised as they had been taught during their foundation course in the school of nursing. Firstwarders on Taylor Ward expected the ward's version of nursing to reflect that of the nursing school; at this stage in their training they assumed a congruence between the two versions of nursing. Second and third year students, however, were prepared to find a divergence between nursing as taught in the nursing school and nursing as practised on the ward.

Melia (1984) looks at this issue and suggests that when confronted with discrepancy student nurses' priority becomes "fitting in" to a ward. She bases her definition of socialisation on Merton :-

the process by which people selectively acquire the values and attitudes, the interests, skills and knowledge - in short the culture - current in the group of which they are, or seek to become a member

quoted in Melia (1984) p 139

This suggests that socialisation takes place primarily through interaction with people who are important to that individual. For nurses in this study, as in Melia's, the relevant people were trained staff and other student nurses on the ward. More experienced students, hence, had learned to adjust their expectations of the experience on any ward to the ward conditions.

The evaluation by student nurses of Taylor as a learning environment related to their perceptions of the willingness of

trained staff to teach them. The orientation of the trained staff towards teaching students reflects both their shared perception of the ward ideology and ward stability.

Ward ideology has already been discussed in Chapter Five. As Chapter Three described, the study can be divided into three ward management periods. The impact of these management periods on nurses' perceptions of learning (students) and teaching (qualified staff) will now be discussed. The discussion focusses on the unstable management period when nurses expressed dissatisfaction with the quality of learning. I propose as an explanation that nurses' shared ideology then interacted with the concept (vision) of a stable management to re-impose the previously high standard of teaching/learning.

Management periods and nurses' perceptions of learning

a) Management Period One : Stability

The permanent nursing staff on Taylor Ward had the reputation amongst students of being willing teachers, and the wardsisters prided themselves on this. The description of Ward Report in Section One illustrated the emphasis that wardsisters placed on teaching as part of the normal life of the ward. A feature of the ward was regular teaching sessions for students, where one of the trained staff would address a particular topic and explore it with a number of the students. This took place approximately once a week until the change in management. The wardsisters suggested that they derived satisfaction from teaching. In addition they had a pragmatic approach to teaching, both formally and informally, demonstrating procedures to students on the ward - they suggested that intensive teaching and supervision resulted in

improved quality of patient care.

During the first management period, most students assessed their placement on Taylor Ward positively, observing that Taylor Ward fulfilled their criteria as a good ward for learners. Third years were enabled to complete their management training comfortably. Students remarked on the willingness of trained staff to teach them:-

N They were always ready to give you support if you needed it, if you weren't sure what you were doing - they always seemed to have time to help you

JK Did you feel that was important?

N Yeah, if I wasn't sure what I was doing, like my careplan for the patients, they were always there to help - they were always saying, "Are you OK, is there anything we can do?"

(Firstwarder; third (individual) interview)

Students observed that the atmosphere on Taylor Ward differed from other wards particularly with regard to social relations between trained staff and students. Students were encouraged to call trained staff by their first names; trained staff joined them for dinner, an unusual occurrence for student nurses at Suburban Teaching.

b) Management Period Two : Instability

With the departure of the senior sister, Anne, and the three staff nurses, the regular teaching sessions for students on Taylor Ward were discontinued. Students whose placements overlapped Management Periods One and Two regretted this but suggested that this was a consequence of a group of new staff nurses prioritising learning ward routines themselves, rather than teaching students.

The relief sister noticed that students on Taylor were not receiving adequate practical teaching and endeavoured to teach as much as possible on the ward itself:-

Sr I would really rather work with a student nurse all morning than do a ward round but I can't. Because I think you get a much better standard of work from them in the end if you teach them. You work with them for a few shifts and then you say "Right, you go out and do exactly the same, keep the standards as high" and you get a marvellous response. And they think you're good, because they've seen you roll your sleeves up, put an apron on, and do the work. They think all the time, I'm sure, that sisters sit in the office and drink coffee.... I actually had a comment from a student who's left who said, "Gosh, you're such a nice sister, I've never had a sister working with me before." Because I just showed her what to do, basic nursing care, turning patients, giving mouth care, they've just never had anyone to do it.
(Sister; second (individual) interview)

This quote illustrates how this sister, having observed that students were not being taught adequately, nevertheless shared the prevalent ideology that students ought to be taught and attempted, within the limitations of her job, to teach whenever possible.

Several negative features characteristic of the worker / learner problem arose during the unstable management period. Student nurses complained that Taylor Ward resembled other wards in the hospital in that qualified nurses were concentrating on their own work and failed to supervise learners. The failure to teach and consequently to learn altered the delicate balance between the trained staff and the students. The students felt disgruntled and patronised, and the staff nurses sought explanations to justify their defects. Student nurses complained that the trained staff gave them little guidance on the ward:-

N1 I think there is very little on behalf of the trained staff

- N2 for the junior members
N1 they should actually help us with our work
JK So you feel you could do with some support in carrying out the technical tasks?
N1 I feel they don't give you the sort of encouraging support - if they ever have anything to say its always to want to know why you haven't done this whilst they've been sitting in the office all morning and haven't seen how busy you are and want to know why (certain things haven't been done)
(Third year; second (group) interview)

The emphasis on teaching, characteristic to Taylor Ward during the stable management periods, became subsumed:-

- N The teaching sessions were so limited, because they always felt that whenever we asked about someone's condition or about what the condition involved they always felt it was going to be such a long drawn out teaching session, they'd always postpone it; they obviously didn't want to discuss it on the ward, like drugs on the ward, they never wanted to tell you on the drug round why they were giving this for a certain condition in the middle of the ward and they never got around to telling you at another time so it was very disjointed, never a continual teaching process there.
(Second year; second (group) interview)

Direct requests from students to staff nurses for help were dismissed:-

- N when you say (to trained staff) ,"do you think you could find time to....." "oh sorry there's not time" or "oh, yeah you do that" and they'll tell you a bit of it, but no-one's got time to teach us, well really if its organised properly there should be time to teach us **thats what we're here for, to be taught.**
(Third year; second (group) interview)

All third year students expressed similar sentiments. During their "medical" placement, they were preparing for their hospital finals and had hoped to consolidate principles of good nursing. In addition, this placement was designated as management practice, which should be taught and then examined (the management assessment) by the sister. The trained staff, however, found it difficult to set aside time to teach third years how to order drugs, and manage a ward. Third year students had to negotiate

(Strauss 1963) a time during which they could clock up the essential experience of managing a ward. Even then, they felt the time spent was wasted because of the general disorganisation on the ward.

N1 It's taken me several weeks to gain information from all the trained staff there about how to actually do a job, like ordering drugs, never actually someone has had time to sit down and explain like this is what you do - I find it very difficult.....

N2 My assessment was for last week and I'd never been in charge and I said no I didn't want to take the assessment I'd never been in charge - so this week I've come on and we're in charge every other day - one day N1's in charge, then I'm in charge but "There's the keys, you're in charge", but that's it, get on with it. I wouldn't have called that working hard with us by giving us the keys and putting us in charge because you just struggle for yourself then, find out what to do.

N1 I find it really difficult because not having the uniform as well - you don't get all the information - people don't come up to you if they want to know something because if they want any information relayed across to anyone they go to the staff nurses or to sister - they won't tell you even though you're in charge
(Third years; second (group) interview)

In addition to the pressures of preparing for their management assessment and hospital finals, third years found themselves having to explain procedures to more junior students.

N Again it's the feeling that as a third year you have to cope with it, it's expected of you to be able to cope, not to break down after all if you break down, who's going to do it, sort of thing? so you have to give support to the younger student nurses - you're expected to give that support and they look for it in a way from you. Then I think it helps **you** to be a little bit stronger in there when the time comes
(Third year ; second (group) interview)

Sometimes this "moral" obligation clashed with their own desire to attain their own goals:-

N As third years there has been too much expected of us, when we did have all the ill patients you were given the

illest or the heaviest to look after - the physically heaviest. Because you can cope with that - I don't know if they think you are more experienced in lifting - I don't know but that is the way it is, plus if there is only one trained staff on, you are given quite a bit of management on top of your patients and if the staff nurse is on a ward round or something you get all the queries from the other student nurses and it just seems that you're the only one there, because everyone is throwing question after question at you and you just want to say, "just leave me alone, I've got my patients to look after", but you can't do that
(Third year; third (individual) interview)

The spectre of end of placement reports influenced the behaviour of both student nurses and trained staff. A staff nurse recalls her student days:-

SN Those reports are always looming above you
JK They are?
SN Yes, definitely, it is an added pressure
(Staff nurse; first (individual) interview)

Trained staff were reported to use reports both as a "carrot" and as a "stick" (common behaviour on other wards). A staff nurse (in her first post after qualifying) remembers being anxious about her report as a student:-

SN As a student one is being assessed and they might think I can't be a very good nurse if I can't cope with death and dying. I think that's how I used to think, anyway it's difficult to remember now; I know I used to try to project an image of self-confidence and being able to cope
(Staff nurse; second (individual) interview)

The fear of receiving a bad report caused students to consider their position carefully before voicing criticism to the staff. One third year describes this:-

N I was angry that I couldn't say to her (sister) really what I felt because you've got to be so careful what you say because of the reports - you can't turn round and say, "Yes, I was bloody annoyed".
(Third year; third (individual) interview)

Student's ward reports were not only about nurses performance but whether or not they "fitted in" (Melia 1984). By the second interview, firstwarders were suggesting that although they were still spontaneous in their responses to trained staff, they wondered afterwards whether this would be reflected in their report. One of the staff nurses implied that the trained staff's personalities influenced a nurse's experience on the ward (Melia 1984).

JK Why is it important to know what the other nurses are like?

SN Because you are assessed throughout your eight weeks. Because you know people are going to be looking at what you do - going to be pulling you up for what you do wrong and at the end of it, you're going to get a report which is not just about your nursing, it's about your character. If somebody takes a dislike to you, then they can give you a really nasty report - it's just human nature - so you hope that from what other people say the staff are easy to get on with, there's no one who's going to impose themselves as a threat to you and you tend to work better - some people like to work under pressure and enjoy the challenge of working with an ogre but personally I prefer to work with people with whom I can communicate with on an equal basis and don't feel threatened by... So the first thing you want to know as a student is what the staff are like, whether you can feel at ease when you walk on the ward on your first day and you hope that you're going to be able to get a good report at the end.

(Staff nurse; first (individual) interview)

During the unstable management period the wardsisters admitted to the researcher that it was possible that students were struggling with their work and requiring assistance but their anxiety relating to reports prevented them from coming forward with requests for help.

Students whose placements straddled managements periods One and Two noted a change of atmosphere. The ward became tense, with the

trained staff intent on getting the work done (Melia, 1987) rather than achieving the balance between working and teaching characteristic of management period one. In particular nurses observed that the gap between trained staff and themselves widened. The staff nurses appeared distant and condescending in their attitudes towards students. One "mature" firstwarder complained:-

N It annoys me that I'm just as old as them, yet they patronise me. The only thing that I don't know is nursing, now I know everything else, I've done quite a lot and they can't patronise me to the sort of thing, well she doesn't know anything, it's only nursing I don't know - it quite annoys me that there is a divide. I feel as if I have to sort of bow down to them and I don't feel I should really. I appreciate that they know more than me and that they have got authority over me, because I could do something really terribly wrong, it's sort of a social barrier as well, its not only working - I can't explain what it's like.
(Firstwarder; second (group) interview)

Another firstwarder, from another set, made a similar observation about the interactions between students and trained staff:-

N One thing that surprised me was that the student nurses are looked upon as being very low
JK By whom?
N By the trained nursing staff; I got the immediate impression that there was a lot of hierarchy, that first years have to beg third years, and first years have to keep their mouths shut and do certain things - that shocked me a lot, there's no respect for them, they're not given any respect. It was a general attitude, not to me as a person.
(Firstwarder, third (individual) interview)

A third year corroborated this firstwarders impression that a rigid hierarchical system was at work:-

JK Do first years and second years ask you questions about what patients know? Is it a problem for them?
N yes, first years in particular.. again it was difficult the first couple of weeks we were here but now we know what the patients know or don't know, and generally

what's happening to them. We know what the doctors have said because we've chatted to the doctors about it so we can pass it on to the first years anyway. It's like a tiered system, first years go to second years, second years go to third years and we go to the trained staff and then the doctors.

(Third year; third (individual) interview)

During tea breaks, the trained staff remained in the office rather than join students in the canteen. Trained staff also joined students for meals less frequently, and when they did students found this inhibiting:-

N Sometimes they may come to supper with you but I don't really enjoy it; I can't relax if sister says, "I'm coming to supper with you", it's a different talk about work altogether - it's completely different - again you're being careful what you say - you can't turn round and say or I wouldn't turn around and say if I disliked a patient

(Third years; first (group) interview)

Part of the explanation for the rapid integration into the culture of Taylor Ward during management period one lies in the teamwork approach to nursing on Taylor Ward. Nurses, irrespective of their rank, were able to share work, responsibilities, grief, and even leisure. When unstable management did not convey a sense of belonging and cohesion, nurses felt ill at ease and manifested the signs of transience described by Melia (1984):-

N The thing I felt about the ward as a whole was the lack of everyone working together, there's a real distinction between the trained staff and the students. If there was something happening on the ward, we were always left in the dark about things and they never included you in any information going on about patients or prognosis or patients or "do patients know what was the matter with them, do they (wardstaff) know, did relatives know", you were never included in any of these discussions that went on, they spend hours and hours in the office.

(Second year; third (individual) interview)

c) Management Period Three : Towards Stability

The strength of nurses' shared ideology which stressed the importance of learning and teaching is evidenced by the reinstatement of teaching sessions on Taylor Ward which commenced a fortnight before the new permanent senior sister was due to take up her post and without consultation with Joan, the junior sister who had been in post through-out the unstable management period, but had de facto withdrawn from managing the ward. This recommencement of formal teaching signals the beginning of the third management period - "towards stability".

The decision to re-commence teaching sessions was taken unanimously by the relief sister and the staff nurses:-

Sr I was talking to the staff nurses yesterday, and they've all noticed that nobody is learning anything. They're not actually having a sit down for half an hour and talking about what they're learning or not learning. So each staff nurse is taking a subject and when there's an afternoon where there are students free, we will take half an hour, either in the room here or in a treatment room just talking. This afternoon I'm going to do general nursing care, because everybody who is in bed at the moment has got a pressure sore and nobody should have them - the doctors are furious, 'cos the care is not being done and you can see how many staff we've got - there's no excuse and the nurses are not doing what they say they're doing and that's because senior nurses are not working with them - they don't know (how to nurse).
(Sister; second (individual) interview)

From the above quote, it is clear that this decision was somewhat prompted by the medical staff, suggesting that despite nursing management's claim that they were autonomous, the medical staff kept a close watch on the quality of nursing care.

Students also contributed to the decision to resume teaching on

Taylor Ward. A number of students had told staff nurses that they were disappointed at the lack of teaching. One second year student presents her version:-

N I did feel that SN4 was very good though - she always made sure that everyone was ok; and she was always very interested to know and that's how we got the teaching sessions started because she said to the students, "Do you think the trained staff spend a lot of time in the office?" and I said, "yes". And she was really quite shocked that I had actually said "yes" instead of umm-ing and ah-ing and saying "Well, I'm sure you have work to do in there" and she said, "Well, oh, yes, I suppose we do" and she said "What else do you think" and I said of all the time they spend in the office on quiet afternoons, "Why can't we have teaching sessions", and so they've started which is one good thing and they don't spend so much time in the office, and they tend to ask now whether or not they do anything, but they do ask whether you're alright, whether you can cope, if you need a hand with anything. She said that if it hadn't been for students being honest and saying what they felt she'd have had no idea what we felt, because once I'd instigated and said, "yes" then everyone else said "yes".
(Second year; third (individual) interview)

A third year student describes the first teaching session and how this met some of her criteria:

N we had a teaching session, the first teaching session yesterday which ended up to be more of an informal chat with everyone asking, what's his diagnosis, what's his prognosis, really does go to show how much people are in the air about things and it ended up, you know, going on for ages with people just asking well, why are we doing that for them, etc. It is needed, yes, maybe you disagreed with doing things at first and only when someone put the reason to you, gives you a fresh approach
(Third year; third (individual) interview)

Anselm Strauss and his colleagues in their paper , "The Hospital and its Negotiated Order" (1963), suggest that hospital staff are constantly negotiating with one another to attain individual or group goals. As Hall (1979) states:-

the concept of negotiated order does direct our attention to the processes observable in the ward, and provides a way of linking individual activity with the shared or imposing of common perspectives on values (1979 p 170)

Even amongst one occupational group, there are difficulties in creating a uniform value system, especially a hierarchically disparate group such as nurses. On Taylor Ward, however, student nurses, **both of their own accord and in response to direct questions from staff nurses** set about ensuring that teaching sessions were re-instated. Thus with the re-introduction of teaching sessions the situation stabilised. Management's positive response to students' criticisms can be seen as evidence that the nurses, regardless of rank, subscribed to a similar worldview and values.

With the re-introduction of formal teaching sessions in combination with the new senior sister, Lynne, starting work (which removed some of the responsibility from staff nurses providing them with some security), the superficial trappings of the hierarchical system vanished. Students felt comfortable using the office as their "base" and interacting with nurses of different ranks.

Lynne's management style differed somewhat from that of Anne, for example, her interpretation of the nursing process, although this did not imply a change in the organisation of nursing work. She was particularly concerned about the ability and suitability of the prospective student nurses for the job of nursing, and particularly nursing on a cancer ward. She suggested that teachers of nursing should acknowledge that student nurses are young and

may be vulnerable, have limited experience of life which does not necessarily prepare them for the job of nursing. In addition, Lynne pointed out that adjusting to new living circumstances, and often a new city was in itself a considerable adjustment:-

Sr At eighteen they've got so many traumas. And it was something that struck me, there were a couple of students on the ward that were toiling to get to grips with London, being away from home, and then they had to come to grips with the fact that they had a few deaths.
(Sister, second (individual) interview)

Lynne's style was to "befriend" student nurses on a "human" level rather than accentuating the hierarchical differential. An example of this was her acknowledgement to a firstwarder that she, too, was homesick. This signalled that she was willing to listen to the concerns of students.

Teaching on Taylor Ward under new management reflected the philosophy characteristic of Management Period One that students should have opportunities to be taught; students should be encouraged and their successes re-inforced.

Sr I think they need to be told how well they're doing, particularly as firstwarders. As firstwarders I think they need to know whether they're progressing..... we are trying to do that **now**. I think they need emotional support and they should be given an opportunity to discuss anything that can be considered a problem for them - might not necessarily be a patient dying
(Sister; second (individual) interview)

Student nurses's accounts of ward atmosphere on Taylor Ward during Management Period Three resembled those of Management Period One. The trained staff seemed competent, friendly and willing to teach.

Students once again used the office as a base and ward report was used primarily as a teaching session. Students identified "teamwork" as an important characteristic of the ward:-

N Here there is no massive distinction between trained staff and students, you know everybody sort of mucks in together and we can call each other first names (not up to the sister)... just to know that they don't discriminate against you, it makes teamwork a lot more easier - it doesn't mean to say that my regard for them (staff nurses) is any the less, it just makes it a lot nicer.
(Second year student; first interview)

Students developed a sense of belonging to Taylor Ward (an unusual sensation for them) and described feelings of loss when they left the ward:-

N I cried when I left Taylor Ward. I really didn't want to go and I got a good report which made it worse as well, because you realise they really liked you .. I got an absolutely outstanding report and it really boosts your confidence and makes you feel that that's perhaps the sort of nursing you should do
(Second year; third (individual) interview)

When students completed most of their ward placements at Suburban Teaching they rarely returned to visit patients or permanent nursing staff. Return visits to Taylor Ward were, however, a common occurrence. On qualification, nurses requested to return as staff nurses, and hence it was unusual to have to introduce the ward culture anew to qualified staff. This demonstrates the sense of belonging and comfort that nurses felt on Taylor ward.

Conclusion

This Section has explored how worker/learner conflicts common to other studies (Melia 1987) were kept in check on this ward through

steady management who perceived teaching as part of their role, and how this fell apart when nursing management was unstable thus illustrating the centrality of stable management to the system. Unstable management may be seen as the primary cause of disequilibrium. When this occurred, newly qualified staff nurses, although they shared the same approach as the students, were struggling to learn their new job and were unable to do all they expected to do, and were expected to do. They acknowledged student nurses' complaints as legitimate and attempted and succeeded in re-instating teaching as soon as they got a grip on their job. The "triumph" of the shared ideology in setting management right is indicative of its strength.

Project 2000 (UKCC 1986) recognised that the conflicts inherent in using student nurses as a work force compromise nurse education in Britain. On Taylor Ward, for the most part, student nurses can be seen as supernumary. Consequently, students could expect to be taught at the same time as learning the job. During the second management period, students complained that the educational component to their work was neglected and that they perceived themselves as workers, not learners.

The strength of the nurses' shared worldview of nursing can be seen to have overcome "hiccups" caused by changes of staff and a lack of leadership. Proper nursing and proper teaching were re-instated on Taylor Ward through nurses, irrespective of rank, appealing to their shared worldview. This illustrates the main argument of this thesis.

CONCLUSION : THE IMPORTANCE OF CONTEXT

Although student nurses on Taylor Ward were allocated particular patients, after each block of days off they were rotated through the ward so that within a short space of time they were familiar with the **whole** patient community as well as with the different nursing procedures used on the ward. They were taught to view the patients as individuals, yet their allegiance was to the ward, rather than to individual patients (like the doctors). Nurses "worked" the ward, which included patients, making beds as well as cleaning the sluice, the kitchen etc. The ward had an idiosyncratic identity and culture with which nurses strongly identified. This culture respected nurses, even students, as responsible individuals, not a set (number) to process through the ward. This was mirrored by the approach to patients who were seen as individuals with needs and personalities, not bed numbers or a disease type. Unlike the patients whose temporary residence on the ward was of a uncertain duration, nurses knew exactly why they were there and how long they would remain on Taylor Ward. For the duration of their stay nurses saw themselves as the rightful inhabitants of Taylor Ward.

Student nurses assigned to Taylor Ward during periods of stable management appeared to embrace the ward culture. Their accounts of their experiences on Taylor Ward implied that they integrated into the ward life far quicker and less superficially than on other wards in the hospital.

Nurses working on Taylor Ward during the unstable management complained about the discrepancy between the ward's reputation and

the ward as they saw it. Their attempts to create a better ward stemmed from a fervent belief that good nursing was possible on Taylor Ward. The external impediments characteristic of other wards (hi-tech machinery, interfering doctors etc.) were absent and hence the only potential obstacles to good nursing related to whether their worldview was mirrored by ward practice, and whether ward organisation facilitated this. The fact that the staff nurses co-operated to re-instate teaching and restore the status quo for which the ward was famous, just weeks before the new senior sister was due to start work, emphasises the importance they too, attached to good nursing and the strength of their worldview.

In summary, good nursing can only be achieved under certain circumstances. Congruence between the nurses' worldview and ward ideology are fundamental.

CHAPTER EIGHT

CONCLUSION

Nursing is regarded as inherently stressful partly because nurses repeatedly confront fears and feelings about death (Menzies 1959). In addition many nurses traditionally have identified themselves with the curative aims of medicine (Benoliel 1977), and hence find dealing with death and the dying, stressful. Research has demonstrated that to cope with the problems generated in nursing the dying, nurses adopt a variety of strategies to limit or avoid contact with patients (Field 1987). Task allocation as the system of nursing facilitated the use of these strategies. Previous research focussed primarily on communication practices between healthworkers and patients. Communication with the dying should be seen on two levels; firstly as a source of stress for healthworkers; secondly as a strategy for containing stress.

Sociological research has examined the strategies employed by individuals to "make sense of" and cope with stressful work and the ways in which such strategies are incorporated into organisational structures and customs, including variations in different types of organisation (Cooper and Marshall 1980). Whyte's study (1946) illustrates well how members of one occupation (waitresses) come to terms with and survive occupational stress. Healthworkers in traditional settings are believed to organise their work with dying patients around two definitions: the first relates to healthworkers' definitions of patients' levels of awareness about their condition - on the basis of this assessment, healthworkers tailor conversations with patients; the second concerns healthworkers' predictions of

patients' likely dying and death trajectories - this can be seen as enabling healthworkers to prepare themselves both personally and professionally for patients' deaths (based on Glaser and Strauss 1965, 1968).

One indication that nurses have shared the approach of the medical profession towards the terminally ill is their view that cancer patients should not be given full details about their illness - they justify this on the grounds that incurable patients would become depressed and difficult to manage (Bond 1982). To minimise the likelihood of disclosure and as a measure of self-protection against becoming "over-involved" with patients, many nurses have employed a distancing strategy (avoidance or withdrawal). This results in patients receiving essential physical care but becoming emotionally isolated from nurses. Efforts to change this behaviour have focussed on psychosocial methods with limited success.

With the introduction of the nursing process and increased use of patient, rather than task, allocation on hospital wards, nurses have been encouraged to engage in conversation with patients. In the USA, the implementation of various versions of the nursing process has led to a view that nursing values affective/emotional work over providing physical and technical care (Dunlop 1986). This concerted attempt to provide counselling type work, without training in counselling skills, may be seen as partly responsible for symptoms of burnout in nurses. Although the concept of burnout is still woolly, the notion is useful. It describes a type of work-related stress (not dissimilar to professional depression discussed by Firth et al. 1987), particularly common in

people-work (Stacey 1982) jobs. Nurses working in high death, high stress areas are believed to succumb to burnout; this results in attrition and / or frequent bouts of physical and emotional illness. Burnout can be seen as an extreme response to stress in nursing.

Different conceptualisations of stress abound. Most describe stress as unpleasant, noxious and to be avoided or lessened. Stressful factors in nursing include not only the job per se (see above) but a number of other factors relating to medical category and personality of patient, characteristics of nurse, type of setting and the way in which nursing work is organised. Most studies reporting stress in nursing cite these factors (as stressful) and suggest psycho-social measures to ameliorate symptoms. Marshall (1980) and Antonovsky (1987), looking at stress from different perspectives, suggest that the assumption that certain events are stressful for all people at all times needs to be questioned. It is possible that what for one group is stressful, is perceived by another as challenging. Marshall (1980) and Firth (1986) also question the assumption that nurses find psycho-social measures of relieving stress appropriate - they wonder whether talking about experiences of stress is perceived by nurses as helpful. This study goes some way towards investigating these crucial questions.

The study reported in this thesis was undertaken to verify the supposition that nurses in the UK experience stress when working with cancer/dying patients in an acute setting and to ascertain whether over time, they learned to employ strategies such as distancing or alternatively displayed symptoms of burnout. The

aim was to elicit accounts of stress from nurses working in a cancer ward in order to establish which types of support structures could best alleviate this stress. As death in Britain still occurs primarily in acute settings, this type of ward was chosen as the fieldwork location.

The methodological approach adopted explored the relationship between caring for dying patients and nurses' perceptions of stress. This kind of sample was chosen because most nurses who care for dying patients do so without having chosen this as their particular vocation. This study did not take a single snapshot view of the ward, but re-interviewed the same nurses over time to ascertain whether their views of stress and indeed of caring for the dying changed as they were socialised onto the ward.

The data generated in the fieldwork redefined the research problem into a number of constituent questions (described in Chapter One). The first concerned how nurses in this study conceptualised "stress". In explaining their perceptions of stress, nurses provided an account of their views of nursing. Stress for these nurses related to whether they experienced conflict in attempting to operationalise their concepts of "good nursing". This clearly articulated approach to patient care was based on a personalised, individualised model which was unrelated to patients' medical categories. The second question explored why nurses' on Taylor ward did not experience caring for cancer / dying patients as stressful. I have argued that when nurses feel enabled to practise nursing as they see fit, and experience the ward as supportive both of them and of patients, the nature of patients' conditions is at one level irrelevant. (At a structural level the

patient's condition is relevant insofar as those conditions commonly viewed as most stressful i.e. where patients are dying, provide the best setting for such congruence). The third question sought to identify those aspects of this situation which differ from other circumstances in which cancer patients are nursed (and have been shown to cause stress for nurses). Superficially there are few differences; although replication of this study was not undertaken, this ward was chosen because it seemed representative of the settings in which dying / cancer patients are nursed in Britain. Much of the nursing was undertaken by students, also a feature of British hospital care. Other than the sisters who had chosen oncology nursing as a vocation, and the staff nurses, many of whom had requested to work on Taylor Ward, nurses were simply assigned to this ward regardless of their personal preferences. Although many student nurses were at first apprehensive of working on a cancer ward, these anxieties were quickly dispelled. The explanation for these findings lies in the interaction between the nurses' ideology of nursing, "good nursing", and the "good ward", the context in which they were working. Although several authors have pointed to the importance of these separate features and the ideal that they should be compatible, this thesis illustrates how this worked, and under what circumstances it floundered.

This thesis aimed to explore whether nurses' conceptualisations of stress and support for nurses working with dying / cancer patients, changed during their work on this ward. Accounts from firstwarders, who joined the ward reflecting lay perceptions of cancer and death, suggested that as they worked on the ward they became less fearful of corpses; on the contrary they discovered the therapeutic value of laying out patients whom they knew well.

They also moderated their views regarding disclosure. More experienced nurses, however, showed little modification in their views towards caring for dying / cancer patients over their eight week placement. What did emerge from this study was the effect of changes in ward structure on nurses' feelings about the ward and about the quality of their nursing. This study thus identifies changes in the context of their work which forced nurses to clarify their perceptions of nursing, stress and support.

The nature of good nursing

Nurses shared a worldview that their primary responsibility was to the patient. The quest to do "Good nursing" was articulated frequently. Nurses equated "caring" with "good nursing". Their conceptualisation of caring was not restricted to emotional / affective aspects of nursing. "Caring" included all aspects of nursing: physical, technical, practical, domestic, emotional and affective. Caring included aspects of labour and love, as well as routine and ritual.

"Good nursing" implied an ability to assess and meet patients' needs regardless of which components of nursing were required. "Good nursing" meant spending considerable time with patients, ascertaining their bodily requirements, as well as emotional / social/ practical needs. Some patients were comatose, or semi-comatose; ascertaining whether these patients were in pain or had other physical symptoms could be problematic. All patients were viewed as individuals with rights. Nurses believed that whatever concerned the patient, became a nursing issue. This required "counselling type" skills, to elicit the problems and then "reassure and encourage" patients.

In contrast to other studies, nurses on this ward, irrespective of rank, valued basic nursing. Basic nursing care was the foundation stone of nursing. Nurses in this study took pride in providing basic nursing care, and believed that this was something they could and should do well. Even those nurses who expressed a preference for surgical or high-tech nursing admitted that basic nursing care was fundamental to good nursing. "Good nursing" implied "really caring" - viewing the patient as a whole person and paying attention to all his/her needs.

Smith (1988a) found that only on oncology wards, where the medical specialty legitimated patients' affective needs, did student nurses learn about affective as well as technical nursing. She reports that on other wards even where wardsisters were committed to emphasising patients' affective needs, students did not recognise this either as work or learning material (p548). In this study which was of an oncology ward, all ranks of nurses saw meeting patients' affective needs as legitimate work, requiring skills which could be taught or learned (by imitation). Nurses suggested that "good nursing" incorporated affective and emotional components. These affective nursing skills were part of their professional repertoire, and were not simply based on women's intuitive skills derived from mothering etc. "Good nursing" could be practised by male nurses, too; the male charge nurse on this ward fitted their definition of a good nurse. He was not feminised by these nurses; on the contrary they suggested that his status as a man and as a shop steward influenced the way in which doctors and other non-nurses interacted with him.

Other than firstwarders experiencing their first ward allocation, nurses arrived on Taylor Ward with clearly articulated perceptions of "good nursing". Most nurses had encountered "good nursing" on previous allocations (i.e. in contrast to Smith's (1988a) findings, affective nursing was valued and practised in settings other than the oncology ward); those nurses who had not personally encountered "good nursing" before, derived their concept from the nursing school and colleagues' accounts.

The nurses' concept of good nursing can be seen as embracing a care model of nursing which could cope with patients dying whereas the integration of the concept of dying is more problematic within the cure model (medical ideology). Contemporary nursing can conceptualise a role (for itself) vis a vis dying patients; this stance has been strengthened through the adoption of some of the principles of the nursing process which in particular acknowledges patients' emotional well-being as a legitimate component of nursing.

Thus "good nursing" as a category can be distinguished from good or curative medicine. In contrast to student nurses in Smith's study (1988b), nurses on Taylor Ward subscribed to a philosophy which they believed to be "the nursing process". This was a patient oriented caring approach which was a way of gaining knowledge and acquiring skills. To many nurses in this study, particularly student nurses, the concepts both of task allocation or a medical approach to nursing were completely alien. Thus nurses in this study shared a conceptualisation of good nursing.

Nurses viewed caring for the terminally ill as challenging. Many nurses perceived this as "really nursing" because it emphasised those components of nursing not incorporated in other disciplines. Terminally ill patients were different from other disease categories of patient only insofar as they rarely required technical nursing. This afforded nurses freedom to plan nursing care with minimal interference from other disciplines.

Nurses in this study incorporated nursing the dying and the dead into their professional ideology. "Nursing care" could take over when medicine failed to cure. The strength of this belief has been demonstrated. In contrast with Smith (1988a), the concept of tender loving care (TLC) had a positive connotation for nurses. Nurses felt aggrieved and dissatisfied when patients did not have "good deaths".

Stress for nurses was caused by factors which prevented them from practising good nursing. Impediments to acquiring particular skills specified by the nursing school were also a source of stress to student nurses. In contrast with other studies, nurses did not view interacting with cancer patients as a cause of stress. This can be explained by the fact that in their view, Taylor Ward was a good ward.

The nature of the ward

Taylor Ward had the reputation of being a good ward. Nurses described a good ward as one which had a good atmosphere, where good nursing was practised and had a stable permanent staff, supportive to students, with a compatible worldview of nursing. The primary feature of a good ward is that it contains rather than

generates conflict for nurses. This ward was not experienced as a good ward throughout the study; this facilitated a comparative analysis of those features which constituted nurses' perceptions of a good ward.

When nursing management was stable, the context of nursing work on Taylor Ward contained the causes of stress documented in other studies. The structures on this ward gave nurses the means to make sense of personal stress within their role and gave them role definitions which could cope with this. This was imposed on nurses through a set of rules which were conveyed to nurses in a positive, protective way rather than with the threat of punishment.

A good ward facilitates good nursing. Certain features of the ward's ideology, culture and structure interacted to create the atmosphere of a good ward. On Taylor Ward nurse / patient ratios were higher than on other wards - this reduced pressure of work and enabled nurses to spend concentrated time with patients. Nursing leadership was strong and had clearly defined management goals. Nursing management gave clear signals to nurses regarding acceptable demeanour on the ward. Although nursing management worked alongside medical staff, they saw themselves as relatively autonomous, possibly because research was not a particularly important component of medical work. Inter-disciplinary relations were good.

The principles of good nursing were emphasised during ward report, and re-inforced on the ward. Good nursing practice was ensured through constant supervision of students and peer review. Nurses

were encouraged to work as pairs. This diminished emotional isolation of nurses (Bond 1982) and created an instant support network.

Melia (1987) identified the conflicts inherent in the worker / learner status of student nurses. She found that the priority of student nurses in her study was to "fit in" to the ward to which they were currently allocated. The process of fitting in meant acknowledging that nurses were juggling with (and being conflicted by) two potentially competing versions of nursing - nursing as taught and nursing as practised. Nurses on Taylor Ward reported having experienced these conflicts on previous ward assignments.

Taylor Ward was selected by the nursing school to provide training for student nurses; these students were concerned to meet their educational requirements. At the same time, they did not wish to compromise the concept of patients' needs as the priority. Ward management used learning as the vehicle for students to ascertain these needs. Hence when the ward worked well, students rarely experienced conflict between these priorities. In contrast to Smith (1988a) who notes that wards rarely accommodate the changing personal and professional agenda of student nurses as they work towards qualification, nursing management clarified goals with individual students and worked towards achieving these. This partly explains why nurses who had been assigned to Taylor as students clamoured to return as staff nurses.

Smith (1988a) noted that the system of patient allocation as practised at "City" hospital fragmented rather than facilitated nurse / patient contact. After Menzies (1959) she suggests that

this protected nurses from becoming over-involved emotionally with patients or with each other "in the absence of structures to enable them to do so" (Smith 1988a p553). Taylor Ward provided these structures. Unlike the system of patient allocation in Smith's study, nurses on Taylor Ward were allocated patients for a seven or ten day stretch depending on the off duty rota. Nursing management acknowledged that such intensive and extended contact would imply that students shared their lives with patients as well as vice versa. The relationship had to be contained within professional boundaries without destroying the caring component which was seen as fundamental. The professional aspect of the relationship was emphasised by nursing management. Students had a responsibility to ensure that patients' needs were established and met. This required nursing skills. At the same time, the opinion of the student was valued precisely because the student knew the patient best.

Nicklin (1987) suggests that nurses experience role ambiguity unless regular appraisal and constructive feedback is built into the system. Although appraisal did take place on an individual basis, the structure of ward report incorporated elements of constructive feedback as a learning device. During ward report, trained staff taught students methods of eliciting information from patients without risking imparting confidential information in return. This approach was re-inforced on the ward. In addition students were actively discouraged from maintaining personal contact with patients after discharge or with relatives after death. Grieving could be achieved within the confines of the job. Nursing management thus conveyed that the affective / emotional components of nursing patients were confined to the professional

relationship. This relationship was both facilitated and contained by the rules of behaviour. Chapter Five described those pertaining to the management of death, the management of information and the management of emotion, three critical areas which could give rise to stress for nurses (see Chapter Four).

Nursing management acknowledged lay fears of cancer and cancer deaths. Newly assigned nurses, regardless of rank, observed how deaths were discussed in terms of "good and bad deaths" and how nurses struggled to achieve good deaths for patients, and for their relatives. Death was carefully managed to protect both patients and nurses. Temporal predictions (Glaser and Strauss 1968) facilitated a better experience for all concerned. Laying out was seen as almost a religious ritual. Nurses derived professional satisfaction from the concept of performing the last job well. Laying out also enabled nurses to grieve quietly or communally with a peer. Trained staff kept a high profile to reassure nurses that help was accessible. The prominent way in which deaths were recorded (writing R.I.P. in the ward book in red next to a cross, if appropriate) also reflected that death was a normal occurrence and not a failure.

The issue of disclosure of illness has already been raised. Nurses learned that it was possible to develop relationships with patients and elicit their concerns without revealing information. An elaborate system controlled information about patients on the ward. (This system of controlling patients has marked similarities in another occupational culture - how waitresses controlled customers, politely but firmly, described by Whyte (1946)). On Taylor Ward, this control of information had a number of elements;

this included the banning of notebooks which was counterbalanced by repeatedly encouraging students to approach trained staff for help. In this way, students had access to learning whilst trained staff retained control over information (and students). Students began to adopt the ward philosophy towards disclosure, which emphasised the complexities of this issue, and the position that neither nurses nor doctors should impose their views of disclosure on patients. Patients signalled what they wanted to be told and the nurses' task was to pick up those signals. Specialist oncology training and experience in the field taught nurses how to disclose where necessary. Such expertise was available amongst the trained staff and indications that patients wanted information should be directed at them. Student nurses were reassured by promises, followed by action, that responses to patients' questions would be forthcoming. Through interpreting the nursing process, coupled by long term patient allocation nurses could develop considerable knowledge about patients. Regardless of rank, this knowledge was respected and consequently nursing and medical management considered individual nurses' opinions when making decisions.

Nursing management acknowledged that maintaining this level of nurse / patient involvement could lead to responses of grief when the patient died. Nurses' accounts demonstrated that emotions were legitimated on this ward and clear boundaries were set within which to express these emotions. This challenges both the image of the nurse as composed and detached irrespective of the emotional component of the work (which has been described by Smith 1988a) and findings from other studies (e.g. McElroy 1982) which depict the nurse as unable to cope in the face of emotional

strain.

Consideration of what less experienced nurses could take on board emotionally implies setting clear boundaries in areas where nursing management viewed nurses at risk. Rules were not simply for sanction (for which they were used rarely) but designed to clarify nurses' roles and protect them from difficult situations and emotional trauma. Thus in addition to disclosure of information, the management of emotions was also encompassed by rules, providing nurses with a coherent framework within which to work.

The structures within which nurses worked provided support for nurses, including dimensions of emotional support. Transience (Melia 1987) is a well documented feature of nurse training. Melia suggests that student nurses, in order to progress, learn to adapt to different circumstances and develop strategies to protect themselves from excessive emotional involvement with patients or wardstaff. Nurses do not develop a sense of belonging to a ward; this facilitates the next move. Findings from this study suggest that when nurses are not faced with role ambiguity and conflict they can become integrated into a ward environment albeit for a short time, and that this might have implications both for student learning experiences and quality of care. (This long and short-term implications of adjusting to the next placement have not been addressed by this thesis).

On Taylor Ward, nurses did not suffer emotional isolation because they worked in pairs within a large "team". Nurses developed a sense of attachment to the ward, as a comfortable place in which

to work. This was facilitated partly because other nurses on the ward shared the same approach to nursing and therefore **understood** their perception of conflict and when it arose, they were suitable confidantes.

During the stable management periods, nurses' reactions to the concept of additional psycho-social support is partly in line with Marshall's (1980) hunch that nurses might feel uncomfortable at the thought of being coerced to share their feelings with work colleagues. Nurses' objections to this can only partly be explained by their fear of revealing "weaknesses" to superiors who wielded power over them. On the other hand some nurses had had positive experiences of groups elsewhere and acknowledged that they had found these helpful when in conflict or distressed. Nurses were in agreement that when this ward worked well, the nursing staff rarely experienced conflict or distress. In this study, individual nurses who viewed themselves as requiring emotional support, reported that they had developed personal strategies (separating work from private life) or support networks (confiding in mothers, boyfriends or colleagues) to deal with this. Hence, in contrast to other studies, findings from this study suggest that decisions to introduce psycho-social support measures should not simply be made on the basis that the particular job performed (for example nursing the dying) is viewed as stressful. Contextual factors need to be taken into account.

On other wards, nurses had learned to restrict demonstrations of emotion to peers usually of the same rank. On Taylor Ward nurses discovered that they were permitted to display emotion in front of all ranks of nurses. Shared grief was also legitimated and

enabled nurses to work through outstanding issues with colleagues on the ward. Nurses were permitted and encouraged to cry but were expected to shield this from patients. It was permitted to cry with relatives. Demonstrations of distress should be confined, if possible, to the sister's office and should be time limited. Nurses had responsibilities to other patients which had to be fulfilled.

Field (1987) points out that

one way to break down or reduce anxiety is to provide a positive experience of nursing the dying within a supportive environment, so that these initial apprehensions can be overcome before they become part of a negative feedback sequence of anxiety, avoidance, low satisfaction and reward, and lack of confidence in the nurse's capacity to relate to the dying (Field 1987 p 160)

Nursing work on Taylor Ward was organised in a manner to provide such a positive experience. Field (1987) cites time available as the critical factor determining how nurses perceive their work. Findings from this study corroborate his view - nurses repeatedly acknowledged that they had sufficient time to do good nursing (See Chapter Four). They contrasted this with time pressures on other wards, suggesting that nursing terminally ill patients required flexible working conditions and that the structure of nursing work on other wards did not accommodate this. Self-caring radiotherapy patients were sometimes placed on other wards, when Taylor Ward was full, but even if it meant relocating self-caring patients, space for the terminally ill was always found on Taylor Ward, which had the structures to cope with their needs. These structures were multi-faceted, and included high staffing levels. Another structural feature which minimised potentially stressful

situations was the planned location of patients with particular requirements, for example moving dying patients out of multi-bedded wards to avoid disturbing other patients.

Sudnow (1967), James (1986) and Field (1987) raise the issue of how types of patient are constructed as "normal" on different wards. Nurses' emphases on how this ward accommodated the needs of dying patients corroborate this view, that nurses construct definitions of normal patients in each situation and order their work around these definitions.

The importance of role certainty to the way in which nurses perceive their work and their work environment has already been discussed. Another aspect of this related to the clarity with which nursing work was assigned. This contrasted with other wards where nurses reported that they learned what was expected of them and how they should interact with patients by trial and error. On Taylor Ward there were clearly verbalised and non-verbalised indications of appropriate behaviour.

The importance of context for nurses thus emerges in this study, for example their sense of belonging, albeit for a short time, to a particular ward, to a particular group of other nurses doing the same job at the same time. The sense of cohesion amongst nurses on this ward contrasts with other studies of nurses, particularly nurses during training, and with the fragmented way in which doctors work; doctors see themselves as responsible for individual patients or even individual "beds" rather than being part of a team which has a setting of its own.

This study presents findings about nurses' perceptions of context which are dissimilar from most accounts from similar settings (acute wards in general hospitals), but to an extent corroborates the accounts of nurses working in a continuing care unit in Scotland reported by James (1986). Although nurses in James' study were less well supported by structures enabling them to operationalise their "carework" ideology, they could describe organisational features which could have facilitated operationalising their carework principles.

The account of context presented above, describes Taylor Ward when it worked well (the first and third management periods) and when nurses perceived it as supportive of their goals. An analysis of their concepts of a supportive context was facilitated because for part of the study (the second, or unstable management period) nurses viewed the context as failing them and no longer supporting their goals nor meeting the patients' needs. At that time those features which usually supported nurses and minimised experiences of stress and distress flagged, and nurses no longer viewed Taylor Ward as a "good ward" nor facilitating "good nursing".

The interaction between ideology and context

This thesis is about processes and interaction - that of the nurses' worldview and the context in which they worked. The way in which the ward was managed was possibly unusual in the NHS with nurse managers so autonomous that they could decide to admit a researcher to the ward without requesting permission from superiors. The nursing management appeared to make nursing decisions without permission from the "consultant in charge."

The congruence between the nurses' worldview and ward context supported them against well documented causes of stress in nursing and reduced anxieties that might have emanated from primitive fears of cancer, the dying, the dead or from feelings of failure. The structures of Taylor Ward, and the way nursing work was organised mirrored the ideology of the nursing staff. It emphasised "caring" as a concept, an ideology, a method and a behaviour. "Caring" on Taylor Ward resembles James' (1987) equation that care = emotional labour + physical labour + organisation. "Caring" for nurses in this study transcends emotional / affective nursing, embracing the needs of the nurses as well as the patients.

Fundamental to this argument is the strength of the nurses' worldview that nursing incorporates caring as well as a responsibility to support doctors in their quest for cure. Feminist research has suggested the centrality of 'caring' and the need to take nurses' views seriously to ascertain whether nursing embraces an ideology distinct from medicine. This thesis has pursued this view and furthered an understanding of the conflict faced by nurses in some settings.

In the nature of things, interaction is not static. When the ideology of the nurses flagged, the ward structures responded to prop it up. Even when the reverse occurred, the ward management was able to acknowledge this and redress the balance. The period of unstable management when this balance was not maintained, gives a good example of the way in which it was this interaction between ideology and context which supported the nurses.

Nurses in this study had highly articulate concepts of nursing. In particular they shared a belief that nursing was about "caring for patients". The congruence between the priorities of student nurses and nursing management must be seen as facilitated by nursing policy determined by the hospital nursing service. This compatibility between ideology and work setting (where the demands of the job usually prevail) may appear unusual, but with the profession of nursing working towards a clarified ideology might be indicative of nursing goals in the future. A second year student perceived this congruence:-

N I think the patients always come first but having said that you have to have a very sound staff to be able to put the patients first - you can't give the patient adequate treatment in any way unless everybody is happy about it and you can actually go and do it - the patients' well being is the priority - there does seem to be an understanding between the staff in order for that to happen.
(Third year; third (individual) interview)

When these concepts were mirrored by the context, nurses derived satisfaction from their work and felt integrated into the ward culture. In the same way as nurses were enabled to develop trusting relationships with patients and consequently feel loss at their death, nurses developed a sense of belonging to Taylor Ward and verbalised feelings of loss when they moved on to the next job. As this study did not include re-interviewing nurses after their next allocation, findings can not answer how nurses dealt with this loss - further research is needed in this area.

Nurses praised the quality of nursing care practised on Taylor Ward but did not ascribe this primarily to the emotional style of management manifested by the wardsister (cf Smith 1988a). This thesis supports the contention of many writers that wardsisters'

management styles influence the way in which nurses perceive and experience their work. Findings from this thesis, however, suggest that wardsisters' management styles are only one constituent factor of the context of nursing work. Other structural factors also contribute to the context, and hence the way nurses perceive their work. For example, however much a wardsister emphasises affective / emotional aspects of nursing work, nurses cannot operationalise this (i.e. spend time with patients) without adequate supportive structural features e.g. staffing levels. This reinforces the contribution of Glaser and Strauss (1965, 1968), who demonstrated the way in which structures determine the experiences of healthworkers caring for dying patients. Nursing management in this study also constructed rules and routines to enable nurses to work with dying patients but these rules incorporated the concept of caring into nursing, both for the good of the nurses as well as the patients .

Proposing psycho-social measures to alleviate stress in nurses, the literature has suggested a relationship between support for nurses and the quality of patient care. This thesis proposes that support can relate to congruence between the nurses' ideology and the ideology espoused by the context and that additional support measures may be unnecessary. A shared ideology of what nursing is and how it differs from other disciplines, can shape the context of nursing work.

The thesis demonstrates the interaction between the dynamics of nursing ideology and nursing context and consequently could be relevant to other situations, both in nursing and in other health care professions or people-work jobs.

Practical implications

The practical implications of these findings suggest that unless there is congruence between their own ideology and the context in which they work, nurses working in high stress areas might still benefit from additional support measures, some of which have been described. Medical oncology, the cancer specialty, promotes cure as the ultimate goal; hence in units where dying patients are admitted alongside treatment patients, nurses may feel themselves in conflict with the predominant ideology or with certain nursing or medical practices. It might, on the other hand, be more important to look at ward management and see how attitudes and the structure of nursing work might be changed to enable nurses to provide the care to all categories of patients that they feel constitutes professional nursing.

Theoretical implications

Professional stress as a theoretical concept has assumed that stress is always malevolent. It requires further work to analyse whether stress should or could be perceived as a facet of an individual, a facet of a situation, or a response to certain interactions. Much of this work can be done using the principles of symbolic interactionism in order to ascertain whether what has been presumed to be stressful is indeed perceived as malevolent at the individual, circumstantial or interactional level.

This study suggests that the stress described in other studies of cancer nurses might be related to their frustration at not being

able to provide what they see as appropriate "nursing care" - be good nurses. An alternative explanation might be that these stresses related to role ambiguity - an uncertainty concerning their role in the face of death in studies where nurses did not have a clearly articulated ideology. Contemporary nursing is redefining itself, in relation to the services it provides, and in relation to other health professions. Nursing responses to the care of the dying will no doubt be re-evaluated, particularly in response to predictions that large numbers of young people will contract AIDS.

Recent nursing rhetoric has begun to describe different models of nursing (e.g. summaries by Aggleton and Chalmers 1984; Kozier and Erb 1988) as opposed to the nursing process, which many writers agree is a method, rather than a model. Although findings from this study cannot constitute the basis for a nursing model, it is clear that nurses had developed for themselves their own model of nursing. The nurses interviewed in this study were ordinary nurses, not self-selected for cancer nursing. They clearly did not subscribe to the medical model of nursing (in contrast to Smith 1988a) - their model embraced some of the principles underlying the nursing process; these emphasise whole person care and include aspects of "caring" not evident in many studies of practice which support the view that nursing is still subordinated to the curative medical model in Western Health care systems.

The interaction between nurses' expectations of nursing (their ideology) and how it is practised on the ward could be seen to be a crucial determinant of how nurses experience their work. Ward

culture and idiosyncratic practices can be at variance with nursing as it is taught, bearing in mind the separation between teaching in the nursing school and teaching on the ward. A synchronisation of goals between ward and school, taking context (which includes nature of patients' illnesses) into account, might reduce the symptoms of stress in nurses. As the nursing profession gains confidence in its separate identity, with its own agenda for training nurses as professionals rather than as workers (Project 2000 proposals), and develops an ideology of a comprehensive nursing service which includes the emotional component as well as technical skills, other health professions may be willing to acknowledge which situations put nurses at emotional risk and lobby for better conditions for nurses, for example, higher staffing levels.

APPENDIX

Abstract of research proposal

January, 1983.

Title:- The experience of nurses caring for dying patients:
A case study of nurses in one or more London
hospitals

An investigation into the experience of nurses caring for dying patients into a general hospital setting

- (1) to identify areas of distress and dissatisfaction
- (2) to examine the extent to which distress and dissatisfaction (if found) are alleviated by existing support available to the nurses both within and without the hospital and nursing school settings.
- (3) to explore those facets of care of the dying which the nurses find to be satisfying and rewarding

The hypothesis is that the experience of caring for dying patients differs in several respects from the experience of caring for patients likely to survive; the experience of caring for dying patients can cause distress (suffering) of an emotional or physical kind in some of these nurses; this distress can lead to an inferior quality of nursing service (as assessed by the nurses themselves and by objective criteria). This distress could be (and may be) alleviated by the provision of support for these nurses. Different types of support for oncology nurses have been documented, primarily abroad. An attempt would be made to gauge which types of support would be appropriate for nurses caring for dying patients in British general and/or teaching hospitals.

Setting

An oncology ward in one or more London teaching hospitals which also function(s) as (a) district general hospital(s). This would ensure a greater distribution of types of disease and minimise the chances that most patients were from out of town seeking specialist attention. The researcher would first spend a week or two observing the ward to familiarise herself with ward structure and routine. Following this, she would meet with student nurses and trained nursing staff in groups and / or individually to learn about their experiences of working in an oncology unit. To facilitate accurate analysis of data these sessions would be tape recorded. Any transcription of data would be done solely by the researcher and an effort would be made to disguise all identifying characteristics.

Jeanne Katz

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