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PROFESSIONAL IDEOLOGY AND THE PRACTICE OF WORK: NURSES' CARING WORK IN A SURGICAL INTENSIVE CARE UNIT

by

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A dissertation submitted to the Graduate Faculty in Sociology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York

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Abstract

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by

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For the past two decades the nursing profession has embarked on a professionalizing project that claims caring is the essence of nursing. Nursing's scholarly discourse has generally described caring in terms of nurses' interpersonal relationships with patients and their family members. Using ethnographic methods, this research investigated the relevancy and meaning of this ideological stance to nurses' actual "caring work." Following Arlie Hochschild's concept of "emotional labor," caring work was defined as efforts by nurses to assist a patient or family member with emotional suffering. Day shift nurses in the surgical intensive care unit of an urban hospital were studied. The cultural, social structural and situational contexts of the nurses' caring are described. The research revealed that an ideology of care was of limited use to the nurses. Caring accounted for only a small part of the nurses' daily work and neglected their wide range of technical competence. Care as ideology also demeaned the nurses' status as professionals because they regarded their caring work as unskilled labor that had little value in the surgical intensive care unit or to society.

DEDICATION

I have been given two lives.
This dissertation is dedicated to those who made it possible:

For my supportive, wonderful and loving parents, Betty and Edgar Merkel.
Thank you for delighting in every bit of my life.

For my extraordinarily skilled and kind physicians, Dr. Ira Wagner and Dr. John Koulos.
How fortunate I am that one is already my friend and the other is my new "pal."

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CHAPTER ONE

INTRODUCTION: NURSES' CARING WORK

The Nursing Profession's Ideology of Care

For the past two decades the nursing profession has embarked on a theoretical and empirical project to distinguish caring as the conceptual center of the profession (Leininger 1984; Morse et al.1990). Although nursing's ideology of caring has its origins in the popular legend of Florence Nightingale as the nurturing and self-sacrificing savior of the sick, scholarly attention by the profession to this subject is fairly recent (Armstrong 1983; Whittaker and Olesen 1962). The idea of caring has become so significant to some as a definition of nurses' work that one author goes so far as to suggest that a failure "to care" is a failure to practice professional nursing (Paternoster 1988).

But what is "caring?" Many emphasize its interpersonal dimension. Indeed, the profession's positioning of caring as its primary work comes at a time when nursing is increasingly examining the interpersonal aspects of the nurse-patient relationship. Armstrong (1983), in his review of nursing texts, points out that prior to the early 1970s the caring role of the nurse was restricted primarily to the biological functioning of the patient in a way that rendered the patient as object. In this role the nurse monitored and tended to the patient's body. Gradually nursing began to rewrite its history to construct an identity of the nurse as concerned with the patient as subject. The nurse was now committed to caring for the patient's psychological needs and communicating with the patient within a nurse-patient relationship. May (1991) also notes nursing's transition

from, what he calls, "practical material labor focused on the body," to labor that is oriented towards a patient's social and emotional problems. He characterizes this work as an informal, friendly relationship with the patient.

Jean Watson and the nurse-anthropologist, Madeline Leininger are considered the forerunners of caring theory in nursing. Leininger (1988) considers care to be "the essence and the central, unifying, and dominant domain to characterize nursing." She calls on nurses to study the phenomenon of care as a way to legitimize nursing as a professional and academic profession. Although she views caring as the definition of nursing, her description of caring emphasizes almost exclusively the interpersonal nature of nurses' work.

> Caring refers to the direct (or indirect) nurturant and skillful activities, processes, and decisions related to assisting people in such a manner that reflects behavioral attributes which are empathic, supportive, compassionate, protective, succorant, educational, and others dependent upon the needs, problems, values, and goals of the individual or group being assisted (Leininger 1978).

Watson's theory of caring similarly emphasizes the nurse's relationship with the patient as the locus of nurses' work. Considering care to be the moral ideal of nursing, Watson (1985) sees the goal of nursing, "to protect, enhance, and preserve humanity by helping the person find inner meaning in illness, suffering, pain, and existence, to help another gain self-knowledge, control, and self-healing wherein inner harmony is restored regardless of external circumstances."

Nursing's caring project has its critics from within the profession. Morse et al. (1990), in their review of twenty-three conceptualizations and theories of caring, conclude that it is underdeveloped as a concept and often lacks relevance for nursing. Dunlop (1986) observes that nursing theory within the United States increasingly ignores the body

and its associated physical care and emphasizes the psychosocial aspects. She wonders if it is wise to claim that nursing is the form of caring as opposed to a form of caring, as many nursing theorists propose. To do so gives little credit to other healthcare workers and devalues the physical care nurses render to patients.

The notion of caring as the essence of nursing has taken several forms. Morse et al. (1990) capably summarize and categorize the many forms of caring found in the nursing literature as, human trait, moral imperative, therapeutic intervention, interpersonal interaction and affect. The diverse nature of these conceptualizations makes difficult a universal definition, therefore, discussion of caring. There are a variety of ways in which caring is thought about, but they have in common the core conviction that care is an essential element in nurses' relationships with patients, meant to effect the patient's emotional well-being. Caring does not allow for the patient as object. It demands the nurse concern herself with the patient as subject, an individual, whose emotional experiences are to be known and attended to.

Caring for the emotional needs of patients and family members is a directive for nurses in most specialties. Hospice and palliative care nursing are specialty areas for which attention to the emotional needs of patients and families would seem an obvious professional norm. A recent palliative care textbook, in fact, devotes half of its chapters to such topics as the psychosocial needs of patients and families, grief and bereavement, spiritual care and sociocultural care (Kemp 1999). Perioperative nursing might seem a less likely specialty to impose norms on its members about handling patient's emotions. However, nurses who care for patients in the operating room and immediately after

surgery in the recovery room are also directed to take a patient's emotional state into consideration during their work:

> Research indicates that under general anesthesia some patients are able to recall conversations among surgical team members. Discussions of anatomical characteristics of patients, off-color jokes, and other non-health-problem-related comments might be remembered by a patient and considered a violation of the privacy right (Kneedler and Dodge 1994, 6).

Nurses who work in intensive care units are instructed that:

> . . . the course of illness is heavily influenced by the individual's psychological and social milieu. Each nurse, working with each patient, must find a way through the maze of equipment and the stress of nursing in today's environment to develop a therapeutic relationship that combines technical proficiency with caring (Clochesy et al. 1998, 49).

The professional dictum to tend to the emotional needs of all patients and families runs strong in nursing. However, studies of nurses' actual practices suggest that attention to patients' and family members' emotional needs may vary by specialty areas. Nurses in a neonatal intensive care unit studied by Swanson (1990) sent cards to the parents of neonates on holidays and special occasions. These nurses characterized their involvement with the babies as "falling in love." AIDS nurses have embraced a philosophy of practice that gives preeminence to the emotional and spiritual needs of patients (Fox, Aiken and Messikomer 1990; McGarrahan 1994; Merkel 1994). Chesla (1996) found that nurses who worked in pediatric and neonatal intensive care units tended to be more involved with families than nurses who worked in adult intensive care units. Although the nurses in the adult intensive care units in Zalumas' study (1995) believed that providing emotional support to their patients was important, they thought their most substantial contribution to

patient care was their ability to rapidly assess life-threatening physiological changes in the patient.

Research Interest

I have long been interested in nursing's caring ideology as it pertains to the interpersonal aspect of nurse's work. When I was beginning my undergraduate nursing education in 1974, I was schooled in Hildegard Peplau's theory of psychodynamic nursing that emphasized the nurse-patient relationship as the basis for nursing practice. Peplau (1952) described nursing as "a significant, therapeutic, interpersonal process." During my first year of study an entire course was devoted to her theory. I learned a set of communication techniques that were to enable me to meet the patient's emotional needs. I was taught to listen carefully to the patient and respond in scripted ways that were meant to validate patients' emotions, encouraging them to share more of their feelings and thoughts. Attending to a patient's emotions was considered to be a legitimate and important aspect of a nurse's work in that it confirmed a person's experience of their illness and facilitated healing. I was also expected to consider the emotional needs of the patient's "significant others," that is, their family members or close friends. We were taught that illness affects the patient and their significant others as a system.

Although unaware of it at the time, my early nursing education marked the beginning of the ideological shift in the profession from caring as defined primarily as concern with the body to caring as concern for the emotional. I started to become interested in the continued efforts of nursing to establish the interpersonal aspect of the nurse-patient relationship. Caring theories and the research that followed had become an

ideological position for the profession. They prescribed that the nurse seek a specific type of relationship with the patient in order to attend to the patient's emotional well-being through actual or feigned demonstrations of concern. Caring was a mandate to feel, although as evidenced by its many theoretical and empirical formulations, its implementation seemed to be left to the imagination of the nurse. Caring as ideology, however, specified nothing about nurses' actual work or feelings.

It was Arlie Hochschild's (1979, 1983) concept of "emotional labor" in one's job to orient feeling towards clients and customers according to norms for specific situations, that helped me frame nurses' caring work. She explains that social guidelines, "feelings rules," tell us what to feel in various situations. These rules are implicit in all ideological stances. Hochschild (1979) goes on to point out that people may not conform to the norms of behavior that are associated with an ideological stance. Individuals can do this by holding different interpretations of situations, or different sets of feeling rights and obligations. Inconsistently adhering to an emotion norm, therefore, might signal a rejected or irrelevant ideological stance, whereas consistently conforming to an emotion norm signals deference to an ideological stance. Hochschild's observations about the relationship between an ideological stance and feelings assisted me to formulate questions about nursing's caring ideology and the actual work of nurses with patients and families.

Preliminary Work

I have conducted two studies to explore nurses' caring work (Merkel 1990, 1994). For these studies I adopted James' (1989) expanded definition of emotional labor as my definition of caring work. She defines emotional labor as the work one does to deal with

other people's feelings that may or may not include trying to change one's own feelings. Hochschild (1990) has since modified her definition to fit James'. This definition includes both the idea of caring as an interpersonal relationship between nurse and patient aimed at knowing the patient's feelings, and the notion of a desire or feeling of responsibility to do so, implied in the idea that the nurse might have to change her[1] feelings. James' formulation of emotional labor was especially applicable to my investigations of caring work since it was derived from her studies of nurses' work with dying patients in a hospice setting.

My preliminary findings show that nurses accepted the legitimacy of the norm of caring work and tried to conform to the emotional norms set by the profession. They professed, or perhaps "fronted" great concern for the emotional well being of their patients, yet were not always able to conform to the norm to care (Goffman, 1959). Nurses differed in their definition of "care" according to the type of unit on which they worked. Nurses working on an AIDS unit defined care almost exclusively in terms of the emotional support they provided patients, although the physical care of these patients is quite demanding. Nurses working in an intensive care unit included emotional support for patients in an all inclusive "mind-body-spirit" definition of their philosophy of care. As interviews with the intensive care nurses progressed however, it became clear that caring for patients was more a matter of the physical and technical work they did, and it was with family members that nurses performed emotional labor. Curiously, the nurses often positioned themselves in adversarial relations with families as they described their

[1] The female pronoun she will be used throughout since all of the nurses in this study are woman as are most in the profession.

emotional (albeit tense) involvement with family members, a kind of "us versus them" stance.

The data also revealed that there is a wide range of caring work and the existence of "emotional deviance," those feelings or displays of affect that differ from what the norms prescribe in a given situation (Thoits, 1990). A nurse on the AIDS unit told me:

> When we make rounds I'll make sure that I touch these people, I'll lean over and give them kisses on their forehead (Merkel 1994).

Yet another nurse on the same unit reported hearing the head nurse ask family members who gathered in a hallway grieving the death of a loved one to move themselves. The head nurse told the family that they posed a fire hazard where they were standing.

The deviant emotional feelings that were observed in the intensive care unit might be more properly thought of as a manifestation of an occupational subculture (Trice, 1993). Nurses on this unit were often observed treating family members in an abrupt, cold manner. Their deviance from the nursing profession's emotional norm of caring was actually normative for that unit, although deviant for the hospital as a whole.

Besides revealing the existence of emotional deviance or occupational subcultures of uncaring, interviews showed the nurses to experience ambivalence about their caring. While feeling proud and satisfied about their caring work with patients, they also felt angry and doubtful about its importance when telling of physicians and patients who viewed the nurses' work as natural for women, custodial and servile. For example, one nurse reported that elderly patients tended to view the nurse as, "a nun, or a mother, and that all goes back to Florence Nightingale." A different nurse said she believed that physicians tended to think that, "the doctor is the smart man and the nurse is the pretty young girl."

The data produced from these studies suggested a need to further explore the caring work of nurses, specifically as it relates to the following phenomena:

1. An occupational ideology of caring creates a double bind for nurses. It serves the purpose of providing positive meaning and direction for their work, yet it also forms the underpinnings of a view that their work is unskilled and of low value.
2. Although nurses' general reports of caring work conform to professional emotional norms, their actual feelings did not always conform. Caring work was not natural personally, nor necessarily a characteristic of all spheres of nursing, but varied with regard to different patients, nurses and situations.

Fundamental to understanding these dilemmas about nurses' caring feelings and behaviors is the recognition that nurses' work is situated in organizations and institutions in which cultural beliefs about gender and work are patterned. For example, they are subject to processes of occupational sex segregation, the division of labor between and within genders and occupations, definitions of work, and the reward systems (Epstein, 1992). Thus, nurses' caring encounters with patients and families occur in a social context shaped by macro-level structures in society and within organizations and groups.

Purpose of Study

By the use of ethnographic research techniques, this study proposes to integrate macro and micro-levels of analysis by conceptualizing the everyday "caring work" that nurses do with patients as influenced by and reinforcing cultural assumptions about gender embedded in the social structure (Lamont & Fournier, 1992). More specifically, the study will attempt to relate macro-level phenomena such as cultural beliefs about women,

membership in a sex-typed profession, and structural arrangements in institutions, to the caring work of nurses at the micro-level of interaction. As well, the study will consider how nurses' caring feelings and behavior in turn reproduce structures of difference and dominance.

In this study, *caring work* will be understood to mean nurses' efforts to assist a patient or family member with their emotional suffering. The work calls upon the nurse to *feel* and *demonstrate* concern for suffering. For example, a nurse may help patients and families maintain their emotional composure through hand-holding or encouraging words. A nurse might take a family member aside when they begin to cry at the patient's bedside. Requesting that someone from the pastoral care department speak to a family or asking a physician to prescribe an anti-anxiety medication for a patient, are ways the nurses might do caring work. Although caring work requires the nurse to feel concern, as well as demonstrate concern for patients' and family's emotional suffering, a nurse may or may not try to change her *actual* feelings should they not be in accord with the norm.

Specific questions to be considered include:

1. What form (specific practices) does caring work take?
2. Under what conditions do nurses perform caring work?
3. How is caring work sanctioned?
4. How do nurses manage deviant emotions related to caring work?
5. How does an occupational ideology of caring inform the actual caring work that nurses do?
6. What beliefs do nurses have about their caring work?

7. What do nurses understand their caring work to mean to patients, families, nursing management, physicians, and other nurses?

Relevant Literature

Emotions as Social Processes

As sociologists speculate about the nature of emotions, three theoretical frameworks emerge. Positivists argue that there are universal, physiologically based, primary emotions, though Kemper (1978, 1987) believes secondary emotions are grafted onto primary emotions through socializing agents who define and label the primary emotions as people are experiencing them. Similarly, symbolic interactionists, although assuming a physiological component in emotional experience, emphasize that emotions are the product of social labeling and interpretation of physiological arousal (Hochschild 1979; Schott 1979). Social constructionists consider emotions to be socially determined, and view emotions as roles that are functional within a cultural system (Armon-Jones 1986; Averill 1980). These theories lead us to consider whether emotions are primary physiological, hard-wired psychological processes, or socially defined and constructed feelings which can be understood as experiences mediated through situations wherein the meanings of interactions are structured by the social roles people occupy. Central to Hochschild's (1979, 1983) theory of emotional labor is the idea that people can do "emotion work" to try to alter their emotions to conform to a standard of what they believe they should be feeling in a particular situation. This is akin to Rosenberg's (1990) "emotional display," and Goffman's (1959) "impression management," both purposive processes by which individuals seek to express specific emotions to produce effects in

others' phenomenal worlds. The emotion work involved in emotional display is a part of enacting a social role that imposes norms on individuals for emotional expression. Gender roles that dictate women express care and men appear unimpassioned are common examples of this.

Emotions have also been hypothesized as having social control functions. Primary emotions may be socially labeled with the intent of regulating socially undesirable behavior to promote attitudes that uphold the cultural beliefs of a society (Armon-Jones 1986). More specifically, Shott (1979) maintains that empathic role-taking emotions that motivate normative and moral conduct facilitate social control. If we relieve the distress of others with whom we empathize, we in turn relieve our own distress. Thus, the well being of others is closely connected with our own feelings. It follows then, that women's roles that prescribe empathic emotions function as a form of social control in that they ensure the social reproduction of society.

Emotions in Work

Sociologists have investigated emotions as part of workplaces and organizations, disputing the "myth of rationality" that emotions are inappropriate to the instrumental nature of organizations (Putnam and Mumby 1993). As Fineman (1993) points out, feelings shape and lubricate social transactions, contribute to, and reflect, the structure and culture of an organization. Hochschild (1979, 1983) views emotions to be distinctly instrumental when she describes how flight attendants use "emotional labor" (the emotion work required in one's job) to display specific emotions to produce a proper state of mind in their customers. Similarly, healthcare professionals were identified by Strauss et al.

(1982, 1987) as doing "sentimental work" to help patients manage their illnesses. The nursing staff in the hospice James (1989) studied performed emotional labor to help their dying patients manage feelings of grief and fear. O'Brien's (1994) study of public health nurses also reveals the instrumental nature of emotions. He showed that the nurses used their emotional laboring skills as a method of social control, specifically manipulating patients into behavior changes that were consistent with physician determined programmatic statements.

Hochschild (1979, 1983), and James (1989) also point out that when feeling and displaying certain emotions are considered important in one's job, or when more invisible forms of workers' emotional labor are made use of by employers, emotions become a commodity since they are bought and sold as an aspect of labor power. Hochschild (1983) believes that feelings as commodities cause workers to become estranged from their feelings and suffer burnout. Other studies both support and dispute this.

Sutton's (1991) study of bill collectors shows they often experienced emotional dissonance between felt and expressed emotions, and employed a variety of strategies to cope with this. Detectives studied by Stenross & Kleinman (1989) would frequently feel burdened by their emotional labor with victims, but interestingly, felt energized by their interactions with criminals. The detectives discounted the criminals' emotional displays, redefined their emotional labor as relevant to chasing criminals and turned the encounters into a game. Wharton's (1993) study of workers employed in the hospital and banking industries suggests that the performance of emotional labor does not have uniformly negative consequences. The effect of emotional labor seemed to be contingent upon workers' level of job autonomy, job involvement and self-monitoring abilities. The

Disneyland employees studied by Van Maanen and Kunda (1989) reported inducing an emotional numbness in response to the constant onstage demands to act enthusiastic and polite.

Other studies reveal how work structures organize emotion work. Menzies Lyth (1988), in her psychoanalytic analysis of organizations, sees their very structure as socially organized defenses against emotions. For example, the anxiety that arises in nurses as they cope with issues of sexuality and death is controlled by the distancing and impersonal way that nurses organize their work. Patients are referred to by diagnosis and room number, and patient care assignments are devised according to task requirements (e.g., medication administration, dressing changes).

Sociologists and scholars in other disciplines have described the socialization process for emotional expression at work and emotional norms in occupations as diverse as drill sergeants and high steel ironworkers (Katz, 1990; Haas 1977). Rafaeli & Sutton (1987) have reported the benefits to an organization of properly socialized emotions as including such things as increased sales, repeat customers and enhanced reputation by word of mouth communication.

Normative prescriptions for caring feelings and behaviors in healthcare professionals were probably first addressed by Parsons (1951) as he explained the pattern variables related to the expression of emotion in familial and professional roles. Using the example of physicians, Parsons used the term "affective neutrality" to characterize one aspect of a general role definition of professionals. Similarly, Lief and Fox (1963) explained the "detached concern" physicians are expected to maintain toward patients.

Smith and Kleinman (1989) have described management strategies used by medical students to maintain norms about expressed emotions when interacting with patients (both alive and dead). Hafferty (1988) explains the telling of cadaver stories by medical students as emotion work in which norms for emotional detachment in the physician role are initially encountered and internalized. James (1989) and Smith (1992) have investigated the emotional labor of nurses in a hospice and hospital setting. These studies describe the process by which nurses learn to labor emotionally, the emotion norms for different nursing roles, and the structural arrangements that constrain and facilitate their emotional labor. The student nurses in Smith's (1992) study described how ward sisters communicated the feeling rules of a floor by showing the students appreciation and support. This provided the students with a model for their interactions with patients. May (1991) has also studied emotional norms for nurses' interactions with patients and identified three different levels of involvement ranging from intense involvement with patients to a level of involvement closer to Parson's affective neutrality.

Gender Distinctions in Caring Work

Just as the assignment of caring work seems to be sorted along gender lines, so too we see that distinctions in caring are institutionalized in the workplace as sex-typed occupations viewed as extensions of women's sex roles (Epstein 1970, 1988; Reskin and Hartmann 1986). This is visible in the predominately female semi-professions of nursing, social work and elementary school teaching (Etzioni 1969). Viewed as the innate and relatively unskilled work of women, these jobs are afforded little prestige or remuneration (Davies and Rosser 1986; Epstein 1988). Nurses in particular are seen as proto-mothers

whose duty it is to care for others (Reverby 1987). Although for Florence Nightingale, the founder of nursing as a respectable profession, caring was connected with the definition of woman, as the distinct work of nurses caring was more an issue of class than of gender. By Nightingale's standards, a nurse had to be of good moral character and thoroughly trained. The Victorian religious and class-based ideal of womanly virtue informed her definition of the art of nursing. Nightingale sought to shape a separate but equal sphere for nurses as partners with physicians in the provision of care for the sick and used this idea of woman's duty to care to legitimate nurses' work. However, nursing's history shows that this claim is bound up with gender ideologies and has actually contributed to the inferior status of nursing (Reverby 1987).

Gamarnikow (1978) and Pringle (1983) locate the nursing profession's subordinate status directly in the physician-nurse relationship vis-à-vis the patient, which mirrors patriarchal relations. Hearn (1982) similarly theorizes the female dominated semi-professions to be largely in the service of the male dominated professions in the control of labor reproduction, thereby creating and maintaining the system of patriarchy.

The semi-professions are, of course, not the only occupations in which women perform caring work. Women's caring skills are appropriated in all sorts of jobs, as retail clerks, administrative assistants, waitresses, flight attendants and secretaries, where this invisible type of work facilitates social interaction among employees and between employees and clients (Benson 1986; Davies and Rosser 1986; Hall 1993; Hochschild 1979; Kanter 1977).

Caring and the Nursing Profession

Much of the research conducted by nurses in the United States and published in the profession's journals proceeds from an essentially structuralist perspective of immutable roles. That nurses will perform caring work is presumed since caring is judged to be normative for nurses. Scholars then describe specific emotions and behaviors that nurses believe to embody caring, or that patients perceive as caring (Brown 1986; Forrest 1989; Larson 1984; Leininger 1984; Paternoster 1988; Swanson 1990; Wolf 1986; Wolf et al. 1994). Themes such as presence, listening, respect and technical skill emerge in all of the studies. Drew's (1986) and Reiman's (1986) research are exceptions in that they include accounts of uncaring behaviors and attitudes displayed by nurses. Not surprisingly, patients perceived nurses as uncaring and belittling them when the nurses were in a hurry or felt to be just doing their job.

Few empirical works by nurses seek cultural explanations for nurses' caring, relate it to social structure or describe caring as a context dependent social interaction. Yet nurses and physicians, as students and practitioners, have long been investigated by medical sociologists from just this perspective (Anspach 1987; Becker et al. 1961; Freidson 1975; McKinlay and Stoekle 1988; Mizrahi 1986; Olesen and Whittaker 1968; Simpson 1977; Waitzkin 1989). Forrest's (1989) study revealed structural and situational determinants of nurses' caring experiences when she reported on how care is affected by the physical environment, lack of time, nursing administrators and characteristics of patients. A number of British sociologists and nurses have examined the nurse-patient relationship from an interactionist perspective. Kelly and May (1982), in their literature review of "good" and "bad" patients, suggest that patients come to be labeled as good or

bad as a result of the interaction between patients and staff, not because of a patient's personal characteristics as much of the research suggests. They argue for a theoretical framework that views the nursing role from an interactionist perspective that elucidates the form and meaning of the role and the way it is legitimated. May and Kelly (1982) accomplished this in their case study of psychiatric patients on an inpatient unit. They found that psychiatric nurses who lacked readily identifiable technical tasks and clear authority defined patients as problematic when they did not legitimate the nurses' therapeutic aspirations.

Hewison (1995) looked at nurse-patient relationships as encounters in which power is exerted through language, linking macro-level influences such as the institution to the micro-level interactions of nurses with patients. He observed nurse-patient interactions and found them to be superficial, routinized and related to tasks.

Smith (1992), a British nurse who has studied with Arlie Hochschild, examined student nurses' emotional labor and showed it to be shaped by such factors as ward sisters' management styles that dictated emotional norms, and ward specialties such as oncology for which emotional labor was legitimized. Emotional labor in this study was also stratified according to student seniority, with more senior students being expected to cope better with patients' emotions. Emotional labor was also stratified among the nursing staff in a hospice studied by James (1992). Auxiliary workers were found to do most of the emotional labor because of the increased time they spent with patients as compared to the nurses. In my 1990 paper I also found nurses' caring to be patterned by several factors: patient's status (gay versus drug abuser), emotion norms set by a head nurse, the type of specialty unit and its definition of care for nurses (intensive care unit versus AIDS unit).

Caring as Occupational Ideology

The work and discourse of nurses' caring occur within a culturally determined web of social relations that inevitably sifts and separates people into distinct categories marked by symbolic and cognitive boundaries (Lamont and Fournier 1992). These social constructions of difference create not only categories of people (e.g., male and female, proletariat and bourgeois,) but such mental distinctions, albeit real experiences, as the nature of work as, for example, clean or dirty, skilled or unskilled, scientific or non-scientific, male or female (Hughes 1958; Cockburn 1983; Gieryn 1983; Epstein 1992). Cultural categories of difference, which structure ways of organizing experiences, evaluating reality and regulating conduct, equip social actors with a "tool kit" of resources from which to construct "strategies of action" (Swidler 1986). The idea that individuals' actions can be understood as influenced by their social positioning, is useful when analyzing the activities of nurses as they create a discourse of caring. It also helps us understand the meaning caring has for nurses, that is, to understand how culture structures social relations at the micro level of interaction.

One of the most pervasive social distinctions is that made between men and women, the institutionalization of which can be seen in a sex-typed profession such as nursing (Epstein 1992). As cultural expression, nursing's occupational ideology of caring both articulates cultural beliefs about gender differences and reflects a way of organizing oneself in the world to obtain certain goals based on one's cultural competencies. However, as Epstein (1992) reminds us, difference invariably results in inequality, and so although an occupational ideology of caring may be functional for the profession in ways

discussed below, it is also dysfunctional largely because of the contradictions and tensions inherent in an ideology based in gender divisions (Trice 1993).

Consequences of Caring Ideology

An ideology of caring may serve the nursing profession by providing solidarity, identity and status for members (Trice 1993). Hochschild (1983) observed that collective emotional labor promoted solidarity among flight attendants. Nurses I have studied enjoyed their elevated status as the best nurses in Manhattan due to their superior bedside nursing skills (Merkel 1994). Nursing elites have distinguished the profession from other health care professions in claiming caring as the essence of nursing. Nurses have a lexicon of care (e.g., "complete care," "total care," "care plan," "care map," "taking care of," "nursing care," "intensive care unit") that infuses their vocabulary and articulates the primacy of this identity.

However, occupational ideologies also create ambivalence, conflicts and opportunities for schisms between members (Trice 1993). Nurses in the same hospital but in a different study I conducted, expressed simultaneous pride in their caring work and the status it brought them, yet felt anger and frustration that their caring was often invisible to others and devalued by some physicians, patients and families as merely "women's work" (Merkel 1990). This ambivalence is explained by understanding that caring work, as a gender/occupational strategy of action, is motivated by internalized "feeling rules" but through them nurses must deal with the realities of a system of stratification that devalues such work (Hochschild 1990).

The clash of professional and apprenticeship ideologies in nursing since the 1920's continues to divide the profession and thwart unified efforts for upgrading nursing as an occupation (Melosh 1982). Professionalism appealed to those in the profession trying to shake the archetype of nurse as physician's handmaiden. Yet the apprenticeship culture in nursing has provided an alternate ideology to professionalism, and an important way for nurses to affirm their skills and define their work. Melosh points out that for women, nursing as paid work both confirmed and contradicted cultural expectations for women. Waged labor brought them closer to the "male" public world, advancing technology increased nurses' expertise and authority, yet the structure of their work reinforced existing gender, wage and power inequalities.

Chua and Clegg (1989) describe the clash between the professional ideologies of senior nursing management and ward nurses. Senior managers embraced an ideology stressing managerialism and credentialism as part of a professional project, yet the work of the ward sisters was informed by vocational ideals of nursing such as a desire to care. Their study suggests that there were important gaps between formal representations of the professionalism project and the actual practice of nursing. Similar to Melosh's historical analysis, the authors believe that these contradictory ideologies have implications for the professional status of nursing. They speculate that while providing a rallying call for the profession's elite, ideals of managerialism and credentialism do not speak to all nurses and will fail to unite the profession in a quest for professional status.

Study Overview

I conducted my study of nurses' caring work on the day shift of the surgical intensive care unit (SICU) at St. Paul's Hospital[2]. Although I am employed in the hospital as a nurse, I have never worked in the SICU, nor do I have any administrative responsibility for it in my present position. I performed participant observation over a period of six months and conducted in-depth interviews with the nurses. A detailed description of the study methodology is included in the appendix.

I will show that although the nursing profession has adopted an ideology of caring, the ideology was counterproductive for the SICU nurses. Caring as ideology bore only a small resemblance to the nurses' occupational identities and actual practice of their work. In the next chapter I will set the background for understanding the nurses' work experience by describing the hospital, the SICU and the nurses themselves. Chapter three will discuss the value that the nurses' caring work had to other nurses in the SICU as well as to physicians and administrators in the hospital. In chapter four I describe the workplace ideologies that operated in the SICU – tradition-based practice and science-based practice. This will help us understand the place that caring work had in the SICU's beliefs systems and the professional identities the nurses constructed around their work. Chapter five will examine how time as a central feature of the social organization of the SICU played a significant part in structuring the nurses' caring work. Chapter six describes the norms for feeling and expressing feeling that were part of the SICU's workplace ideologies I will make the argument in chapter seven that we can use time as a

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[2] Not its real name.

structural element in the SICU and the nurses' professional identities, to account for the nurses' real feelings about patients and families and their efforts to conform to the feeling norms in the SICU.

As the reader proceeds I hope that I am able to make clear the personal and professional difficulties the nurses confronted working in the surgical intensive care unit. Each nurse brought a distinct personality to their job that clearly influenced the caring work they did with patients and families. Overall, I believe the nurses usually did their very best to emotionally support a group of very sick patients and distressed family members. I have tried to make this come through in my accounting of their work. However, ultimately my research is about how the work culture and social structure of the SICU were stronger arbiters of the nurses' caring work than the profession's ideology of care.

CHAPTER TWO

SAINT PAUL'S HOSPITAL

Description of Site

St. Paul's Hospital

St. Paul's is an 800-bed voluntary, tertiary care hospital located in a major northeastern city. It is situated in a residential neighborhood and considered by many residents there to be the local community hospital. St. Paul's was founded by four nuns in 1849 and is now co-sponsored by the Roman Catholic Archdiocese of the city. The hospital serves as the flagship hospital of an alliance of seventeen Catholic healthcare institutions in the city and surrounding area. It is a major affiliate of a medical college and offers residencies and fellowships in most specialty areas of medical practice. St. Paul's has a Level I trauma designation. This certifies that it has the emergency facilities and personnel to care for patients who have suffered any type and severity of injury. This population of trauma patients contributes to the overall number of surgical patients in the hospital. St. Paul's was also one of the first state-designated AIDS centers in the city.

St. Paul's had the last diploma-granting school of nursing in the city at the time of the study. The school was taken over by a baccalaureate granting nursing program in 1999. By tradition St. Paul's graduates were hired first into vacant staff nurse positions in the hospital. St. Paul graduates managed fourteen of the twenty-one nursing units. Two of the three directors of nursing graduated from St. Paul's, as did the assistant vice president for nursing. The nursing department's recruiting literature boasts that the hospital is widely respected for the quality of its nursing staff. This is common lore in the

hospital. I have heard both older attending physicians and St. Paul's nursing graduates alike proudly say that the nursing care in the hospital surpasses that of any other hospital in the city. An attending physician once told me it was his reason to accept a position at St. Paul's, passing up an offer at a prestigious university hospital in another part of the city.

When one enters the hospital one feels as though they are in a chapel. A large statue of St. Paul is the focal point of this space. The statue depicts St. Paul reaching down to a sickly man dressed in rags lying at his feet. Presumably this is to remind all that enter the hospital of the compassionate mission of the hospital. Backlit stained glass windows that reach from floor to ceiling have been fitted into another wall in the lobby. The windows in the lobby were salvaged from the original hospital building since torn down, as were the floor tiles surrounding the visitor desk. On the same wall as the stained glass windows are photographs of Pope Paul and the Archbishop of the city. A prayer is said every morning at 8:00 A.M. over the public address system. Priests and nuns are commonly seen around the hospital. They serve in administrative positions and in the pastoral care department in the hospital.

St. Paul's Surgical Intensive Care Unit

The lobby scene contrasts with that of the SICU. There are no religious statues or stained glass windows there. The unit is furnished with stretchers and resuscitation equipment. The only item hanging on the wall is a large chart that displays information about cardiac drugs used in the intensive care unit. Machinery emits high-pitched whines, low bleeps and musical chimes that signal changes in the patients' conditions. Rows of

colored, wavy lines run across monitors mounted in the nursing station and high in a corner of every patient room. Patients are attached to sophisticated looking equipment. There is a distinctly "high tech" look to the unit. The central focus in the surgical intensive care is clearly the physiological condition of the patient as opposed to the spiritual as suggested by the design of the lobby.

The SICU is a long and narrow unit. It has twelve individual patient rooms, nine are spread out on one side of the unit and three are concentrated at one end of the opposite side. A long desk extends from the third room to two-thirds of the way down the unit. The desk is chest-high from the visitor's side. Behind it, continuing down from the third patient room and opposite the nine patient rooms are a pantry, nurses' lounge, nurse manager's office, and a table that holds two large monitor banks and a computer terminal for accessing laboratory test results. There are storage rooms at one end of the unit and a room where medications are stored at the other end. Another monitor bank sits on top of the long desk. There is some equipment scattered in the hallway. A cart containing emergency resuscitation equipment is against the wall in the middle of the unit. It is also common to see stretchers and reclining patient chairs.

Each patient room has a large glass window that allows the patient to be visible from outside the room, and another window between patient rooms. Curtains surrounding the bed can be drawn for privacy. The patient's bed emerges from the center of the far wall and is flanked by small chests of drawers that hold routinely used equipment, a washbasin and bedpan. There is a sink and pull-down toilet in the room. Monitors are mounted high on one side of the bed. These give readouts in colored numerical form and waveform of the patient's physiological functions being monitored. For example, heart

rhythm, blood pressure measured directly from an artery, and the pressure within the brain may all be monitored. There are small windows almost at ceiling height behind the bed in only nine of the patient rooms. Little light filters in from these windows so the rooms seem mostly artificially lit.

Depending on the surgical procedure the patient has had and how sick they are, various equipment will surround the bed and be attached to the patient. Every patient receives intravenous (IV) fluids and medications, and so commonly two to four metal poles that hold the IV fluids will be on either side of the bed. It is important that the rate of infusion of these fluids be precisely regulated. Infusion pumps the size of a shoebox are used to do this and they are mounted on each IV pole. Many patients require the assistance of a ventilator to breathe. This machine is about the size of a washing machine and stands near the head of the bed. Plastic corrugated tubing carrying oxygen extends from the ventilator to a tube inserted into the patient's trachea (windpipe). The patient's bedside is crowded with all of this equipment, and the nurse often has to push things around or squeeze between it to actually reach the patient, particularly near the head of the bed.

The SICU is located next to the post-anesthesia recovery unit (PAR) which attaches to the operating room (OR). The proximity of these areas is not accidental. Since the patients in the SICU are considered to be critically ill, it is important for the transit time from the PAR to the SICU to be brief. The criteria for admission to the SICU depends on the seriousness of the surgery itself, the occurrence of intraoperative complications, and pre-existing illnesses that make it risky for a the patient to undergo a surgical procedure. For example, all patients having a resection of an abdominal aortic

aneurysm, a complex surgical procedure, will be admitted to the SICU. However, another patient who is having a less complicated surgery might still require an SICU stay because their pre-existing heart disease requires special monitoring post-operatively.

The nurses are informed by the resident physicians early in the morning before surgeries begin of the number of beds that will be needed according to the surgical procedures and medical histories of the patients having surgery that day. Once the nurses know how many beds they will need there is a race to discharge stable patients from the SICU so that the new patients can transfer over from the PAR. There is constant pressure to discharge patients from all these units. If the PAR is full and cannot transfer a patient to the SICU, they are not able to receive patients from the OR, preventing another surgery from beginning. The same is true for patients that the SICU receives from the emergency department (ED). It is common for the SICU to get admissions from the ED, especially because of St. Paul's Level I trauma status. For example, patients who have been in motor vehicle accidents, received knife and gunshot wounds, will either come directly to the SICU or arrive there after going to the OR. Events such as these, as well as other unplanned major surgeries on patients already in the hospital or surgical complications requiring SICU admissions, create a sense of urgency on the unit. The nurses and the admissions department must scramble to find beds on other units and ready patients to be moved out of the SICU. However, the majority of planned surgeries are admitted to the SICU in the afternoon and this allows some advanced planning to occur.

Visiting hours in the SICU is from 11:00 A.M. to 4:30 P.M. and 6:00 P.M. to 9:00 P.M. These visiting hours had been in effect for only a year when I started my research. Previously, visiting hours was severely restricted to only one hour in the afternoon and

evening. A visitor complaint to the hospital prompted the director of nursing for the intensive care units to survey other hospitals' policies and review the professional literature on the subject. This led to the current extended hours.

The Surgical Intensive Care Unit Nursing Staff

Division of Labor

There are four levels of nursing staff in the SICU. The unit has one nurse manager who has twenty-four hour responsibility for the administrative concerns of the unit. This nurse works eight-hour shifts Monday through Friday and does not carry a patient assignment. She is responsible for such things as staff scheduling, hiring, disciplinary actions and the daily functioning of the unit.

There are twenty nurses, eight staff nurses and two assistant nursing care coordinators on the day shift (8:00 A.M. to 8:00 P.M.) and ten staff nurses on the night shift (8:00 P.M. to 8:00 A.M.). Both the assistant nursing care coordinators and the staff nurses are responsible for direct patient care and have an assignment of two to three patients depending on how critically ill the patients are. Having three patients as an assignment was a relatively new occurrence in the SICU. It was typical in the past for the nurses to have only two patients assigned to them. The nurses believe an assignment of three patients to be very unfair and at times formally protest this through their union. The assistant nursing care coordinators are almost indistinguishable from staff nurses in their function on the unit. When the nurse manager is not working, they are in charge, but the staff nurses also assume this duty if an assistant nursing care coordinator is not working.

The staff nurses are responsible for a huge variety of patient care tasks, from such simple things as giving baths to the complex titration of potent intravenous medications. In addition to carrying out physician's orders, the nurses are also expected to initiate care independently. For example, having knowledge that a post-operative patient is at risk for developing pneumonia and blood clots in their legs, the nurse will help a patient to deep breathe and cough, exercise their legs muscles and shift position in bed.

Nursing attendants who work eight-hour shifts assist the staff nurses. There is one nursing attendant per shift. Their responsibilities are primarily related to assisting the nurses with physical care of the patient, such as bathing, positioning the patient in bed and cleaning excreta, the routine "dirty work" of caring for the body (Hughes 1958). The nursing attendants also perform errands for the nurses, such as picking up blood from the bloodbank and getting equipment from central supply. Unlike nursing attendants on other units of the hospital and in other healthcare settings such as hospices or nursing homes, the nursing attendants in the SICU have little or no care functions independent of assisting the nurse in the way described above (Foner 1994; James 1989). This is partially due to the fact that the care a nursing attendant could render, such as bathing and positioning patients in bed, requires two people simply because the patient is attached to too much machinery for this to be accomplished by one person. Virtually all of the other patient's needs in an intensive care unit require the skill of a registered nurse. Still, the help of a nursing attendant is desired. If there is no nursing attendant the nurses must wait for help from another nurse or try to perform the care on their own.

A ward clerk is present on the unit from 8:00 A.M. until 12:00 A.M. Although the ward clerks do not perform any patient care tasks, they are under the direction of the

nurse manager. The ward clerks function as the secretaries for the SICU, doing such things as answering the phones, keeping the patient's chart in order, transcribing physician's orders to the appropriate chart forms and entering patient data into the computer system. The ward clerks also perform errands for the nurse, as do the nursing attendants.

The ward clerks, and particularly the nursing attendants, are often a source of frustration for the nurses. The nurses view themselves as overworked and become irritated when the nursing attendants and ward clerks do not assist the nurses as much as the nurses need them to, or when none are available to assist the nurses at all.

Two nurses, Maureen and Elizabeth, expressed this frustration.

> Maureen: The most frustrating thing is not having enough hands. I mean really, if you're, at one point I thought it would be better down in the ICU because it's a 2 to 1, 3 to 1 [patient to nurse] ratio, but you can't imagine the things you do to these 2 people and you had 7 people up on a different [non-ICU] unit. There's just different care. I mean, you're replacing everyone's magnesium [intravenously], you're replacing everyone's calcium, you know.

> Elizabeth: And sometimes too what's been frustrating here is that sometimes you feel that you give a lot of time and other non-professionals – not to get into that – other people in other positions, I don't know if they're not as conscientious or don't care as much. I don't know if I can even say that, but you don't think they're doing as much or try where they could pull their weight a little bit more.

The Surgical Intensive Care Unit Nurses

The ten nurses on the day shift share many social statuses and are largely a homogenous group (table 1). Of the eight nurses interviewed, all are White and Catholic, with a mean age of thirty-two years. One of the two nurses not interviewed was African American. On average, those interviewed have been in nursing for 10.2 years, 7.2 of those

years have been worked in the SICU. Seven of the ten nurses received their basic nursing education at St. Paul's School of Nursing. All of the nurses have furthered their education by receiving or pursuing bachelor's degrees. Six of the ten nurses are pursuing master's degrees. All of these nurses but one have pursued their education in nursing. One nurse has her bachelor's degree in health care management and is pursuing her master's degree in public administration.

TABLE 1

SURGICAL INTENSIVE CARE UNIT NURSES[1]

	Age	Race	Religion	Marital Status	Number Children	Years in Nursing	Years in SICU	St. Paul Graduate	Bachelor Degree	Masters Degree
Mary	30	White	Catholic	never married	0	10	5	no	pursuing	
Dianne	30	White	Catholic	married	1	8	6	yes	yes	pursuing
Lynn	32	White	Catholic	married	2	10	9	yes	yes	pursuing
Elizabeth	38	White	Catholic	never married	0	17	2	no	yes	no
Maureen	31	White	Catholic	never married	0	10	1	yes	yes	pursuing
Pat	36	White	Catholic	never married	0	11	11	yes	yes	pursuing
Janie	28	White	Catholic	never married	1	6	3	yes	pursuing	
Suzanne	30	White	Catholic	married	0	11	5	yes	pursuing	
Rhonda*		African American						no	yes	pursuing
Barbara*		White						yes	yes	pursuing

*Did not consent to be interviewed

[1] All names are fictitious

CHAPTER THREE

THE VALUE OF CARING WORK

Emotional Labor in the Workplace

Arlie Hochschild (1979) first suggested that feelings expressed as part of one's job come to resemble commodities. In her framework, what are usually thought of as social relations are redefined as formal tasks (Diamond 1996). The display of emotions, part of the mix of skills workers bring to their job, usually take on value for an employer because they are thought to be part of market relations (Rafaeli and Sutton 1989). For example, the flight attendants studied by Hochschild (1983) were trained to manage their emotions in the airplane cabin by acting friendly and expressing concern towards customers as a way to generate business for the airline. Waitresses smile, and flirt to secure better tips and satisfy customers (Hall 1993). Young workers in Disney theme parks are extensively schooled in the University of Disneyland to smile and adopt courteous demeanors for their guests (Van Maanen and Kunda 1989). The display of emotions serves other important functions. Katz (1990) found that the emotional expression of drill sergeants was crucial to the organizational effectiveness of the military. The sergeants were socialized to suppress individual emotions and express only feelings associated with motivation and a positive attitude as a way to ensure discipline and foster the group behavior so necessary in the performance of army roles.

The value of an employee's emotional labor may take on different meanings depending on one's place in the organization, as for example, supervisor, coworker, or even customer. We might imagine that the supervisors at Disneyland viewed their

subordinate's emotional labor with visitors as a means to their own promotion. Coworkers may find opportunities for friendship and job solidarity through the shared exhaustion of their constant displays of staged emotion, while customers may feel a sense of pleasure at being welcomed and respected by the employees of an organization.

The expression of certain types of emotion in the workplace may be normative for an occupation, but may not be a central feature of the occupation's identity or function. For example, although we expect clerks at our local supermarkets to be polite to shoppers, we tend not to define this job in terms of its emotional labor as much as we define it in terms of the exchange of money for material goods. In contrast, many in the helping professions, such as social workers, counselors and nurses, are fundamentally defined by the emotional labor they perform, both by those they serve and through the profession's ideological system (Etzioni 1969; Meyerson 1991).

Under the ideal of caring nursing has increasingly sought to define itself in terms of the emotional labor it performs as a way to distinguish itself from other helping professions and as a strategy to achieve full professionalization. However, analysts of nursing point out that patriarchal relations are inescapably embedded in nurse-physician relations. Nurses' work is strongly linked with essentialist notions of the feminine nature – altruistic, empathic and nurturing – which reinforce nursing as the domain of woman, contributing to its lack of power and low status in medical settings relative to medicine (Garamarnikow 1978; Hearn 1982). James (1992) suggests that associating care with women's work, and the invisibility of this type of labor, gives caring an ambivalent status inconsistent with efforts to professionalize. Contrary to the intentions of the nursing profession, its association with emotional labor is viewed by some as a cause of its semi-

professional status, not a remedy for it (Lupton 1994; Manley 1995). The invisibility of caring work, its association with women's domestic labor and the low status of nurses might be expected to influence the value others in the workplace place on the SICU nurses' caring work.

Caring Work - Its Value to the SICU Nurses

A measure of the value the SICU nurses place on caring work is the extent to which they refer to it in routine discussions of patient care. The most common example of this is nurses' reports to one another before going on meal breaks and during change of shift report. The later was the longest, most detailed and formal exchange of patient information between nurses. It is here that we find discussion of important elements of patient care. Wolf (1988) points out in her study of nursing rituals, that in addition to exchanging vital information about patient's physiological status, change of shift report serves the implicit function of upholding nursing standards and maintaining nurses' responsibility for patient care. Therefore, the nurses' discussion of caring work during the change of shift report signals the significance of this type of work.

In this twice a day exchange of information the SICU nurses discuss each patient's medical condition by body system (e.g., respiratory, gastrointestinal, cardiovascular) in a very methodical manner. A report is given about the current status of each system by indicating, for example, the patient's vital signs, fluid intake and urine output. Current medical treatments are discussed, as well as immediate plans for diagnostic tests or transfer to another unit.

Usually missing from these reports are explicit conversations about managing a patient's feelings in the same way the nurses discuss managing a patient's pain, labile blood pressure or elevated temperature. However, it is common to hear the nurses talk about a patient's anxiety or agitation as it relates to administering sedative medication. In these circumstances the patient's anxiety and agitation are not discussed with reference to their emotional distress, but to the effect this distress has on other body systems, or what the agitation and anxiety might signal about the patient's physiological status.

Change of shift is also a time when the nurses regularly exchange information about a patient's "mental status" as a general measure of wellness. The nurses discuss how awake and alert a patient appears as part of a report on the neurological system. The nurses commonly talk about a patient's personality, describing them as a "pain," or "cute." However, discussions of personality traits, mental status, and degrees of agitation are very different from discussions of a patient's psychological state and emotional distress, particularly if the purpose of the discussion is to intervene to alleviate suffering. On the occasions when the nurses do mention that a patient is "down in the dumps" or "looking depressed" there are few exchanges among the nurses about how to handle the patients' emotions, unlike the work they do involving caring for patient's body.

When interviewed, the nurses talked directly about how important they thought their caring work with patients and families was to other nurses in the SICU. Although believing it had generally little value, they were willing to speculate that it might have different value to different people. Yet, some nurses, as we see in Maureen's quote below, indicated that caring work had value to them personally.

> The other day I was in the room with Janie and this was a person [patient] who was down in the dumps and it was really noticeable. It was her patient. We went in to change his sheets and pick him up and she was saying, trying, not even cheer him up but just let him know that things were going to get better and that he had a really good, supportive family and he was lucky that he did, and all that. And she was almost making me cry in there. And I'm like; I've got to get out of here. It was nice she said it and actually see someone do that.

Despite Maureen's appreciation of Janie's caring work with a patient, she did not believe this type of work was valued on the unit. In the interview excerpt that follows, she reveals that it is the technical aspects of patient care dealing with the condition of the patient's body that have value to the nurses. I asked Maureen to replay the same patient situation in her mind but imagine that Janie did not offer her patient any emotional support. Would Maureen wonder why she did not?

> Maureen: Probably not, and it's not something that is even brought up in [change of shift] report – oh, I provided emotional support to this patient. We might say – he's really depressed and down in the dumps, and you take it from there. What I did is then my doing. It's more, the IV [intravenous] lines are changed . . . we'll make comments – he's got a really nice family, he's a nice patient, things like that. But we won't start in on their emotional needs.
>
> Interviewer: Well let me ask you this, do you think it's important?
>
> Maureen: It probably is. It is important, but I can't tell you why it's not something that's ever done. Maybe in the psych ward they do. I hope they do. We're more geared toward lab values and urine outputs and [blood] pressures.

Agreeing that caring work was not particularly valued on the unit, Diane went further and suggested that this was because caring was not considered a skill. I asked Diane, a nurse with six years of SICU experience who I considered the most skilled at caring work, if handling patients' emotions was valued in the SICU.

Diane: Not specifically, no. I don't think so.

Interviewer: As opposed to?

Diane: Knowledge is maybe valued more, or skill. How to deal with situations? I don't know if talking to patients, well, maybe a little bit. . . knowledge, yah, how you care for the patient. Maybe on our unit, how clean you leave the room might be valued a little more up here [laughs].

Diane implies that there is a hierarchy of work in the SICU. Caring work is least valued and work requiring knowledge and skill is most valued. I pursued the idea of caring work and skill with Elizabeth. She was one of the newer nurses on the unit with only two years of experience. I also considered her to be talented at managing patient's emotions. She exuded gentleness and always took time with patients and their families.

Interviewer: Do you think of what you do when you're providing emotional support as a skill?

Elizabeth: No, I don't . . . just part of your personality. I think so, I think if you like to work with people. Yah, I basically think it's part of your personality. I don't think you can be trained to do that. You can maybe make yourself aware of doing it but I don't think it's a skill.

Even though about half of the nurses said they learned to do caring work while on the job, much like they learned other aspects of their work, they did not consider it to be an area of expertise in a similar way. Knowledge and skill were not words the nurses readily associated with caring work. When they spoke to me about knowledge and skill they were referring to knowledge of the human body, surgical procedures, medication side effects and technical skill using sophisticated equipment. This was the knowledge and skill that was revealed during the change of shift report.

In addition to devaluing caring work because she did not think it required special knowledge or skill, Elizabeth believed that caring work had questionable value for some of the nurses on the unit because it added to their overall workload. She expressed her ambivalence about caring work:

> Sometimes it's good and people will appreciate it [caring work], but sometimes, don't give too much because they're [patients or families] are going to expect it all the time. You know, don't spend too much time every time they come because they're going to expect it.
>
> Interviewer: Oh, so then it will set a standard?
>
> Elizabeth: It will set a standard, right. And I'm not saying I'm always like this, but in certain situations if you go in there every time they [patients or families] snap their fingers . . . then they're going to think they run the show too. So I think some of the girls [nurses] think that too – don't go too crazy.

Lynn agreed with Elizabeth, telling me she sometimes resented the increased amount of work that caring work created. "The more you give, the more they expect," she explained. Elizabeth was also implying that caring work had little value because the nurses have less control over it than other aspects of their job. Unlike work such as the routine administration of medication and surgical dressing changes that are dictated by a schedule or determined by the nurse, work that involves addressing a person's anxiety and fear is determined by the patient or family. Although, in the strictest sense, all of the nurse's work is determined by patient and family needs, the nurses' day is not organized around the provision of caring work as it is around hospital routines that organize nursing care of the patient's body.

Caring Work - Its Value to Physicians

The SICU nurses do not have a uniform conviction about the value that attending and resident physicians place on their caring work. Some nurses believe that physicians never recognize it, so cannot value their caring work (Strauss et al. 1982). Other nurses are able to name individual attending physicians who they are sure value the nurses' caring work. This certainty comes from the nurses' ability to engage the physicians in conversations about a patient's emotional state or the fact that the physicians themselves will approach the nurse seeking their viewpoints on patients' and family's emotional issues. The nurses have known these physicians for several years and have established relationships with them that allow and foster this type of discussion.

Most nurses believe physicians vary in the ways they evaluate caring work according to the physician's personality, gender, medical specialty and years of experience. They generally attribute the physicians' appraisal of the value of nurses' caring work as a function of the physicians' own caring work with patients. If a physician performs such work himself or herself, the nurses seem to believe that the physician is more likely to value the nurses' efforts.

Some nurses' believe that the physicians' views of the nurses' caring work adhere to gender and medical specialty stereotypes. One nurse believed female surgical residents are more attuned to patients' needs for emotional support and therefore value the nurses' caring work. Other nurses remarked that "surgeons are surgeons," too "incision oriented," crediting the internal medicine physicians as being more involved with the psychological aspects of their patients. The nurses may be correct. Many internal

medicine attending physicians have had long relationships with their patients that foster the desire and ability to emotionally care for their patients.

The nurses believe other physicians encourage the nurses' caring work because it benefits the physician. The nurses believe that some attending physicians are aware of the nurses' caring work for their private patients and assign value to it because they indirectly derive prestige from the nurses' labor. If a patient's and family's emotions are attended to by the nurses, the patient and family feel better and often let their physicians know this. Similarly, patients and families complain to their physician if they are dissatisfied with an aspect of their hospital care. Some nurses believe that attending physicians consider the nurses' caring work to reflect on the physicians themselves.

Like attending physicians, the nurses think there are some residents who value the nurses' caring work and others who do not. Lynn talks about the value that her caring work has to attending physicians and contrasts it with the value it has to some residents:

> Lynn: The residents, very, very much. I mean some of them are very good with families and talk to them and others spend their whole residency program trying to avoid them.
>
> Interviewer: So what would be their feeling about your involvement?
>
> Lynn: Their feeling would be, I don't think they have any feeling at all [laughs]. I feel that they hope that we'll [give] enough information that they don't have to come into the room and talk to them [patients and families]. That's what I feel they like. They hope that we won't say, Mr. Jones wants you to come into the room and talk to him. That's what I think most of them hope. But there are some good eggs that I've seen talk to families, that I would say, that's the kind of doctor I would want to be.

Interviewer: So they value the kind of work you do with families and patients because it keeps them from having to do it, whereas the attendings value it more because uhm?

Lynn: The families are happy.

Interviewer: Happy and it reflects on them?

Lynn: Oh they definitely think that.

Similar to the attending physicians, Lynn believes that some resident physicians derive a type of secondary gain from the nurses' caring work. Rather than appreciate it primarily for the good it does patients and families, the resident physicians value the nurses' caring work because it decreases their workload.

Hearn's (1982) theory of the semi-professions may be used to understand this relationship between nurses' caring work and physician prestige. Hearn explains how the system of patriarchy is served by an element of sex role socialization he calls the "patriarchal feminine." Occupations that conform to a feminine ideology of caring, such as nursing, complement the "masculine" doctor and reinforce the masculine stereotype and specialization. The male surgeon[4] who cures and the female nurse who serves the surgeon and his patient by caring, is a kind of fit.

Caring Work - Its Value to Administration

The SICU nurses receive conflicting messages about the value of their caring work from hospital and nursing administrative personnel. Most of the nurses believe that if

[4] I am not aware of any female attending surgeons in the hospital other than a plastic surgeon who would rarely have a reason to admit patients to the SICU.

administrators are asked, they will say they value the nurses' caring work because it attracts patients to the hospital by contributing to its reputation. The nurses think that administrators believe the nurses' caring work distinguishes the hospital from competitors as a Catholic institution, which, by its mission to compassionately serve area residents who are ill, maintains its reputation in the community. It is in this function that the nurses' caring work most closely resembles Hochschild's (1979) conception of feelings as commodities.

Diane framed the hospital's appreciation of the nurses' caring work in terms of the St. Paul's School of Nursing graduates employed at the hospital. Like some of the nurses, who described the value of their caring work to physicians, Diane speaks about the prestige the hospital gains from this type of work:

> Do they value it - sure, they'd love for you to do it because it gives them a very good reputation. But they don't want to provide the time for you to be able to do that. Well maybe I shouldn't say that . . .
>
> Interviewer: So its meaning to hospital management has to do with reputation?
>
> Diane: Sure, because St. Paul's has a reputation for its nurses, or had a reputation and that's because we're taught, I think, to work hands on, to talk to patients, and be hard workers, or whatever. All I can remember is the four-year nursing school programs having no contact with patients until the last year. Friends that had gone [were] saying [that], and I'm thinking, the second semester of nursing school I was in the hospital dealing with patients. It's a lot better and I think the hospital benefits from that, you know. A guy needs you and you say you're a new graduate and they say - really! Because you already know how to talk to people to a certain extent. So the hospital benefits from that.

Most nurses agree with Diane that, if asked, management personnel will state that they value the nurses' caring work because it speaks of St. Paul's reputation. Yet, at the same time, the nurses express anger that neither nursing nor hospital administrators

actually demonstrate to them individually that their caring work is valued. The nurses believe their caring work goes unrewarded, nor does the hospital create conditions that contribute to their performing caring work. The nurses make this judgment based on the view that they are not given the staff necessary to consistently do this kind of work.

> Mary: I think if you asked them [management] they would say, yes, it's important. But if you sat there and told them, well I needed to spend an hour talking to my patient's family, or three hours talking, they'd be like — what do you mean you need another hour or two of overtime finishing your work . . .

Feedback to the nurses from management staff about cards and letters received from patients and families is another way the nurses judge the value of their caring work to management personnel. Often these cards and letters are sent to hospital and nursing administrative offices, not directly to the nursing units. It is common for patients and families to write to administration in praise of care they received or to make a complaint. In my experience, complimentary letters tend to be general references to the caring and kindness shown them by the nurses, probably because it is difficult for lay people to judge the more technical aspects of nursing care. Letters of complaint are often more specific, citing incidents that made the patient or family feel angry or dissatisfied with their care.

Many of the nurses believe the administrators care only about the complaints. This type of letter is forwarded to the nurse manager of the unit with instructions to investigate the incident and report back to administration. Letters of appreciation are also forwarded to the nurse manager but with no accompanying memo from an administrator expressing their gratitude to the nurses for their work. The nurses believe this signals less concern with work done well than with work alleged to have been done poorly.

Nursing As Caring - An Ideology Rejected?

As might be expected from a group of nurses who have few beliefs that handling patients' emotions is valued labor in their workplace, most are skeptical of a nursing movement seeking to define the essence of their profession in terms of caring. Only Pat was entirely in favor of this definition of nursing. She felt that "with the way things are changing, they want you to lose . . . that focus on caring, and I think it's the most rewarding part of it [nursing]."

When I questioned them, none of the nurses had specific knowledge of professional nursing theories of caring. Some nurses said the movement to define nursing as caring sounded familiar to them, thinking they might have heard about it during a course taken in school. Although they did not completely reject caring as a way to describe their work, the nurses had two main concerns with such a characterization. First, they viewed caring as a vague term that implied the ordinary concern people often have for one another. As was also revealed in the previous section, the nurses did not think caring captured the skill and knowledge aspect of their work necessary for a complete definition of nursing. Most of the nurses believed it was important to have a combination of these two dimensions of nursing — caring, as well as knowledge and skill. Caring alone was not considered to be the primary work of the profession.

> Interviewer: So you think it's [caring] an accurate or good definition of nursing? Is caring the essence of nursing?
>
> Diane: Knowledgeable, skilled and caring for patients, because you don't just want to be known as someone who cares. You want to be known as someone who knows what you're doing as well as caring at the same time. Maybe they should broaden the definition.
>
> Interviewer: One doesn't imply the other?

Diane: Yah, one doesn't. You could be a really nice person and care but you might not have a clue what you're doing.

Interviewer: You want to broaden the definition of caring?

Diane: I want to be known as caring but yuck [grimacing].

Interviewer: It would have to be the two [aspects of the definition of caring].

Diane: I think maybe throw in she has brains [laughs]! By the way, she uses her brains.

Mary echoed Diane's worry that caring was an imprecise definition of nurses' work that did not include the intellectual skills required of the job:

> The only thing about caring as the big focus is it takes away the focus of everything else nursing does . . . the physical care, the intellect we use. When we can pick out a situation, whether it's lab values or a change in vital signs or some other change in condition that you know something is wrong and you can pick up on. Sometimes people think we have no intelligence, [we are here] to hold someone's hand only. That may be part of it, but there's another part of it and I think it's an important part and people need to recognize that we're more than a heart, we're a brain too. And it's hard to say which one is a priority because they're each equally important.

Care and skill (heart versus brains) are viewed by the nurses as mutually exclusive categories of work. It is easy to understand why the nurses are uncomfortable with caring as a description of the essence of their work, to them it is essentially a characterization of nursing as unskilled labor.

A second concern for some nurses is that the very word, caring, contributes to a stereotype of nurses that diminishes their status as professionals. I asked Janie if it was helpful to be portrayed to the public and other health professionals as caring:

> Not if people look at you in that old [way], like they say on TV — that's the way the stupid nurse is, you know, not because of just caring . . . like you're that nurse who is just after a doctor and you're not smart . . . but it's okay if you have caring and the academic part too. And we are an important part of the decision-making.
>
> Interviewer: Is what you're saying, that if you're just portrayed as caring your fear is that you could feed into some of the stereotypes of nurses?
>
> Janie: Right. Do you lose the respect you've gained?

The image of the nurse as caring can be bound up with other cultural representations of nurses such as ones that portray nurses as easy sexual partners (Fagin and Diers 1983). Maureen seemed to summarize the concerns of most of the nurses by saying:

> Well to me that almost feels like getting back to Florence Nightingale . . . you know when you say the word caring I think it takes away from the professionalism of a nurse in some respects. I mean anyone can care. You don't have to go to nursing school to care, to provide care in that respect. You need to go to school to provide physical care, other types of care, not mental care. You do in some respect, you need some type of mental type of education, but people care for people all the time. It's just a normal thing in everyday life. I care for my dog. I care for my cat.

The SICU nurses' caring work takes on varied meanings for different occupations and according to different situations. There are circumstances when the nurses' believe their caring work is valued for the work it is intended to be, that is, alleviating patients' and family's emotional suffering. This is particularly true in their interactions with physicians who themselves address the emotional needs of their patients. In other situations however, caring work assumes value because it has utility for those other than patients and families. Furthermore, busy resident physicians intent on learning the

technical aspects of being a surgeon are able to avoid caring work if the nurses step in to do it.

The SICU nurses' belief that caring work requires neither knowledge nor skill is contrary to the intent of those nursing theorists who, staking out an occupational niche in an effort to professionalize, pronounce caring to be the essence of nursing and the exclusive province of the profession (Leininger 1984; Abbott 1988). Indeed, the SICU nurses seem to *refuse* caring as a strategy to achieve professional status, viewing it instead as an obstacle to this goal. To them, caring infers little more than the way most people should feel and behave towards sick patients and anxious families. In the SICU nurses' framework, professional means skilled; if nurses are going to achieve recognition as professionals they should do so based on their "brains."

If caring did not resonate with the nurses as constituting the full substance and meaning of their work, and handling the emotions of patients and families is not consistently valued relative to other aspects of the SICU nurses' work, what beliefs do the nurses have about their work? The following chapter will describe the dominant ideologies that operated in the SICU.

CHAPTER FOUR

WORKPLACE IDEOLOGIES IN THE SICU: WHERE DOES CARING WORK FIT?

Ideologies are aspects of workplace culture that articulate a system of shared beliefs about how things work, and values that indicate norms for behavior and feeling. They are emotionalized, action-oriented beliefs members have about their work that are often associated with the tasks they perform (Geist and Hardesty 1990; Trice and Beyer 1993). The social determinants of ideologies are usually explained in terms of two theories. Derived from Marxist theory, interest theories explain ideologies as struggles for power and economic interests. Strain theories explain ideologies as remedies for chronic social unrest. Ideologies provide common organizing themes (Geertz 1973). Not necessarily contradictory, these theories used together can help us understand how members of an occupation create a belief system to handle pervasive anxiety, promote unity among members, sustain the occupational group by legitimizing it in terms of higher values, or to advance the interests of the occupation. An occupation's ideology may also be used to delineate its function in the division of labor and its relation to other occupations and clients (Trice 1993). In short, members of an occupation create a belief system in order to make sense of their world and explain their social reality even though they may distort social reality to do so (Geertz 1973).

Swidler's model of culture differs from the above theories by de-emphasizing the influence of ideologies during settled cultural periods to explain individual's and group's actions. Swidler (1986) believes ideologies determine people's actions only in unsettled cultural periods when ideology makes values and norms for behavior explicit. During settled periods the connection between culture and action is less distinct since there is no need to use ideology to organize experience as there is in unsettled times. Ideology is more diffuse, operating as habit and common sense. Ideological beliefs shape social action

in settled times by providing a set of resources from which strategies of action may be constructed according to a person's cultural competencies.

Occupational cultures need not be internally consistent belief systems, but may embody ambiguous beliefs and contain multiple and contradictory work ideologies (Meyerson 1991; Trice and Beyer 1993; Swidler 1986). One explanation for this is that occupations accrue explanations about their experiences over time. As circumstances change, new ideological structures are created independent of old ones, or old beliefs are used as a basis for new ideologies. A part of an occupation's past is then carried forward and activated if circumstances call it forth. Therefore, inconsistent ideologies seem to coexist easily among groups (Trice and Beyer 1993).

Meyerson (1991) also maintains that occupational cultures do not have to be neat and unified systems but are likely to contain multiple work identities and contradictory beliefs. The ambiguities felt by the occupation's members are important to examine since they may be some of the most central aspects of their cultural experience in the workplace. Social workers studied by Meyerson embraced both the "medical model," an ideology of cure, and the "psychosocial model," an ideology of care. Contradictions between the two ideologies surfaced as discontinuities in dress, office decor and feelings about working within a bureaucratic system to make it work on behalf of their clients.

Whereas ideologies are belief systems that constitute the substance of occupational culture, cultural forms such as traditions, stories, rites of passage and rituals, are observable manifestations of a culture that convey ideological meaning (Trice and Beyer 1993). In all cases, rituals perform important socialization functions by transmitting norms for behavior and feelings, instructing individuals on how to be members of a group and promoting occupational solidarity. Ritualized practices are found in much of nurses' and physicians' work.

Physicians' mortality and morbidity conferences are a well-described ritual in the medical sociology literature. These carefully orchestrated meetings allow valuable medical

instruction to take place, but they also help physicians to manage mistakes, uncertainty about treatment decisions, and practitioner incompetence without publicly impugning the reputation of individuals or interfering in their practices (Arlluke 1977; Bosk 1979; Millman 1986). Wolf (1988), in her ethnography of nursing rituals, describes practices such as administering medications, performing post-mortem care and medical aseptic practices. She explains that nurses perform symbolic healing through these rituals and learn the pervasive value of nursing as doing good and avoiding harm. Ritualized task performance also assists nurses to cope with anxieties evoked by witnessing suffering and death, and the intimacy of dealing with the body (Menzies Lyth 1988).

Two ideologies operated in the SICU. These ideologies, *tradition-based practice* and *science-based practice*, were beliefs about the most substantial parts of the nurses' work – dealing with family members, personal care tasks involving the patient's body and the more complex care of the patient requiring biomedical knowledge and technical skill. Both belief systems operated closer to Swidler's (1986) model of ideologies in settled cultural periods, providing the nurses with guides for behavior. The nursing practice rituals that articulated the meanings of the ideologies were seen by the nurses more as conventions for practice in the SICU, rather than absolute codes for conduct.

Science-based Practice as Ideology

The significance of skill and knowledge in the SICU nurses' definition of their work and identities as professionals was described in the previous chapter. This image the nurses had of themselves forms the basis of the ideology of science-based practice. In this ideology, the nurses embrace a rational, scientific model of nursing in which they regard themselves as practitioners who deliver patient care based upon biomedical knowledge and skill in the technological requirements of intensive care monitoring and patient care therapies. The patient's body, as the manifestation of illness or dysfunction of

organ systems, is the locus of care in this ideology. Caring for the patient's or family's emotions is not part of this belief system.

The ideological conviction of science-based practice was first revealed in reasons the nurses gave for wanting to work in an intensive care unit. Most of the SICU nurses stated that their primary motive was to learn and be challenged by the intellectual and technical demands of caring for critically ill patients. They also thought working in an ICU would allow them to be active participants in patient care decisions. Diane characterized nursing in the SICU as:

> . . . more exciting, more active, more acute. When they're coming in here they're sicker. I always loved the trauma stuff. We don't get as much of it anymore. The real messy ones I enjoy.
>
> I - Because?
>
> Diane: They're fun, it's exciting to learn stuff and work fast and to try and resolve things.

Lynn also acknowledged the challenge and excitement of intensive care nursing when I confirmed with her the beliefs of science-based practice. Like Diane, Lynn told me that it was most exciting for her to care for patients who were very ill. "We're really like that, it's a little sick," she commented.

The ideology of science-based practice is also a consequence of the SICU as an organizational form. The SICU's emphasis on technology and the delivery of care based on medical specialization (i.e., critically ill trauma or surgical patients), structures the content of the nurses' work and their beliefs about what type of work is valuable in this organizational context (Strauss et al. 1997). An example of this is the method of patient record keeping used in the SICU.

Almost all of the nurses' daily record keeping of the patient's hospital course is done on a twenty-four inch by eleven-inch "flowsheet." The format of the flowsheet allows the nurses to record such things as the patient's heart rhythm and respiratory rate,

several indices of cardiac and neurological function, fluid intake and output by hour and cumulatively over a day. There are spaces for the nurses to indicate the results of laboratory tests, the weight of the patient, and the dates when central intravenous lines are inserted. The flowsheet displays twenty-four hours of data in fifteen-minute intervals of time. The physicians, as well as the nurses, use this data to evaluate the patient's progress. Therefore, the nurses are required to keep entries on the flowsheet current, usually on an hourly basis. It would be a great breach of conduct in the SICU, or any ICU, for a nurse not to enter data in an accurate and timely fashion. The format and information recorded on the flowsheet structures formal communication about the patient's status between the nurses during change of shift report, and between the nurses and the physicians. The data recorded by the nurses serves as the central reference for the physicians during their twice-daily rounds. Typically, the junior resident reads from the flowsheet while giving a summary of the patient's progress to the attending physician. The physicians in Zussman's (1996) study of an ICU joked that the flowsheet was the patient. Both the type of data entered about the patient and the expectations for entering the information reinforce the nurses' beliefs about one of their central contributions to the patient's well being.

The knowledge and skills that are the basis of science-based practice are acquired in a formal orientation program consisting of lecture and supervised practice with patients. It is mandatory that nurses have experience on a general medical or surgical unit before they are permitted to apply for work in the SICU. A nurse may not feel competent in her new role for a year or more. Both Maureen and Elizabeth, with less than two years of experience working in the SICU, expressed to me that they still felt like novices in many circumstances.

Science-based practice, grounded in the very same biomedical knowledge that physicians must master, links the nurse with the professional status and expertise of

physicians (Freidson 1986). Therefore, part of the nurses' prestige within the hospital is derived from the complexity of their work.

> Maureen: . . . we're very much more medical professionals. We're not doctors, I'm not saying we're doctors, but we are on the same, I would consider us on the same level, just providing a different type of skill to the patient.

The SICU nurses believe their advanced expertise distinguishes them from nurses who work on general medical and surgical units, even in areas of nursing practice that are considered common to both. Many physicians are known to keep their patients in the SICU longer than is necessary, or quickly transfer them back to the SICU when the patients suffer complications on the general surgical units. The nurses described this to me as the "weekend phenomenon" since the physicians were most likely to want to keep their patients in the SICU over a weekend, believing care on the general units was substandard because of less nursing staff and resident physician coverage.

The nurses' belief that the physicians judged them as possessing superior skills was also believed to be true of patients and families. Maureen expressed to me that she was amazed to discover that since transferring to the SICU, she was "treated like a god" by many patients and families. She attributes this to her new status as an ICU nurse.

Yet other nurses report discrepancies between their vision of themselves as science-based practitioners and views other professionals have of them. This occurrs when the nurses feel physicians and nursing management dismiss their judgments about patient care. Janie reported caring for an obstetric patient who was hemorrhaging. Believing the patient was in grave danger and the nurses in the SICU were not prepared to handle the situation, Janie urged nursing management to arrange the patient's transfer to the obstetrical unit. Three hours after Janie was told by a nursing department administrator that she was not "paid to think," the patient's physicians ordered the SICU personnel to "either get the operating room down to the patient or immediately get the

patient up to them in the delivery room." Janie considered this an endorsement of her clinical judgment.

Lynn also reported frustration about how some physicians viewed her:

> . . . well the doctors, people have a different view of what the nurse should do. A lot of people think, oh, nurses are great and that's a good feeling. And other days you'll meet someone who will think, you're here to stand and do what I say. And you know, you think you have a good knowledge base and that you should get a little more respect.

Despite these experiences, the nurses' overall confidence in their knowledge and skills is evidenced in the way they interact with resident physicians. The nurses regularly question the most junior resident physicians about decisions they make about patient care. The nurses also engage in a selection process whereby they use their own knowledge and experience to decide which resident physician to approach about a patient problem. Usually the nurses are supposed to approach the most junior resident first. However, they select which resident to consult about a problem based on their judgment of the resident's competency, which includes the resident's seniority, prior experience with the resident and the nurse's own experience with similar patient problems. Some nurses in the SICU have eight or ten years experience in the management of critically ill patients, whereas junior residents, regardless of their formal education, may have only a few months of experience. Junior residents also have to check many routine patient treatment decisions with their senior residents. The nurses then match their questions and the patient's problems with the abilities of the residents. If a nurse does not trust a junior resident's ability to make a sound decision in a particular circumstance, they approach the senior resident first. The nurses also suggest a course of action to a resident in the form of a question, much the way that Stein (1967) described in his classic article, "The Doctor-Nurse Game." Although the nurses feel secure enough in their knowledge to suggest treatments for some

patient's conditions, they still adhere to interaction norms that dictate some deference to the physician's superior knowledge and status. Yet it is common for the physicians to defer to the nurses' experience about such things as, which pain medication they believe will be most effective for the patient or when to order a psychiatric consultation.

One morning, Suzanne displayed the nurses' typical confidence in their clinical judgment. She was having difficulty with her patient who had a feeding tube placed through his abdomen into his stomach. She had done what she could to solve the problem with the tube but was unsuccessful. An anesthesiology resident rotating to the SICU became aware of her difficulty and told Suzanne he would be right in to fix it. Suzanne, a little more resolute and direct than some of the nurses, did not trust his judgment and refused to let him in the patient's room. She told him, "you're not touching my patient." She preferred to wait for the more senior resident, believing the anesthesiologist to be no more skilled than she was at fixing the feeding tube.

The Ritual of Getting a Post-op

The ideology of science-based practice is manifested in the common work practice of admitting patients to the SICU after they have undergone surgery. The nurses refer to this ritualistic routine as "getting a post-op." At least once a day, and sometimes as many as three or four, most of the nurses gather in the room of a patient who has just returned from the operating room. They are there to assist the patient's primary nurse with several tasks that have to be performed quickly. The nurses work together to attach the patient to monitoring devices, ready equipment, ascertain the stability of the patient's vital signs and assure the patient is comfortably settled in a clean hospital gown and bed linen.

Manifestly, this group exercise allows a swift and safe transfer of the patient from the PAR to the SICU so that rapid medical intervention may be provided if necessary. Practically, it takes several people to accomplish this. Patients typically have several intravenous lines, drains and monitoring equipment attached to them when they arrive in the SICU. However, getting a post-op also has important social functions (Merton 1957). This group exercise brings the nurses together in a way that affirms their identities as practitioners with special skills and knowledge, an occupational identity that is important to the nurses. As they deftly hook up EKG leads, calibrate monitoring equipment, position drains and intravenous lines, the nurses are communicating to themselves and to other professionals in the room that they are an elite group in the hospital. Getting a post-op also helps the nurses manage anxiety they have about their ability to adequately care for the patient. They may be uncertain that they have the necessary knowledge and experience, or, as importantly, adequate time to do so (Fox 1957). A "fresh post-op" patient represents a substantially increased workload for the nurse. This is particularly problematic when they are short-staffed and have three patients assigned to them instead of two, a common occurrence in the SICU. The assistance given to the primary nurse by her co-workers signifies an understanding of her anxiety about managing the patient, a commitment to working together, and some assurance a co-worker will receive similar help when it is her turn to receive a post-operative patient.

Getting a post-op is a spirited and well-coordinated affair. The mood in the room is energetic yet purposeful. The nurses have a kind of bravado and confidence about them as they go about their work. The participants seem to know their different but

interdependent roles without being directed by a central person. Friendly banter and joking fill the room as the nurses trade stories about their children, discuss school assignments or complain about work schedules. It would remind me of what one might expect of co-workers in an office or behind the counter of a McDonald's.

Almost every patient in the SICU is an admission from the post-anesthesia recovery room (PAR) after surgery, or a direct admission from the operating room (OR). The PAR and OR are approximately twenty-five feet from the entrance to the SICU. Transfer to the SICU must be a swift, well-planned affair. Although patients are considered to be stable enough for the transfer, they are considered critically ill and therefore at risk for developing complications, even during the short transfer time. Moving a patient to the SICU usually involves two PAR or OR nurses, an anesthesiologist, transport personnel, and a respiratory therapist if the patient is on a mechanical ventilator (machine that assists patients to breathe). The patient is placed on a small, portable monitor so that their vital signs can be observed during the transfer. Before moving the patient to the SICU, the PAR or OR nurse will call the patient's nurse to give her a report about the surgery and the patient's current condition.

Most of the nurses greet patients by introducing themselves and assuring the patient that their surgery is over and they are now safe in an intensive care unit. Those nurses who are available immediately go into the patient's room. They assist the primary nurse and the PAR/OR personnel lift the patient from the stretcher to the SICU bed, and then assist help with a variety of tasks. The PAR/OR nurses and anesthesiologist do not leave the patient without first obtaining and recording in the medical record, a "full set of vitals" (vital signs). This requirement dictates the immediate work of the three to six

nurses who are in the room. Almost at once, the nurses rapidly disconnect the patient from the portable monitor and attach the patient to the monitoring unit in the patient's room. These monitoring devices give the nurses and physicians important, basic information about the patient's heart function. All of the intravenous lines and drains are then carefully moved from the stretcher to the patient's bed. Once this is accomplished the anesthesiologist and PAR or OR nurses leave.

The SICU nurses quickly attach any other monitoring devices the patient requires, weigh the patient and then make sure that all dirty bed linen from the PAR stretcher has been removed and the patient is comfortably positioned in the bed. The nurses now situate the many drainage tubes. Depending on the surgery, it is common to see tubes draining bile, urine, and blood from the abdomen or chest cavity. Getting a post-op takes about ten minutes, but the patient's primary nurse will spend another thirty to forty minutes in the room performing other tasks such as, untangling and labeling the many intravenous lines and calibrating monitoring equipment.

In all this activity the patient as a conscious entity is only minimally acknowledged. Frequently, this is because the patients are heavily sedated when they arrive from the PAR. This is especially true if the patient is being assisted to breathe by a mechanical ventilator. However, there are many patients who are awake and aware of their surroundings when they arrive in the SICU. One such patient was a tiny, eighty-six year old woman who had undergone lung surgery. She had a long incision in the side of her chest and a large tube emerging below the incision line that drained bloody fluid into a collection bottle. While the nurses were efficiently connecting monitors and untangling intravenous lines, the patient was moaning and clutching the side of her chest. Occasionally a nurse spoke a few

comforting words to the patient; however, most of her moaning was ignored. As the nurses saw it, their task was to rapidly attend to the equipment attached to the patient in order to insure that the numerous drains, monitoring devices and intravenous infusions functioned correctly. The nurses believed that this was the best way to ensure this patient's well being. The speed at which they accomplished this would inevitably lessen the woman's pain.

The nurses' displays of confidence and swift skill while getting a post-op are demonstrations of themselves as science-based practitioners. Over and over again the nurses collectively confirm this identity.

Tradition-based Practice as Ideology

Tradition-based practice is a two-dimensional ideology that includes beliefs about meeting the physical care needs of patients and the emotional needs of patients and families. This ideology is closely aligned with notions of nursing as the work of nurturing and self-sacrificing women tending to the sick and infirm (Reverby 1987; Whittaker and Olesen 1962). Tradition-based practice is also similar to, what Melosh (1982) calls, nursing's occupational culture of apprenticeship. She describes a belief system, developed as part of nurses' hospital based training, which values manual skills and direct involvement with patients. Although Armstrong (1983) would argue that attention to the emotional component of patient care is a recent development in nursing, caring for the emotions, as well as the body, is certainly part of the symbolic and metaphorical nature of nursing (Fagan and Diers 1983).

In one of my earlier studies, nurses who worked on an AIDS unit espoused a belief system about AIDS nursing that is a good example of tradition-based practice (Merkel 1994). The head nurse of this unit explained to me that:

> AIDS in a nurse's disease. You can finally practice the way you were taught in school. It sounds corny, but it's total nursing care . . . I consider myself a psychiatric medical nurse.

I conducted the study when AIDS nursing was still in its infancy as a specialty (Fox et al. 1990). The philosophy of care articulated by these nurses was clearly shaped by the nature of HIV disease at the time. Once diagnosed, it was fatal in about a year. Since there were no real treatments for the disease, nurses saw their main roles as soothing the patients' suffering bodies and minds as they slowly died.

Care of Patient's and Family's Emotions.

The ideology of tradition-based practice is, in part, a commitment to providing emotional support to patients, and families in particular. This aspect of the nurses' work is so significant that they asked me to include it in a definition of tradition-based practice that I initially shared with them when validating my hypothesis about this ideology. I then expanded my description of tradition-based practice and re-confirmed it with them. Janie describes why the nurses feel so committed to supporting families.

> Well, the families here, they're helpless I think. They're overwhelmed with noises and stuff, the noises scare everybody. You have to reassure them about it, the alarms . . . and you know some people down here are really, really sick, and they see it and they see this change in their body, they're all swollen and they get upset about that . . . on the [non-ICU] floors they're getting ready to bring them home and they're nervous about that. Here they're more nervous about are they going to live.

Patients' families represent a considerable amount of caring work for the nurses. Visiting hours last from eleven o'clock in the morning until nine o'clock at night. Family members who visit are often distraught about a loved one's prognosis and anxious about the surroundings of an ICU. Because the patients in the SICU are so ill, the nurses believe family members are more emotionally needy than families on the general medical and

surgical units. The nurses also believe that families actually require more emotional support than most patients in the SICU. Many patients are heavily sedated, others are unconscious. The nurses believe that many of the alert patients are preoccupied with their physical needs and discomforts. They also hypothesize that the intensive technological surveillance and nursing care in the SICU make patients feel secure. This is not to say that the nurses do not provide emotional support to patients. However, caring work the nurses do with families is more readily identified by the nurses as labor. This is true for several reasons. As discussed in the previous chapter, the nurses believe that caring work is extra, non-essential work. Family members are not the nurses' main concern, patients are.

> Diane: Well I think it's part of your care [of families] but your primary responsibility is to the patient. Because sometimes family members can be more overwhelming and the patients get overlooked I think. If the family member is a type A lady running around saying she is concerned about the patient but she needs the shot herself or something, that can overwhelm things. But families, I think, maybe they're a little more clear [about their feelings].

However committed the nurses say they are to caring for family's emotions, the work presents them with a dilemma. Although the nurses consider themselves to be "very involved with families," they also experience this involvement as stressful. Family members constantly question the nurses about the patient's condition. The nurses have to reassure families frequently when they visit or call on the phone. Rendering care to families often requires the nurses to delay speaking to physicians, preparing medications, entering data in the chart, or stopping their work with patients. Handling family's emotions competes for the nurses' time with work that is more highly valued in the SICU. Diane explained this phenomenon to me by recounting something a resident physician once said to her. He had told her that "visitors impede care."

Ironically then, the nurses' convictions that they work intently on behalf of families needing emotional support is also a belief that families are a burden. Caring work has seemingly contradictory meaning for the nurses in the context of this ideology as both extra, non-essential work, and work that they are committed to for the well being of families. Chesla (1996), in her study of nurses' involvement with families in an intensive care unit, similarly found that the challenge of the situation for the nurses was the complex physical care and medical and technical procedures the patient required. Some of the nurses in her study viewed families as obstacles to patient care, while other nurses were able to surmount the difficulty of caring for patients and their families by incorporating the family into aspects of the patient's care. The SICU nurses faced the same challenges.

Care of the Patient's Body.

In addition to a commitment to care for patient's and family's emotions, tradition-based practice is a commitment to caring for fundamental patient needs. Often known as "hands on care," or "bedside nursing care," personal care tasks are the domain of this aspect of tradition-based practice. Through this work the nurses provide comfort, assuage pain, maintain the cleanliness and integrity of the patient's skin, and attend to basic physiological processes such as bowel and bladder function. Despite the technological demands of caring for critically ill patients, the SICU nurses believe they are able to keep these fundamental care needs central in their nursing practice. While much of this work is now informed by scientific knowledge, it has been the constituent work of nursing since Nightingale (1970) outlined it in her treatise, *Notes on Nursing*. Most of these personal care tasks are considered elementary, yet primary nursing activities, requiring so little formal training that nursing attendants are able to perform many of them. However, the SICU nurses hold to the belief that it is important that they alone perform this work.

The majority of the patients in the SICU are entirely dependent on the nurses for care. A patient's pain, nausea, itching, feeling of being too warm or cold, are all tended to

by the nurses throughout the day. Much of tradition-based practice is the "dirty work" of nursing (Hughes 1958). High fevers, leakage from drains, and persistent diarrhea require that patients are washed frequently and their hospital gowns and bed linens changed. Yet, the nurses consider this important work within the larger context of their commitment to the personal care tasks of tradition-based practice. Strauss et al (1997), discussing Hughes' concept of dirty work, explain that different aspects of work can cause it to be considered dirty according to organizational circumstances. In the SICU, for example, the constant cleaning, turning of patients and changing of bed linen is sometimes felt to be dirty work because it is boring and physically exhausting, especially when the nurses have no assistance. The nurses become frustrated in these situations. Maureen complained:

> I can tell you as of yesterday I must have, not that this isn't in my realm of being a nurse, but I must have cleaned up diarrhea about seven times and four of them were without any help. You know, holding a patient who is bedridden and pulling a sheet. It's ridiculous. . .

However, this same type of work can evoke compassion and understanding. One evening Diane and I were at the nurses' station watching a patient's wife say a tearful goodbye to the staff as her husband was transferred off the unit. This prompted Diane to talk about how nice she thought this man was. She related an experience to me about him and another patient she also liked. Both were stories of having to clean feces, but she did not seem to be defining this as dirty work. Diane was actually telling me how she had helped these two men through the embarrassment of defecating on themselves. One patient had written a note apologizing to Diane for her having to clean him (he could not speak because of the tube in his trachea). Diane told him, "don't apologize for that." She related this to me as if she was saying that she had been happy to help him and felt badly that he would feel shame for what Diane considered a natural, physiological process. Lawler (1993) calls these efforts to minimize patients' shame and embarrassment,

"minifisms." Lawler eloquently captures the nature of a nurse's approach to patients' bodies when she says that much of their work is to "create an environment of permission."

The SICU nurses' commitment to tradition-based practice is a source of pride for them, especially since they believe it is missing from the practices of other ICU nurses in the hospital. Lynn described this commitment to me one day while favorably comparing the SICU nurses to two irritable cardiac surgery ICU nurses reassigned to her unit. As she put it, "we're into patients down here." Although not all of the nurses in the SICU are graduates of St. Paul's, the staff members who are often attribute their commitment to their training at St. Paul's. Suzanne talked about her St. Paul's schooling and lamented the values of these times:

> I think the philosophy [of St. Paul's School of Nursing] was very focused on patient care, being a bedside nurse, the patient being a priority, very into, I don't want to say task-oriented, but I think just really into your patient care as well as dispensing your medications . . . oh we've had graduates, some nursing students who were in here their last year and . . . they just want to look at the monitors and stuff, but when it comes to dealing with the patient [they do not want to]. I just liked to think of ways to make them [patients] comfortable.

Mary, not a St. Paul's graduate, explained her commitment to the importance of tradition-based practice as "it's just basic care." She agreed it was valued on the unit and commented, somewhat critically, that physical care and therefore, the appearance of the patient, a measure of tradition-based practice, was an important norm in the SICU.

> Mary: Well, besides the care you give, regarding your clinical assessment skills and all that, the nurses here are very, very into that everyone is picture perfect . . . but not everyone has to be sitting pretty [with me].

The Ritual of P.M. Care

The ideology of tradition-based practice is made evident in the ritualistic bathing of patients every afternoon during the hour and a half visiting hours break. This ritual

expresses the importance to the nurses of fundamental patient care. Although the night shift nurses bathe patients in the early morning, the day shift nurses repeat this task again twelve hours later. Manifestly, P.M. care maintains the well being of patients by keeping them clean, and provides an opportunity for the nurses to fully examine the patient's body (Merton 1957). Bathing rids the patient of excreta, body drainage and secretions that cause ill health and discomfort to the patient. Common post-operative complications can be observed during the bath. Clearly, the nurses do not have to wait for P.M. care to examine the patient. They can examine and wash the patient at any time during the day. It is more likely that the nurses offer these explanations for the practice of P.M. care as justification for the uncertain practical importance of the repetition of this task by the day shift and the fixed time of the day it occurs. This suggests that P.M care also has important social purposes for the nurses.

A bathed patient wearing a clean hospital gown, lying on freshly laundered and neatly arranged bed linens, establishes one as a good "bedside nurse" — the consummate tradition-based practice-based practitioner at St. Paul's. The physical appearance of the patient is tangible evidence for other nurses in the SICU as well as for outsiders that patients in the SICU are well cared for. By helping each other with P.M. care and performing it at the same time every day, the nurses establish for newer nurses and affirm for themselves the importance of their identities as good bedside nurses. Anxieties about disease, death, handling the body and the uncertainty of caring for patients whose conditions change rapidly, are dealt with through this routinized care activity (Menzies Lyth 1988). The regular schedule of P.M. care helps the nurses handle the stress of their busy day by creating order.

Every afternoon at 4:30 P.M. the SICU is closed to visitors for an hour and a half. A sign posted outside the SICU door announces that 4:30 P.M. to 6:00 P.M. is "Quiet Time." A few of the nurses allow visitors to stay until they are actually ready to bathe the patient; others are stricter and make an announcement asking visitors to leave the unit. I

often assisted the nurses with P.M. care during the visiting hour break. It was a time when I could offer them the most help.

We begin P.M care by gathering clean patient gowns and bed linens, and assembling scented soaps, lotions and powders from a supply the nurses buy with their own money. This store of toiletries often benefits us as much as it does the patients. The fragrances help mask the strong odors we find repugnant and hide the inevitable effects of infections and disease. As Janie commented one evening, as she smelled a bottle of bath soap, "this doesn't smell too good but it smells better than my patient."

Deeply sedated or unconscious patients cannot assist in their own bath and are difficult for a single nurse to bathe and turn in the bed so we often form pairs to do this more efficiently. We position ourselves on either side of the patient's bed and work very quickly, more to get the task done than to lessen any discomfort for the patient. During the bath we attend to the privacy needs of awake or semi-sedated patients by exposing only the areas of the body we are washing. This is how we were taught to do it in nursing school. If the patient is sedated or unconscious we simply strip them naked because it is easier and quicker for us. We usually begin washing the patient's face and finish with their genitalia because it is considered the most unclean part of the body. When we are done with the bath we make sure to apply lotion to the patient's back, sacrum and heels so bedsores do not develop.

It is at this point that any endotracheal tubes (a tube into the windpipe) and nasogastric tubes (tubes into the stomach through the nose) are re-taped to the patient's face. Even for the patient who is sedated this is an extremely uncomfortable procedure. Their discomfort becomes clear when the patient, who had been relatively passive throughout the bath, starts to grimace, gag and cough while we manipulate the tubes. Two nurses are always required to re-tape the endotracheal tube so it does not accidentally dislodge. One of us holds it exactly in place, being careful not to push it down into the trachea or pull it out even a small distance. The tube itself is marked off in

centimeters so that we can verify its placement while the second nurse wraps new tape around the tube to secure it to the patient's face. Most patients struggle while we do this unless they are on medication that paralyzes their muscles. The patients' chests heave as they reflexively try to cough out the tube. They move their heads back and forth and their arms strain at the restraints we have tied around their wrists and attached to the bed frame. The restraints prevent the patient from pulling out their endotracheal tube. We try to work quickly so the patient does not suffer, but we have to be very careful and precise.

Changing the bed is our last task. It takes a significant amount of tugging at the bed linens and maneuvering to turn the patient from side to side, roll the clean bed linen under them and pull the dirty bed linen out. We take care not to dislodge the many tubes and monitoring devices connected to the patient. This too is an uncomfortable procedure for the patient. It painfully jostles tubes in the patient's throat or nose and strains their incisions. Finally, in preparation for the return of visitors, we put a clean gown on the patient and make them look comfortable and well cared for. It takes us thirty to forty minutes to finish P.M. care on a single patient.

At a minimum, it is expected during P.M. care that the nurse bathes a patient and changes their bed linen and hospital gown. Men are shaved regularly by either the day or night shift. If the patient requires bathing or a clean gown or bed linens at a time other than P.M. care, the nurses readily attend to that. Yet there are times when some personal care needs go unmet. One evening I was assisting Janie with a young woman who was heavily sedated. We performed the usual bath and changing of bed linens, but when we were finished Janie announced she could not deal with the patient's hair that day. It was very long and messily tied up in a ponytail and looked like it had not been washed in awhile. Janie and I started to talk of times when each of us had been hospitalized and wanted so much for someone to wash our hair. Janie repeated to me that she could not deal with the patient's hair. I felt so sorry for the patient that I told Janie I had time to do this for her.

The ability to deal with anxiety and release tension in the absence of visitors and through the ritualized practice of bathing patients is apparent when we work together with sedated or unconscious patients. We "talk over" them during their bath and bed linen change. P.M. care, as well as other times when the nurses are in a patient's room for an extended period of time, become opportunities to laugh together and engage in casual conversations with fellow nurses. As Maureen put it, "the room gets a little upbeat." The buddy system created by the nurses to perform P.M. care becomes a social bond between them as well as a practical union. The personal conversation and joking during P.M. care establishes a sense of community among the nurses, relieves the tedium of their work and helps them to manage emotions that emerge while caring for patients. (Coser 1959; Fine 1983; Francis 1994; Smith and Kleinman 1989).

A paradox of the nurses' embrace of the ideology of tradition-based practice is that personal care tasks performed for patients and emotional support of families are associated with images of the nurse as an extension of the female role — tenderly ministering to the helpless and sick by providing physical comfort and concern for emotional suffering (Reverby 1987). This was the very identity rejected by the SICU nurses as not fully representing their work, in favor of one that included skill and knowledge.

There is evidence that the nurses consciously associated aspects of their work as unskilled and female in nature. The image of the nurse as nurturing was reflected in some of the reasons the SICU nurses gave for choosing to enter the profession. Most of the nurses thought of themselves as people-oriented and believed the role would give them an opportunity to help others. For some it was a natural extension of their roles at home as the caretaker of a sick family member or as an oldest sibling.

Interviewer: Why did you decide to become a nurse?

> Elizabeth: My mother was sick for awhile. I was the oldest of four siblings and I always took on that type of role to help everyone in the family. And I always liked to watch all the medical shows on TV. I guess that's it and I always thought it was interesting. I thought it was a caring, good profession.

Suzanne explicitly evoked the maternal image of a nurse one morning while making rounds with the physicians. She was upset that they did not seem to be as concerned as she was about a patient's severe agitation and worsening delirium. The patient did not speak English and his family had not been visiting him lately. She had been trying without success to get a translator. "He has no one, Lynn and I are like his mothers," she exclaimed to me in her anger at the physicians. Mary was more explicit about the stereotype of tradition-based practice. She told me she knew that P.M. care was a "nurse thing in the public's eyes associated with bedpans," adding that you did not have to be a nurse to do it. However, she believed that if P.M. care made her patients more comfortable, that was enough justification to do the work. Mary was quick to add, "but I don't run to work to give tap water enemas." These self-images are in sharp contrast to the nurses' view of themselves as science-based practitioners.

CHAPTER FIVE

FEELING RULES IN THE SICU

Emotions are a fundamental part of our lives and interactions with others. Social arrangements not only induce feelings, but control these feelings. We experience this control as prescriptions, or "feeling rules" for emotions in social situations. (Hochschild 1976, 1979). For example, when we believe we should feel sad at a funeral or happy at a wedding, we are experiencing the regulating effects feeling rules have on our emotions. Similarly, the expression or display of feelings is governed by norms. Different from rules for feeling, Goffman (1959) described expression rules as a form of impression management. This is the work we do to convey to another a certain perception of ourselves. It is a reflexive process that requires us to monitor ourselves and our expressions of emotion in an effort to produce emotional effects in others.

Rosenberg (1990) offers several reasons for engaging in emotional displays. Persuading others that we are conforming to the emotion norms of society is an important function of emotional display. For example, women may act affectionately towards children in an effort to adhere to gender norms that dictate women be nurturing. People also display certain emotions to attain individual goals or effect interpersonal relationships. An expression of regret to a police officer when stopped for a minor traffic infraction is more likely to stave off a ticket than an expression of the annoyance we really feel. In the workplace, dictums for feeling and emotional expression may further an organization's goals. They also permit individuals to effectively perform their jobs. Emotional norms provide not only guidelines for emotional display that fit organizational needs, but a mechanism for employees to manage personal feelings that would otherwise hinder the successful enactment of their jobs (Fineman 1993).

Rules for the feeling and expression of emotion are intrinsic to ideologies. They serve as a framework, or set of "framing rules" according to which we give meanings to

situations (Hochschild 1979). Implicit and explicit feeling and emotional expression rules are part of the SICU ideologies of science-based and tradition-based practice. These ideologies offer the nurses two different understandings of their roles as nurses and interactions with patients and families. Work that requires scientific knowledge and technical skill is highly valued in science-based practice. Within this context, the nurses' primary role is defined as managing the technology in the SICU and caring for complex physical needs of critically ill patients. Work handling emotions of patients or families is viewed as non-essential. Therefore, the implicit feeling rule in science-based practice is that neither feeling, nor expressing concern for patients' and family's emotional distress is an important role requirement of the SICU nurse.

However, tradition-based practice contains an explicit feeling rule that is contradictory to the implicit rule of science-based practice. Feeling and showing concern for patients' and family members' emotional distress is an important role requirement of the nurse in this ideology. Recall that the nurses pointed out to me that this aspect of their work was absent from my original definition of tradition-based practice. They requested that I include "being involved with families" in my descriptions of the beliefs they had about their jobs. Science-based practice and tradition-based practice frame the nurses encounters with patients and families very differently and subject the nurses to conflicting normative expectations for feeling and expressing emotions.

The incongruent role requirements inherent in the ideologies of the SICU are made evident in the nurses' vacillating feelings and expressions of feelings towards patients and families (Merton 1976). The nurses' feelings and displays of emotions are not necessarily consistent with a particular patient or family member, but vary from interaction to interaction and according to whether the nurse's feelings are shown frontstage to patients and families or backstage to other nurses (Goffman 1959).

The explicit feeling and expression rule of tradition-based practice is to attend to the emotional needs of patients and their families by having *regard for their suffering*.

The implicit feeling and expression rules in the ideology of science-based practice are *render the patient insentient* and *undo it backstage.*

Feeling and Expression Rules: Tradition-Based Practice

Regard for Suffering

Regard for the patient's and family's suffering calls for the nurse to feel and display understanding and concern for emotional distress without the nurse becoming over-involved with the patient or family. Concern for patients and families tempered by social distance was first described as a feeling norm for physicians by Parsons (1951) and Lief and Fox (1963). Many scholars have described norms for the patient-health practitioner relationship that prescribe physicians and nurses feel and demonstrate empathic concern towards patients. The norm also requires practitioners to maintain enough detachment from patients and families to avoid being overwhelmed by feelings of horror, disgust, grief or personal responsibility (Hafferty 1988; May 1991; Morse 1991; Smith and Kleinman 1989). Recent scholars have studied the nurse-patient relationship in particular and describe a similar type of engagement with patients as "primary involvement," "therapeutic" and "connected." (May 1991; Morse 1991). An ideal degree of involvement with patients was described by the nurses in these studies as being both satisfactory to themselves and the patients they cared for. This occurred when the nurses' interactions with patients were personally meaningful to the nurses but not stressful.

To have regard for patients' and family's suffering clearly conforms to societal expectations that nurses minister to those who are vulnerable and ailing. St. Paul's religious ethos also enjoins the nurses to provide compassionate care. The SICU nurses' regard for patients' and family's suffering takes three forms: have cheerful demeanors, show respect, and provide families with information about the patient's illness. Although the nurses find it difficult to know when patients are suffering emotionally they engage in, what I termed in my fieldnotes as, "presumptive and preventative caring." This is a display

of concern by the nurses for the patient's emotions without evidence that the patient is actually distressed. Rarely does this entail an explicit conversation about the patient's feelings. Rather, the nurses employ strategies such as the use of endearing names, pep talks, friendly banter and humor. As Maureen explained to me, when her patients require emotional support they are "in need of some chit- chatting."

The nurses' regard for a patient's suffering range from fleeting encounters to much longer contacts. Taking a patient's vital signs every hour merely requires the nurses to read numbers from the monitor display, but this also permits a quick, "how are you doing honey?" Dressing changes and replacing intravenous tubing are more time-consuming and offer the nurses a sustained opportunity for the "chit chat" that Maureen and the other nurses consider a significant way to show concern for their patients' suffering. Caring work with families also occurs when the nurses perform patient care tasks. Family members are often in the patient's room while the nurses perform simple tasks such as injecting intravenous medications or calibrating equipment. Seldom are family members asked to leave the room in these situations, allowing the nurse and family an opportunity to talk. This is especially true if the patient is heavily sedated or unconscious. Apart from the occasions when the nurses provide emotional support to families while performing patient care tasks, family members frequently try to engage the nurses while the nurses enter and exit patient rooms or are at the nursing unit desk.

While adhering to the feeling rule to have regard for suffering, the nurses adjust their interactions to meet the specific emotional needs of those they care for. The feeling rule operates as a guideline for the nurses' feelings and expression of feelings, not a rigid mandate. When interacting with families and patients the nurses take into consideration a patient's or family's personality, ethnic background, and the circumstances surrounding the patients' illness. In the following quotes, the nurse believes a family is in need of emotional support. They fulfill their role obligations to express regard for suffering by

relying on cues from the patient and family to further define the situation and guide their actions (Rafaeli and Sutton 1989).

> Mary: Sometimes depending on their religious or ethnic backgrounds, people don't want you interfering and in the same sense you feel it – they walk away . . . like I said, it's extremely situational and you have to look at the individual. My thing is – here's the tissues and water, and you take it from there, because you're safe that way. And if someone wants something more maybe they'll show you. Even if they don't want that, you're not intruding into their space.

> Lynn: If sometimes people are very serious I really wait for a cue from them . . . I kind of wait to see how they are, because obviously if someone is really dry and serious then you kind of have to [wait]. I think having a sense of humor and kind of being a comical person is not unprofessional but I think that there's a little more serious side that sometimes you have to lean towards with certain people.

Showing Respect

Being respectful towards patients and families is a form of having regard for suffering. Even if the nurses have feelings contrary to this feeling rule, they usually treat patients and family members in a polite and considerate manner. Although the nurses sometimes expressed to me their annoyance with family members' frequent questions and interruptions of their work, most do not betray the magnitude of these feelings in front of the families. Showing respect is part of the nurses' definition of being a professional. Despite occasions when they are unsmiling and restrained in their bearing towards patients and families, the nurses still believe they maintain this identity. The nurses believe that acting "all business" and "cut and dry" are consistent with showing respect. As long as they are not overtly rude to patients and families and meet the patients' physical care needs, the nurses believe they demonstrate regard for suffering. The nurses show this abbreviated form of respect to patients and families who are difficult to deal with. For example, demanding, unappreciative and manipulative patients and family members are likely to be treated by the nurses in a more formal, detached manner.

In the following interview excerpts, Maureen and Pat make it clear that respect is a standard for feeling in the SICU. Yet they often have to work hard to comply with this feeling rule (Hochschild 1979).

> Maureen: . . . you have to respect everyone as a person regardless of anything. What their values and beliefs are might not be yours but you can't judge them on that. But we do leave the [patient's] room cursing, biting you lip, yah, we do.
>
> Pat: I think you should treat everyone with respect, be polite. Sometimes it's difficult, but you have to restrain yourself.

Feelings of respect are demonstrated by tolerating and accommodating patients' and family's lifestyle choices, cultural and religious beliefs, as well as the patient's right to privacy. One family had set up a shrine in the patient's room, but the statues took up precious space used by the nurses to store equipment. Pat, the nurse manager, told me she knew the shrine was important to the family. As far as she was concerned, as long as the family did not light any candles, she was willing to allow it. The nurses treat partners of homosexual men and women as spouses to whom the nurses provide information about the patient, as they do to any husband or wife. Yet the nurses are careful to protect the privacy of a patient's medical condition. Questions from concerned friends are diligently referred to family members.

Respect is also shown to patients who are sedated or unconscious by treating them as sentient. Even though these patients show few signs of being alert or aware of their surroundings, the nurses demonstrate respect by speaking to them. As might be done with patients who are awake, the nurses offer apologies for the pain they are about to inflict, or explain a procedure they must perform. The nurses' "failure to discount awareness" of patients who are clearly not able to hear or understand them, creates the illusion of a

mutual interaction and a relationship with the patient when it is doubtful one can exist (Glaser and Strauss 1965). The nurses' failure to discount the patient's awareness, in effect, de-objectifies the patient when objectification is so common and perhaps necessary in the SICU (Chambliss 1996). Profoundly ill, many of the SICU patients lay limp and non-reactive in their beds while the nurses work on them. Commonly, patients cannot even breath adequately for themselves. As illogical as it seems, caring work with sedated and unconscious patients is a strong feeling rule in nursing. I, like most nurses, remember being taught in nursing school to care for these patients as if they were awake. A textbook instructs nurses on the care of the unconscious patient:

> Although unconscious patients appear completely unaware of their environment, it is impossible to determine this . . . it is important to maintain a positive attitude in the presence of the patients and assume that some stimuli will penetrate the complexities of unconsciousness. Stimuli can be provided by playing the radio, touching the patient and talking. Patients should be told what will be done and should be oriented to time, place, person and reality by describing the surroundings (weather and so forth) (Hickey 1997, 292).

Villanueva (1999) studied critical care nurses' experiences of caring for unresponsive patients. She found that nurses typically approached unresponsive patients with an attitude of "giving them a chance for the best possible outcome." One of the ways the nurses did this was to talk to the patients.

Caring for unconscious and sedated patients can feel disconcerting to the nurses. One of the rewards of their work is feedback from patients that the nurses' caring work relieves the patients' emotional suffering. Although the nurses feel the technical challenge of nursing patients in an ICU is gratifying, many miss having more of the simple human interchange that working on other units provides. Maureen, in the quote below, compares working in the SICU to a day she was reassigned to a general surgical unit. In doing so

she points out the frustration of caring work with patients who are not awake enough to respond to her.

> Maureen: I floated up to [the 7th floor] a couple of months ago. I got pulled up there. It feels good to be up there talking to like seven different people [patients], bouncing into each room, taking [blood] pressures and giving out medicines.
>
> Interviewer: So when you approach a patient [in the SICU] who is intubated [tube in throat], the way you think about them is how?
>
> Maureen: If they're totally sedated . . . I will talk to them but it's nowhere near the amount that if someone was intubated and understands.
>
> Interviewer: Because you're thinking?
>
> Maureen: They can't appreciate my humor, all right. No, only kidding [laughs].

Elizabeth tells me about trying to comfort a patient who is sedated.

> It'll make me feel frustrated a little bit. Because I'll try to say - squeeze my hand . . . or nod to me and if he kind of smiled I think, oh, he understood. But it was difficult so it is frustrating. You do feel better when you know that they do understand what you are doing to them and they're more comfortable with it. But we don't always get that type [of patient].

The common practice of attributing sentience to unconscious and sedated patients is a strong feeling rule in the SICU and helps the nurses maintain a social identity of themselves as contributing to the emotional well-being of their patients. Although the patient's body is always tended to, rendering an unconscious or sedated patient sentient completes the portrait the nurses have of themselves as tradition-based practitioners.

Being Cheerful

Part of having regard for suffering is a cheerful demeanor with patients and their family members. Joking with patients and their families is a large part of this cheerfulness.

The nurses believe humor is therapeutic because it distracts patients and family members from their fears and anxiety. An informality is present in many of the interchanges the nurses have with patients and families. During a morning I spent with Mary, she constantly teased her patient about his "baby," as he referred to his pet boa constrictor.

Janie expressed to me one day the nurses' presumptions that humor and cheer benefit patients and families. She told me about a family member who asked her how she could act so happy while working on a unit that was clearly a place of much tragedy. Janie answered, "would you rather I look sad all the time?" Pat also explains the purpose of the nurses' use of humor:

> We're trying to make them feel comfortable, make them feel better. I think when you treat them as if they were your friends they react completely differently than when you treat them as Mr. so and so . . . a lot of them are feeling anxious because of the surgery or because of the outcome and you try to put them at ease by joking around with them, or some of them are down and depressed and you're trying to joke around with them. Some of them do come out of it.

Giving Information.

An intensive care unit can be an intimidating place for families. The equipment is unfamiliar, constant sounding of alarms frightening, sights and smells offensive. The nurses believe that a major source of a family's emotional suffering is a lack of knowledge about the patient's condition and the overall workings of the SICU. Therefore, a principal way the nurses communicate a regard for the family's emotional distress is to provide them with information about the routines of the ICU and the patient's illness.

> Diane: When someone is initially admitted and you're settling them and the family comes in, most of the nurses here, will go through the routine of – the patient is on a respirator. I mean it's very frightening when they come in here, even if it's just like [we say] – the surgery was long and they have to keep them [patient in the SICU], they weren't awake enough [after anesthesia]. We go through the respirator, the monitoring devices, how the alarm system is very sensitive and how

> we have a monitor bank. Now that's fine, I mean you'll repeat yourself and repeat yourself in the room maybe ten times because people are asking questions.

Although several different nurses are likely to care for patients during their stay in the SICU, the nursing staff is a more constant presence, and more accessible to the families than the physicians. Many physicians, especially attending and consulting physicians, see the patient only briefly once or twice a day. Although reticent to give specific results of diagnostic tests or surgery, the nurses routinely provide family members with information about prescribed medications, attempts to wean the patient off the respirator and explanations of scheduled procedures. The nurses are often able to give family members more information about the patient's general progress than the physicians are. How well a patient sleeps, what they eat for dinner or how long they tolerate being off the respirator indicate to family members how the patient is doing.

> Mary: . . . I'm just trying to make this person [family member] comfortable [by saying], I know this is hard, or supportive [by saying], look at all the progress and all that's going on, explaining that this isn't the only person who has had this go wrong. Just because they get into this complication – to you, you've never heard of it before, but it's not really uncommon.

The nurses accommodate a family's need for information by patiently taking their phone calls and answering their numerous questions during visiting hours. Maureen explained to me how important this was for families:

> We do talk [to families], like, how's the patient doing, things like that. That can make or break their look on this for the day, depending on how much they know and understand of the whole thing.

Feeling and Expression Rules: Science-Based Practice

The feeling and expression rule to have regard for suffering coexists with emotion norms that disregard the patient and family as emotionally vulnerable and needy. These feeling rules – render the patient insentient and undo it backstage – present patients and families as objects of ridicule and transform the patient into someone without awareness or emotions. Render the patient insentient and undo it backstage hardly conform to societal, professional or St. Paul's expectations for feeling or expressing feelings to patients and families. Nonetheless, they are a tacit part of the ideology of science-based practice that marginalizes caring work and values technical and task performance. These feeling rules are sub-cultural in that they differ from the core cultural value of caring held by the nursing profession and the hospital (Trice 1993).

As I will describe in a later chapter, the nurses also use rendering the patient insentient and undo it backstage as emotion management strategies. By using these strategies the nurses effectively deny the patient and family feelings of emotional suffering. This helps the nurses to feel less compelled to attend to the patients' and family's emotions so they may complete physical care tasks. Rendering the patient insentient and undo it backstage essentially provide the "detached" portion of the detached concern that is part of the feeling rule to have regard for suffering.

Rendering the Patient Insentient

As discussed earlier, one of the ways the nurses show regard for a patient's suffering is to attribute sentience to those who were not awake or aware of their surroundings. In an opposite fashion, the nurses also render awake patients insentient by treating them as if they are not conscious. This happens most frequently during routine patient care tasks. During the ritual of P.M. care described in chapter four, the nurses frequently render alert patients insentient. Although the patients are awake or mildly sedated, together the nurses "talk over" or "discount the awareness" of patients as if they

cannot hear (Glaser and Strauss 1965). Elizabeth gives an example of rendering patients insentient when they come to the SICU from the recovery room after surgery:

> Your first thing is to get all that stuff [monitoring equipment] hooked up quick and see what their blood pressure is and their heart rate and stuff, and then you kind of make sure there's somebody there [laughs].

By rendering an awake patient insentient, the nurse is discounting the patient's awareness by treating them as a "non-person" (Glaser and Strauss 1965; Goffman 1959). In the moment she does this she negates the patient as a thinking, feeling individual who has emotional responses to being ill and hospitalized. Zussman (1996) has astutely observed that all too often the patient vanishes in an ICU. Their personhood dissolves into a set of lab values and vital signs.

I would frequently render the patient insentient with the nurses. When assisting with P.M. care, receiving a patient from the operating room or during long procedures, we would talk over the patients as if they were not there. All that seemed to exist for us in those several seconds or minutes, was the patient's body, the tasks we needed to complete and the topic of our conversation.

> Janie: All right, you know what happens. You get this patient in and you're admitting them to the bed and everything is so routine that you don't even have to think about what you're doing. So you might as well talk while you're in there to get you through this because it's just so routine that it's acting without thinking . . . you're looking up at the monitor you know . . . you don't think, oh, I've got the red [EKG lead], where does the red one go, it just goes. You don't even think about it. And you're walking in there and you're already in this conversation and you just keep it going and you start making each other laugh.

> Maureen: . . . that's what we think too, let's kill two birds with one stone and make it enjoyable. We have to stay in there an hour changing the Swan [catheter placed in the pulmonary artery] so let's make it enjoyable. And it's done during routine, monotonous things.

Maureen and Janie make clear that rendering a patient insentient helps them manage the tedium they feel during work. Emergencies are common in intensive care units, but many tasks are routine and repetitive. The nurses count on each other for both kinds of work. By excluding the patient, they connect with each other. The nurses render the patient sentient and insentient in the same interaction. From moment to moment the nurses shift between feeling and displaying feelings that negate the patient as a person, and having regard for the patient's suffering. This was illustrated one typical afternoon when I was helping Diane, Lynn and a couple of recovery room nurses care for a patient who had just returned from the operating room. The nurses and I were having a personal conversation when Diane suddenly looked at the patient, smiled, and apologetically said to him, "you're hearing all this gossip." Occasionally someone else asked the patient how he was doing, but most of the time our discussion was about the outrageous fact that the night nurses were now required to pay for parking in the hospital garage.

Undo it Backstage

Frontstage, the nurses may show regard for patients' and family members' suffering. However, backstage to other nurses, they often undo these feelings and express a very different set of emotions (Goffman 1959). The nurses criticize and mock patients and family members. Fineman (1993) points out that the emotion architecture of an organizational culture contains spaces where different feeling rules apply. The nurses were respectful, kind and compassionate towards patients and families while in the patient's room or on the phone with a family member. However, when they are backstage, behind the nursing station or in the hallway out of earshot of the patient and family, the nurses often undo their frontstage displays of feeling.

In chapter four I described a situation when Diane had patiently explained to the sons of a very sick woman that she and I were changing a dressing while behind the curtains pulled around their mother's bed. Diane gently reassured the latest son to enter

the room that his mother was fine, we were performing a routine procedure. As soon as he turned around and walked out Diane stuck her tongue out at him. She had just undone her feelings backstage.

The nurses label patients and families "loonies" or "weird," gossip about them or make them the object of a joke. Families in particular are often viewed as an annoying cause of extra work. Lynn expressed a common attitude toward families. I was helping her and Pat put a rectal tube in an unconscious patient who was having frequent bouts of diarrhea. I commented that the smell permeated the unit because it is a long, straight hallway. Lynn laughed and said, "good, it keeps the visitors away."

On another occasion I sat with Suzanne at the desk as she talked to the wife and daughter of a patient. She was very sweet to them and offered the phone number of the SICU nursing station so they could call later to ask about the patient. The two women seemed a little surprised by her gesture and were very appreciative. They raised their eyebrows and said thank you. Suzanne kindly acknowledged their thanks, they took the phone number and left. When they walked away from the desk Suzanne turned and said to me, "the daughter is a psycho."

Another form of backstage undoing is to gossip about patients. A very sick woman had been in the SICU for several weeks. She suffered from a form of pancreatitis (inflammation of the pancreas) that is associated with a high mortality rate. The patient, a nurse, developed the pancreatitis as a complication of gallstones. She had refused to have them treated surgically, preferring instead to use holistic methods to treat them. Sedated and on a respirator, she was now in danger of dying because of her decision. The nurses were critical of her decision, especially because she was a nurse. I helped Janie care for this patient one afternoon. At one point Janie whispered over the patient in an admonishing tone, "well, if you would have gotten your gallstones out and not used holistic medicine." The nurses also speculated about a woman who visited her, wondering if she and the patient were lesbians.

As described earlier, the feeling and expression rule to undo it backstage often occurs in tandem with an emotional display of respect and having regard for patients' and family's suffering. In this way, undo it backstage is a "time out" from the constant impression management the nurses engage in with patients and families (Goffman 1959; Rafaeli and Sutton 1989). Away from the requirement to do caring work, the nurses show their real and dissonant feelings, bond with coworkers and collectively deal with the stress of their jobs. However, Rafaeli and Sutton contend that even time outs have emotional display rules. Time outs support a wider range of emotional expressive behaviors and are more frequently a display of true feelings.

CHAPTER SIX

TIME AND CARING WORK

Although the ideologies of science-based practice and tradition-based practice establish norms for feeling and expressing feelings, these belief systems alone do not determine the nurses' caring behaviors and feelings. The SICU's work culture influences the nurses' interactions with patients and families, but structural forces unique to the SICU also organize these beliefs and values into social relationships that connect the nurses to others in the SICU and the SICU as a system (Johnson 1997). Therefore, norms for feeling and expressing caring in the SICU are better thought of as the interaction of the nurses' beliefs and values as expressed in tradition-based practice and science-based practice ideology and structural characteristics of the SICU as an organizational form.

The nurses' position in the status and power hierarchy in the SICU and hospital, one aspect of social structure, was described in chapters three and four. Different paths were set out for the nurses in their roles as emotional caregivers according to the power and status differentials inherent in the nurses' roles as women, professionals, skilled ICU technicians and elite St. Joseph's nurses. Complex and often contradictory, the nurses' roles within the ideologies of tradition-based and science-based practice carried with them different normative expectations for handling patients' and family's emotions.

Mizrahi's (1986) study of resident physicians is an excellent example of the impact of structure on healthcare practitioners' emotions at work. Mizrahi described resident physicians' practices of transferring patients to other medical services who they thought had boring diseases or posed disposition problems. The physicians felt frustrated by these patients and viewed them as undesirable to care for. Structural limitations of the physicians' work such as, bed shortages, patient overload and long work hours, contributed significantly to their negative feelings towards patients and their desire to get rid of them. Yoels and Clair (1994) found that the location of physicians' work effected

their experience of patients. Time spent by resident physicians treating patients in an outpatient clinic was much less valued than the resident's free time, or time spent in the hospital caring for sicker patients. During clinic hours the doctors experienced patients as a source of aggravation and tension. Unlike hospitalized patients, who the doctors viewed as valuable to their development as physicians, clinic patients were re-defined by the residents as enemies and obstacles to their growth as professionals.

Time as Structure

A central structural feature of the nurses' work in the SICU is time. Time distinctly patterns the nurses' social relations with patients and families, thereby creating or constraining opportunities for the nurses to do caring work. The temporal organization of the nurses' work is shaped by the hospital as an organizational form (Strauss et al.1997). Intensive care units are highly ordered and the location of activities in the SICU at a fixed time of day indicates their priority relative to other tasks in the SICU. Tasks and activities have both practical and symbolic importance (Zerubavel 1979). For example, the hourly recording of a patient's vital signs is an important activity that determines the health and stability of a patient. However, it also demonstrates that the SICU nurse is organized in her work and attentive to the physiological aspects of a patient's illness.

In addition to recording vital signs, the nurses perform patient care tasks such as the administration of medications, giving baths and writing notes in the medical record at very specific times during the day. Similarly, change of shift report, physician rounds and visiting hours are regularly scheduled and organizationally determined activities. Throughout the day the nurses also contend with many unscheduled events even though they may be common occurrences. Admissions from the emergency department and operating room, and patients being transported to diagnostic tests are usually unpredictable events in terms of their frequency and the precise time they occur during the day. However, they are routine and expected disruptions of the nurses' workday. The

combination of scheduled and unscheduled events contributes to a collective rhythm in the SICU. The nurses use this "social time" to judge the progression of their workday. They base the progression of their day on the completion of tasks in relation to scheduled and unscheduled events and the SICU's organizational routines (Sorokin and Merton 1937). For example, to feel on time with their work, the nurses have to complete several tasks before the start of visiting hours. By 11 o'clock in the morning they must complete their morning assessment of their patient, three sets of vital signs, and the administration of ten o'clock medications. The tempo and completion of these morning tasks are important to the nurses since the questions and requests by family members arriving for visiting hours (11:00 A.M.) commonly slows their work. If a nurse is still giving out her "ten o'clock meds" when visitors arrive demanding her attention, she will begin to experience "temporal overload" (Fine 1990).

Other circumstances also contribute to a nurse's feeling of temporal overload. Re-assignment of an ICU nurse to the SICU from another intensive care unit often means that the SICU nurse has to spend time with the ICU nurse to familiarize her with the layout of the unit. If one of the nurses is unable to go to lunch before her post-operative patient arrives from the operating room, she is rushed with her work for the rest of the day. The extra care needed by a "fresh post-op" requires a great deal of time and often disrupts the other nurses' lunch schedules. Emergencies require one or more nurses to be involved with a patient for an unusually long time. These examples demonstrate that social time in the SICU is not just defined by clock time, but also "when time" (Jones 2001). When times are non-clock considerations that affect the timing of events. The numbers of nurses at lunch, the arrival of post-operative patients and reassignment of staff profoundly affect the nurses' construction of time in the SICU.

Another useful way to understand the nurses' experience of social time in the SICU is Flaherty's (1999) theoretical model of the perceived passage of time, in particular, his description of the temporal experience of "synchronicity." According to

Flaherty, a person experiences synchronicity when a situation is familiar and comfortable. While experiencing synchronicity, the person feels only a moderate amount of emotional concern for the implications of what is transpiring; circumstances seem relatively routine and unproblematic. However, should the density of a person's experience per unit of time change, their experience of time likewise changes. So, for example, if a nurse is not able to complete her regular morning work tasks before 11:00 A.M. her experience of visiting hours might be altered considerably. She may be rushed and distracted, never feeling as though she will catch up with her work and re-establish a subjective experience of synchronicity. Suzanne explained this experience of time in the SICU when I asked her how her workday was organized. She quickly listed a series of tasks in the order they needed to be accomplished if she was to have a "good day," or, as I am suggesting, an experience of synchronicity. For example, if Suzanne's charts were not done by 6:00 P.M. she was "dead." By dead, Suzanne meant she would be prevented from leaving work on time because there was so much other work to accomplish in the last two hours of her shift.

Caring Work and Patient Care Tasks: All at One Time

Time, as a central axis in caring work, organizes the relationship between rules for caring work and patient care task performance. Diane's answer, quoted below, to my inquiry about the amount of time she devotes to emotionally supporting patients illustrates that task performance and emotion norms are usually fused.

> I think I did that [care work] once, where you actually had the time to sit down for awhile [with the patient]. But it's when you're taking out someone's arterial line and you're sitting there holding it for five minutes, you can talk to somebody, when you're changing the bed and stuff like that. That's how it has to be done. It's no separate time.

Maureen concurred.

> I can't say I ever go in a room and go – okay, I'm going to provide emotional support right this minute. I am going to hang up an [intravenous] piggyback. That's [caring work] not going to be my number one thing . . . it's just not realistic.

As Diane described, the nurses do caring work, or "talk" to their patients when they perform routine tasks such as hanging intravenous medications, giving a bath or changing a dressing. Caring work is grafted onto the technical and patient care tasks the nurses perform. Emotional norms and task performance norms become linked and are experienced by the nurses as one behavior.

In fact, the nurses had great difficulty talking to me about the work they did handling the emotions of patients as distinct from the physical and technical aspects of patient care. Even when I asked them specifically about the emotional support they provided, they often answered my questions in a way that dissolved differences between tending to a patient's emotional suffering and physical discomfort, into simply, "caring." Separating the nurses' caring work from other aspects of their jobs was my construction of their work, not necessarily the nurses' everyday experience.

Much of the nurses' caring work is done with family members.

> Lynn: . . . I'm not saying that we don't give any support [to patients], I mean we've had people who were tearful and you try to talk to them, but I don't think a lot of that happens. We give much more support to the families than the patients if you know what I mean. Like the patients' families that are crying, tearful, like someone is dying or somebody is brain dead . . . or even somebody, like they [family] comes in and the patient is fine but they have a million tubes. Most of the time you're pulling them [family] out saying – they're fine, they're going to look completely different tomorrow.

Although caring work is the only type of professional work the nurses do with family members, it too is often coupled with the physical and technical work of tending to patients. Since many patients in the SICU are sedated the nurse and family members

speak freely about the patient's condition while the nurse is with the patient. As described in a previous chapter, caring work with families primarily involves answering their questions and reassuring them about the patient's condition. Family members also seek out the nurses when the nurses are behind the nursing station desk, walking down the hallway or exiting another patient's room. Because caring for a patient's emotions is connected to performing patient care tasks, it is subject to the temporal organization of these activities. While not directly bound to the performance of patient care tasks, caring work with families is also subject to the same structural forces since the nurses position caring work with families secondary to patient care tasks.

Time to Know Patients and Families

Caring work is partially contingent upon the nurses knowing the patient and their family, and the nurse's ability to recognize emotional suffering. Because of their training and experience with anxious patients and families, we might expect that the nurses are more skilled than other strangers at interpreting patient's and family's behaviors. However, the nurses are also challenged in this regard because they do not know the people they care for. Again, time as a structural concept explains caring work with patients and family members.

The nurses' work schedules, the number of days a patient stays in the SICU, and the length of visiting hours are all temporal determinants of the nurses' caring work (Morse 1991). Because their shifts are twelve hours long, the nurses work only thirteen days a month. Occasionally a nurse works three days in a row, but may not be assigned to care for the same patients each day. The assignment of patients is based on the need to spread the workload among the nurses and less to maintain continuity in the patient's care. Further limiting a nurse's ability to know her patients and families and recognize their emotional distress, is the short amount of time many patients stay in the SICU.

Commonly, patients are admitted to the SICU for only two or three days before they are transferred to another unit.

However, other temporal factors in the SICU increase the likelihood that a nurse performs caring work with a patient or their family members. Patients who suffer severe traumatic injuries or have surgical complications might stay in the SICU for several weeks. A lengthy stay enhances the possibility that the nurses will develop a closer relationship with a patient and family. This is evident when family members visit patients and greet the nurses by name, inquire about their personal lives, even kiss them goodbye at night before leaving for home.

During a nurse's twelve hour shift she cares for only two or three patients, compared to the six to ten patients a nurse on a non-ICU unit is responsible for. The patient's critical condition and the technology in the SICU requires that the nurses be with their patients frequently throughout the day, sometimes for up to an hour at a time. In contrast to general medical and surgical units, very little of the SICU nurses' work is assigned to ancillary staff. The nursing attendant assigned to the SICU is most likely to be in the patient's room assisting the nurse, not independently providing care. Neither is the nursing attendant able to provide families with information about the patients' conditions. Therefore, nursing attendants have little interaction with family members. The nursing attendant's role in the SICU is in sharp contrast to those in more chronic care settings where attendants provide most hands-on care. Such was the case in the nursing home studied by Foner (1994). Since the nursing attendants provided most of the physical care to the nursing home residents, they also rendered the emotional care.

When patients do have long stays in the SICU, the nurses believe they can better recognize emotional distress simply because they know the patient and their families. The nurses also believe that long stays in the SICU are likely to cause patients and families emotional distress. This makes them more alert to the patient's and family's emotional needs.

> Maureen: Most of the time patients are in and out rather quickly. I mean a lot of patients do come back though. They get their second trip down to the ICU after they get off the unit and you'll see a lot of them needing support on their second [admission]. I've been noticing this week that some people are down in the dumps, things like that, which is rightfully so . . . the readmits as far as the patient and family goes, they see it as a real setback, as does everyone. Why are they back? Then it's – well, you're just coming down here for a couple of days again. We'll tune you up and ship you out again.

Maureen's characterization of her work as "tune you up and ship you out again," raises the question of whether the brief stay most patients have in the SICU itself contributes to norms for feeling. Nurse-patient relationships in a hospital are bound by an expectation about the duration of the relationship (Merton 1984). Unlike spousal or close friendships, nurse-patient relationships in acute care settings are usually quite short. Either the patient improves enough to be discharged or the relationship terminates when the patient dies. Even in situations when chronically ill patients are admitted many times over the course of their illness, there is no expectation that the nurse-patient relationship will continue once the patient is discharged. Surgical patients, such as those in the SICU, are most often admitted because of an acute illness, not a chronic condition. Therefore, the SICU nurses are likely to encounter the patient only once or twice.

Despite occasions when the nurses are able to spend time with a patient and their family, they find it difficult to discern emotional suffering. Intensive care units are environments where most indices of a patient's health are measured objectively. For example, heart rate and body temperature are closely and accurately assessed. The nurses are trained for such procedures and the technology in the SICU reinforces the importance of care of the patient's body. Patients' feelings cannot be sent to a laboratory or probed with monitoring devices to be displayed as colorful waves on a computer screen. Nonetheless, the nurses interpret physical signs such as tremors, an unexplained rapid pulse or increased blood pressure as signaling a patient's emotional distress. Anger

directed toward the nurses is often understood as a patient's or family member's emotional suffering. More commonly the nurses believe that patients communicate a need for caring work through indistinct signs such as acting withdrawn or a "look in their eyes." Only occasionally will patients express their need for caring work directly by crying or telling the nurses they are frightened and concerned about their illness. Most of the nurses concede that it is difficult for them to know when their patients require caring work.

Time as a structural feature of the SICU interacts with the personal reactions patients have to illness, as this description by Mary shows. She finds it difficult to know when patients are in need of caring work.

> I think it depends on the individual because some people will just start talking and say things like little clues, like – they're sick, they're going to die, whether that be true or not. Or – oh, how horrible this is. Others you may see a tear, others may not talk at all. And I think here, unless the patient is here for awhile and they're sick and they're not quiet, because if they're a quiet person, I think it's hard to tell. Some people are sick and are being quiet because they're reserved . . . but they're not here long enough to figure that out.

The nurses' perceptions of family's heightened emotional needs is also affected by the length of visiting hours. The extended nine and a half hour long visitation period had been in effect for only a year when I began my fieldwork. Prior to this change, families were allowed on the unit for only two, one-hour sessions during the day shift. Now the nurses have to contend with families and visitors throughout most of their shift. The nurses have mixed feelings about this. Most acknowledge that restricted visiting hours serve no real purpose for the patient and, in fact, deprive the patient of an important source of emotional support. Many of the nurses concede that once visitations were spread out over nine hours their effect on the unit did not seem as profound as they

expected. However, longer visiting hours also mean that the nurses have to deal with visitors over a longer period of time.

Too Little Time Alters Caring Work

As a cultural construction, social time in the SICU contributes to a sense of order in the nurses' workday. If emergencies and admissions disrupt the social time of the unit, the nurses' experience of time is no longer one of synchronicity. As a result, their perceptions of the relationship between caring work and patient care task performance norms shifts. The nurses' relations with family members are also altered. The nurses' framework for their workday is a constant juggling of patient care tasks and organizational routines with unexpected problems within a twelve-hour shift. This provides the background understanding of all other events (Goffman 1975). A nurse in Zalumas' (1995) study of intensive care nursing echoed the SICU nurses' feelings when she observed that an intensive care unit is like "one big clock." In short, the nurses feel rushed (Fine 1990; Flaherty 1999).

If the nurses are late beginning personal care tasks, or the tasks take a long time to complete, task performance norms are experienced as more urgent and norms for caring work less imperative. Patient care activities are markers of time for the nurses, not caring work. Patient care tasks and caring work, once connected in time because they can be performed together easily, are now experienced by the nurse as competing for her time. The nurse's perception of her commitment to do caring work with families shifts similarly. The nurses believe they usually provide families with the emotional support they need when the families are in the patient's room. However, technical and personal care tasks prevail when the nurses lack time.

In the quote below, Diane describes the tension she feels between caring work and task performance.

Diane: . . . he was worried about his surgery, he was having surgery the next day and he was starting to talk, and I just felt like - oh, I feel bad leaving, you can't leave. He's looking for someone to talk to. So I just sat down and talked to him.

Interviewer: So it just happened to be that you had gone in the room for a task?

Diane: Yes, I forget what I went in for, but you knew he wanted to talk.

Interviewer: Did you feel pressed for time?

Diane: Yes, I felt like when he wanted to keep going on I needed to get out of the room and do something else because I was going to get behind.

I continued to ask Diane about circumstances that might take precedence over caring work.

Diane: If you're busy that definitely does happen [not give emotional support]. Morphine takes priority over the emotional.

Interviewer: Like you were saying, the more task-like stuff?

Diane: Yah, you have to complete the tasks unfortunately. I've seen that, I've done it myself - I'm sorry I don't have time, I'll put you to sleep [with medication] and deal with you later.

Lynn gives a particularly dramatic example of task performance supplanting caring work. Although Lynn's attention to the patient's serious physical needs is entirely appropriate in the circumstance, she still expresses the tension she feels between task performance and feeling norms on the unit.

We had a patient that I had taken care of and had come back acutely the other day, and she was bleeding to death. She came back talking and awake and then a half-hour later she started bleeding. And it's like she knows your voice and you're trying to talk to her and you're trying not to sound upset. It was like crazy in the room because of all the things that were going on. But one minute you're infusing blood and the next minute you're thinking, I still have to talk to this person because they're awake, you know.

Although caring work is performed with patient care tasks, it is not an organizing feature of the nurses' work, nor did they consider it to be crucial to the well being of patients. Caring work with families is important to the nurses, yet it is often separate from, and defined as secondary to patient care activities. Although having family members on the unit for an extended period of time affords the nurses a greater opportunity to know the families, recognize their emotional distress and do caring work, it also poses difficulties for the nurses. As discussed in chapter four, the nurses believe that family members are more emotionally needy than patients, but they are not the nurses' primary responsibility. Therefore, the nurses are more likely to experience disturbances in the social time of the unit as limiting their ability to perform caring work with families, not patients. Even though involvement with families is part of the SICU's ideology of tradition-based practice, the reality of this belief is that families often mean more work for the nurses.

> Maureen: Some people are more involved than others with families. The only thing is that, even myself, you get so involved you get behind, but you have to find a happy medium.

About a year after I completed my fieldwork I met Maureen in the cafeteria. She asked about my research and told me she would change some of her answers to my questions if I were interviewing her now. Maureen explained that she still felt new to the unit at the time of my research (she had worked there one year). Now she finds dealing with family members much too time-consuming and difficult. The first year she worked in the SICU she tried to handle families as she had on her previous unit, always finding time for them. But now she saw that was really not so possible in the SICU.

In emergency situations such as those described earlier by Lynn, although the nurse is physically with the patient, she may have to abandon verbal expressions of caring work. Hopefully in these circumstances patients perceive the nurse's presence alone as

emotionally comforting. However, during unusually full days of time-intensive patient care activities, family members risk losing altogether the nurse's emotional support. When the nurses are extremely busy, the imperative of patient care tasks results in an exchange of a commitment to care for family's emotions, for a view of families as burdensome. Lynn described doing caring work with families as having to deal with both "their stress levels and our stress levels." She talked further about the conflict she felt concerning her commitment to families:

> For example, there's a big family down the hall and there are like twenty-five family members. Believe me, I have no problem [with families], we were joking around before, like I spend time with families and repeat myself and repeat myself and repeat myself. But when you spend a lot of time and you have two other patients, or you have one other patient and you're admitting another patient and just when you get out of the room they're [family] out looking for you again. And you turn the patient and clean them and they look comfortable, and they're at your heels, then I start to pull off a little and say – you know, I'm trying to give you information and do the best I can. But you have to pull back and I think we all do it.

Lynn's experience of having to "pull back" from the family is similar to the other nurses' experiences when they are rushed. An experience of temporal overload makes the nurses feel and act differently than the feeling rule of tradition-based practice would dictate. In the next chapter I will discuss the real feelings the nurses had during their interactions with patients and families and how they managed these feelings when they deviated from the primary feeling rules in the SICU to have regard for suffering.

CHAPTER SEVEN

NURSES HAVE REAL FEELINGS TOO

Thus far I have described the social structures and normative regulations that provide a framework for the nurses' caring work with patients and family members. However, neither structural forces nor rules for caring and expressing caring are necessarily statements about the nurses' real feelings in these situations. When presented with tragic patient circumstances or overbearing families, do the nurses' actual feelings coincide with the primary feeling rule to have regard for suffering? It is reasonable to expect that on many occasions they differ. We saw in chapter five that during "time outs" backstage, away from the demands of caring work, the nurses often express feelings that are quite contrary to concern for patients' and family's emotional suffering. The question is, how are we to understand the nurses' real feelings and displays of feelings sociologically? Specifically, what social circumstances evoke feelings in the nurses other than those prescribed by the professional mandate to do caring work, and how do the nurses manage these feelings? A micro-sociological analysis is in order to answer these questions, and the basic tenets of symbolic interactionism are well suited to do so.

Schott (1979) asserts that the actor's definition of a social situation is crucial to an affective experience. Issues of motivation, perspective, identity and temporality come to play when individuals interact with one another. Therefore, to understand the nurses' real feelings and efforts to manage those feelings in interactions with patients and families, we must understand from the nurses' perspectives, how they construct these interactions (Blumer 1969; Pestello and Pestello 2000).

I have argued that the nurses' definition of their work situation is greatly influenced by two factors: social time in the SICU, and their dual and often contradictory identities as tradition-based and science-based practitioners. I will use these structural features of their work to ground my discussion of the feelings the nurses experience while interacting with patients and family members, and their subsequent management of these feelings.

In an earlier chapter, I used Flaherty's (1999) concept of synchronicity to explain the nurses' experience of the normal passage of time when emotion and task performance norms are fused. Drawing on Harold Garfinkel's work, Flaherty asserts that synchronicity is necessary for orderly interaction. As a temporal experience then, synchronicity is actually a skill for which we are socialized. Throughout our lives we learn to regulate our involvement in a situation so that our feeling is one of a routine density of experience per unit of time. Flaherty conjectures that individuals do "time work" to create not only a temporal experience of synchronicity for the sake of social order, but as a way to self-actualize and create an experience of time that is pleasurable. Therefore, we should recognize that the nurses' emotional mandate to care for patients' and family's emotions has a temporal component. Following Flaherty's theory, we can presume that a particular amount, duration or intensity of caring work within the nurses' larger experience of social time in the SICU will result in a feeling of synchronicity. The nurses are motivated to attain a feeling of synchronicity because it makes them feel good about their work and contributes to the orderly workings of the SICU.

The nurses also enter into relations with patients and families with a particular professional self in mind. That self is informed by the workplace ideologies of tradition-

based and science-based practice. These ideologies both distinguish the nurses as compassionate caretakers of patients' and family's emotions, and diminish this work as unskilled and subordinate to the complex technical work of caring for critically ill patients. That the self is realized in relation to others was a fundamental insight of Mead's (1934). Our social identities are formulated because we occupy statutes associated with, for example, our gender, age, ethnicity or occupation. These role characteristics also separate us into hierarchies. Therefore, beyond descriptions of themselves as nurses, their professional identities are implicit statements about the nurses' status and ranking in relation to others, including the people they care for (Kemper 1978).

Clark (1990) suggests that emotions factor importantly in the creation and negotiation of these social hierarchies and, therefore, also in professional identities. The concept of "social place" was developed by Clark to describe the hierarchical position a person holds in an interaction with another. A more micro-level of interaction than the macro-sociological concept of status in structural arrangements, social place implies power, prestige, social distance or face to face status. Feelings we experience while interacting with others give us information about our social place. Clark calls these feelings "place markers." Place markers may then confirm or disconfirm professional identities by signaling to us our social place in an interaction. "Place claims" are messages sent by people about where they *want* to stand. For example, a nurse may angrily scold an intern who has just fumbled through a procedure, spilling blood all over the sheets she has just changed (place claim). The intern may feel shame and embarrassment as a result (place marker). In this situation the nurse has expressed an emotion and the intern has experienced an emotion that upset the traditional doctor-nurse power structure and status

hierarchy. The momentary encounter evokes emotions in the intern and nurse that place them in very different "social places" than their statuses normally would.

The nurses' framework for their interactions with patients and families includes an assessment of their identities as science-based and tradition-based practitioners, as well as their experience of the SICU's social time. Therefore, I propose two ways of understanding feelings the nurses have that are contrary to the feeling rule to have regard for emotional suffering. These feelings occur when the nurses' temporal experience in the patient-family encounter is not one of synchroncity, or their preferred identity of themselves as nurses is threatened. Various strategies are used by the nurses to do caring work and align their feelings and display of feelings with the primary feeling rule to have regard for suffering. These strategies are fundamentally manipulations of their temporal experiences in the patient-family encounter ("time work"), or efforts to change perceptions of themselves in the patient-family encounter ("social place"). Managing time is a way for the nurses to moderate caring work and patient care tasks demands and the nurses' experience of herself as a professional. To both provide emotional support to patients and families, and complete patient care tasks is to be a "good" SICU nurse at St. Paul's. Therefore, the nurses' perception of time in the SICU, their professional identities, and their affective experience during encounters with patients and families are intimately connected processes.

Real Feelings

Emotional Harmony: When Caring Work Comes Easily

Rafaeli and Sutton (1987) describe emotional harmony as an indication of a good fit between the person and the environment. Based on our understanding of the nurses' real feelings described above, we can explain emotional harmony as an experience in which the nurses' ideal professional self is maintained and they experience social time in the SICU as normal. In these circumstances the SICU nurses speak of their caring work more as familiar and informal encounters with patients and family members than as true labor. Felt as neither burdensome nor stressful, the nurses describe caring work as a personally enriching and mutual experience with the patient or family member. The encounter feels genuine to the nurses, rather than a laborious effort to handle the patient's or family's feelings (Hochschild 1979).

> Diane: If you can sit down with and speak with a family and be able to . . . in your own personal way you're relating to the family more so you're showing yourself more I guess.
>
> Janie: You feel better that you've reached that point with somebody [when you share yourself].
>
> Maureen: an opposite [to a problem patient] is a surgical patient who is going for a carotid endartarectomy, who you know is a little nervous and comes back out of the operation. He's fine, he's talking, you're giving him lime jello. Everything is great. You're goofing around with him, his wife is there, everyone's happy. I feel you do cross a barrier with them.

During my interview with Pat, I asked her to recall how it made her feel when she did caring work with patients or family members.

> I feel very good, I feel like I've accomplished something, or I am attempting to accomplish something. I felt very good yesterday when I walked out of that room and I thought that maybe he will get relief and feel better.

Pat describes caring work with one of her patients as successful and satisfying. Her caring work conforms to the SICU's feeling norm to have regard for suffering. Pat expresses no internal conflict about the interaction, in fact, she describes a feeling of accomplishment. Her pleasure with her interaction with the patient may be because she is able to maintain an ideal sense of herself as a nurse. The positive feelings evoked in Pat give her information about her "social place" in her interaction with the patient. Pat's feelings of pleasure, accomplishment and pride tell her she has been successful in her attempt to regard the patient's suffering. Her prestige and self-regard as a competent and caring professional is maintained.

In the interview excerpt below, Lynn describes an experience of emotional harmony. The interaction sustains her professional ideal of herself and motivates her to make time for this family.

> A family that's friendly and nice and recognizes how you're caring for the patient, and asks questions, but is nice and realizes you have other patients and things to do. I end up in there a half hour talking to people sometimes.

The nurses actively construct situations that help them sustain agreement between their real feelings and the SICU's feeling norms for caring work. In these situations the nurses' goals are to confirm their identities as emotionally nurturing, tradition-based practitioners and experience a normal and pleasurable passage of time that allows them to do caring work (Flaherty 1999; Goffman 1961). The nurses' interactions with "cute" patients highlights how their dealings with patients plays a part in their definition of a professional self. Like the nursing home residents called "the lovelies" in the facility studied by Treweek (1996), cute patients are pleasant, and above all, compliant with the

nurses' care. Cute patients require the nurses to do little work for them other than what the nurses determine is necessary and reasonable. By their cooperative nature, cute patients facilitate the work of the staff and willingly accept the role of a "good patient" (Coombs and Goldman 1973; Lorber 1975).

Mary told me that she thought a patient of hers was cute simply because the only thing he asked her for was "agua frio" (cold water). I mentioned to Maureen that I thought many of the nurses tried to make the patient's "cuteness" more obvious.

> Yah, just like Carl, blowing all the kisses and [saying] I love you, these are all my girlfriends. In a book of nursing it's probably totally inappropriate, but how could you not want to hear that. It's just great. Come in here and look at Carl and we're all putting on the TV, laughing, things like that. That's a good day.

In the quote below, Maureen goes on to describe a typical cute patient.

> Maureen: A cute patient is someone who is trached on a ventilator [to assist breathing] and is waving at you at the desk. And you look at him and say, look how cute he is . . . he probably doesn't have any teeth in his mouth and he's bald. It's not based on physical appearance descriptions.
>
> Interviewer: You're talking about the Irish guy?
>
> Maureen: Right, I love him. He's my favorite. And you know his legs are crossed in the bed, it's unbelievable. He writes down on a pad – all I want is a grilled cheese sandwich. Now that's cute.

Although the patient is clearly ill, breathing only with the assistance of a mechanical ventilator, he asks the nurses for little, even waves to them when they pass his room. Cute patients are a true pleasure for the nurses to care for. They do not unduly tax the nurses' time and make it easy for the nurses to conform to the SICU's feeling rule to have regard for suffering.

Emotional Discord: When Caring Work Is Difficult

Doing caring work with patients and families can be a formidable task for the nurses. The SICU's diverse population of patients challenges even the most experienced nurses. A myriad of feelings are evoked in the nurses when they care for frail, elderly patients, "VIP's" from city government, non-English speaking immigrants, handcuffed prisoners, and patients who remind the nurses of their own families. Each nurse brings to her dealings with patients and families, a distinct set of beliefs about the nature of the patient's illness, expectations of them as patients and family members, and an identity of herself as a nurse. Given the complex nature of the nurses' interactions with patients and families, it seems inevitable that they have feelings that are not always consistent with the SICU norms for caring work.

Emotional discord describes an experience in which feelings vary from a feeling norm, not just in kind, but in quality or degree (Clark 1990). Therefore, to deviate from the primary feeling rule to have regard for suffering, the nurses' feelings may differ in their range, duration or intensity. Emotional *dissonance*, a type of emotional discord, describes a circumstance when an individual's emotions differ from the feeling rule operating in that particular situation, but displayed emotions are consistent with the norm. Emotional *deviance* occurs when neither real feelings nor displays of feeling are consistent with the prevailing feeling rule (Rafaeli and Sutton 1984; Thoits 1990). During emotional deviance, a person's real feelings "leak" (Ekman 1981). Pat and Diane described this very phenomenon to me.

> Pat: My problem is usually my facial expressions will say what I feel. Even though I don't realize it, people can tell usually be my facial expressions.

Diane: Oh I don't think I can act it (laughs).

Interviewer: So you don't think you can make yourself be . . .

Diane: I don't think I can try to make myself be concerned. I would get caught, the person would know. They can tell when you really mean it.

Interviewer: You tend to do all the business stuff.

Diane: I guess I'll probably be – good luck with the surgery, whatever. Maybe I wouldn't be as empathetic or as open. I don't think I'd make it up.

The nurses' experiences of emotional discord are prompted by feeling emotionally over-involved or under-involved with a patient or family member. In other words, caring work becomes difficult because the nurses feel too much or too little regard for suffering.

Too <u>much</u> regard for suffering

Van Maanen and Kunda (1989) observed that the more emotional labor is involved in a work role, the more difficult work identity becomes for the role holder. Emotional labor requires some measure of self-investment. It can become difficult then, for the worker to distance themselves from their work. Describing the emotional difficulties of practicing medicine, Perri Klass (1994, 158), a pediatrician and novelist, writes, "The patients you see, however different they may be from you and yours, steadily remind you of the frailties of the flesh, of the thinness of the line between normal life and tragedy." Mary expressed a similar sentiment to me.

Mary: Like I said, I've cried with patients.

Interviewer: What do you think makes you cry with some and not others?

> Mary: I think it's the relationship you build up either with the patient or the patient's family member. I really recall standing in this room crying to a patient's daughter whose father was dying, and she's consoling me. And [I am saying] – I'm so sorry, there's something so wrong with this.
>
> Interviewer: How did she respond?
>
> Mary: She was – Mary, it's okay. But I think, we had a rapport with the family. He was terminal, he died here. It was very sad and it could have been anyone's father. Sometimes I think that's what you think of, it could have been mine, it could have been me.

Instead of experiencing a comfortable and rewarding engagement with a patient and family, caring work causes the nurses to feel intense worry, anxiety, or grief about the patient's and family's suffering. But this experience goes against the feeling rule to have regard for suffering *without* having uncomfortable or threatening emotions. The emotional discord the nurse experiences is having *too much* regard for suffering. In the quote above, Mary reveals her discomfort with her level of involvement with the patient and family, as well as a sense that her affect is inappropriate for her role. Over-involvement is also demonstrated in an interaction that I observed Lynn have with a patient and his wife.

One afternoon Lynn was preparing to transfer Mr. Yee to another unit. He had been in the SICU for several weeks. That morning Mr. Yee had a special type of tracheostomy tube placed in his neck that allowed him to speak for the first time since his admission. Happy for the patient, Lynn asked him what he would like to say. "Thank you" were his first words. As he was wheeled down the hall his wife hugged Lynn and started to cry. Mrs. Yee repeatedly said "thank you", one of the few things she knew how to say in English. Lynn asked the wife not to cry, explaining that it would cause her to cry

too. Mrs. Yee then found Diane and the scene was repeated. Lynn and Diane were clearly moved by Mrs. Yee's display of gratitude. Sounding concerned, both nurses told me how much they thought another patient's wife would miss Mrs. Yee. The women, both Chinese, had become friends. They would come to visit, put on their slippers, care for their husbands and then go together into the visitors' lounge. Lynn turned to me teary-eyed and explained that she had no idea what to say to families when they reacted like Mrs. Yee had. She told me it was difficult for her to handle extremes of emotions. Lynn's sense of herself as a composed professional was upset in this situation. Nine years of experience in the SICU did not quite prepare her for the feelings she encountered in herself.

Diane also expressed unease about performing caring work with patients and families. As she put it, "you're not in their shoes, you're not going for surgery the next day. You could be walking around fine and they could be dead." Sometimes feeling a bit overwhelmed and inadequate to properly respond, she told me she offered platitudes such as "you'll be fine" and "don't worry." A few of the nurses talked about their emotional difficulties working on other units. Suzanne had worked for several years in the medical ICU before transferring to the surgical ICU. The AIDS epidemic was just beginning during the time she worked in the medical ICU, when managing this disease was not as successful as it is now. She requested the transfer because it depressed her to care for so many dying patients. Suzanne once considered working on the pediatric unit. She told me her husband was incredulous when she discussed it with him. How would she manage to care for sick children, he wondered, when she had come home from the SICU in tears so many nights. Mary had worked with children for a few months in the hospital's neonatal

ICU, but felt emotionally drained caring for premature babies and supporting their parents at the same time. She transferred to the SICU, reasoning that she might be able to cope better with adult patients.

On many occasions, the nurses told me stories about patients or families who had touched them in some profound way. Janie told me about a patient of hers who had died. After bathing him and wrapping him in a shroud, she gathered the patient's personal belongings and found a quarter in his pants. She burst into tears at the thought of him dying with only twenty-five cents.

In the examples described above, the nurses had feelings that were inconsistent with the SICU's principal feeling rule to have regard for suffering. Clearly, the nurses had shown concern for the patients and family's emotional suffering, but it is the intensity of these feelings that violates the principal feeling norm. Depression, crying at the end of a workday and feeling chronically emotionally drained, are evidence of emotional over-involvement. The nurses experience these feelings as uncomfortable and inappropriate, even reasons to transfer to other units. The social place the nurses occupy in these encounters is more like the social distance experienced in friendship or kinship, not a nurse-patient relationship.

Too little regard for suffering

While many patients and families evoke *over*-involved feelings in the nurses, other patients and families make them feel quite the opposite. Encounters with patients and family members who criticize and argue with the nurses, reject their efforts to help, or offend their sensibilities about moral and acceptable behavior, often make the nurses feel

under-involved. The nurses describe under-involved as an experience of detachment from a patient or family.

Different patients and families tax the nurses' ability to do caring work when they feel under-involved. The nurses often mention drug addicts and criminals as patients for whom they feel little concern. They view drug addicts and violent criminals as willfully disregarding their own health (Papper 1978; Roth 1986). However, it is not necessarily the patient's or family's personal or social characteristics that cause the nurses to resist performing caring work. Instead, these patients and families typically challenge the nurses' professional ideal of themselves by resisting being cooperative objects of their nursing ministrations (Chambliss 1996). The negative and hostile feelings these patients and families project onto the nurses are a kind of place claim about where they want to stand relative to the nurses. In the case of drug addicts and criminals, it is as if by their very lifestyles, they are rejecting the nurses' efforts to help them. It is difficult for the nurses to feel like they are competent and compassionate professionals when patients and families express feelings that deny the nurses the prestige or power they believe they should be accorded.

In their study of psychiatric nurses, May and Kelly (1982) observed that nurses' perceptions of their relationships with patients was primarily about issues of control and authority. Nurses labeled patients as problems if the patients "did not acknowledge the relevance and legitimacy of their therapeutic aspirations." The SICU patient's or family member's doubting manner and offensive demeanor send a place message to the nurses about their prestige and status as SICU nurses (Clark 1990). For both the nurses in May's and Kelly's study and the SICU nurses, their identities as skilled practitioners are not

confirmed in interactions with patients or families who do not accede to the nurses' effort to help. Physicians' ideals of themselves have been shown to be vulnerable to challenges by patients who confront them with uncertainty and the limits of medical science. The resident physicians in Leiderman's and Grisso's (1985) study disdainfully labeled patients "gomers" when they failed to improve despite the physicians' efforts to cure them.

Elizabeth talks about patients who strain her ability to do caring work with them, patients who she believes are responsible for their own illnesses.

> Sometimes they're here because of the way they took care of themselves sometimes. You know, sometimes they were drinking, or drug abuse or they hit someone in a car and not only could they have killed somebody else but they're here because they hurt themselves. You look at them in a different light. Sometimes they've killed their spouse and they've ended up here.
>
> Interviewer: Killed meaning homicide?
>
> Elizabeth: Yah, sometimes upon doing so they hurt themselves so I guess, you know, you have to care for them, but you don't like what they did.

"Pains" are the equivalent of gomers for the SICU nurses. A kind of opposite to patients thought of as cute, pains are not compliant with the nurses' efforts to care for them. Not only do these patients resist legitimating the nurses ideal of themselves as skilled and caring nurses, they increase the nurses' workload and disrupt the social rhythm of the SICU. Pains fit Lorber's (1975) description of "problem" patients. In her study, patients were labeled as problems whether or not they were seriously ill. Their complaining, anxious demeanor and refusal to cooperate with medical routines earned them their label as problems. The SICU nurses identify patients as pains because they are perceived as illegitimately monopolizing the nurses' time – a precious commodity in the

SICU. Pains cause the nurses "a lot of stress" and make them feel "physically exhausted." An almost willful intent is assigned to patients who defy the nurses' frequent efforts to keep the patient's body clean and beds tidy. Maureen talked about patients being pains because they were "floating down to the end of the bed all the time." Diane and Elizabeth define a pain:

> Diane: The ones that don't want to do anything, they lay there, spitting on the bed. You know, they don't want to get up and then they want to go back to bed, then they want to get up again.
>
> Elizabeth: Sometimes non-cooperative, wants to do things his own way, usually grumpy or quick tempered, asking a lot of questions rather than just going along with what you say to do . . . or has to have a million reasons why for doing something, or [will say] I'll follow through with my doctor, I'll call my doctor, if they disagree. I think more somebody who doesn't go with the flow, they're a little bit more of a problem.

The significance of time and professional identity in the nurses' perception of their interaction with patients and families is especially clear when they talk about pains.

> Maureen: A pain in the neck, miserable, you can't make them happy. You could turn and spend, you could turn and live in the room with them and the moment you leave they ring the bell. Like I have one here right now, although he's been pretty mellow today. Like I'm gone for fifteen minutes and he calls out in the room, or he says, where have you been? Like as if I should be sitting next to him.

Families are pains when they reject the nurses' expert knowledge. One family in particular annoyed the nurses. Members of this family would ask the nurses technical questions about the results of the patient's blood tests, or bring a monitor reading to the nurses' attention. Despite the nurses' careful answers, the family acted as though they doubted the nurses were correct or even understood the patient's problems.

> Lynn: Repeated questions is the thing down here, the same questions repeated daily. Trying to see if you're going to say something different than the nurse that was there the day before, things like that. That's when you become a pain.

Families are also labeled pains if they cause the nurses extra work, usually in the form of questions. Lynn talks about the practice that some of the SICU nurses have of letting visitors stay on the unit during P.M. care, when visitors are normally asked to leave.

> Lynn: I ask the nurse, she's visiting him [the patient] right, she's not going to be visiting us at the desk. You know, because it's [visiting hours] a little peace for us for an hour and a half.
>
> Pat: And the visitors are pains, someone who is continuously at the desk.
>
> Suzanne: They can just ask you the same questions every time they come out. We had a patient here yesterday who had a very large family and we all consider them a pain because one person gave everyone the telephone number.

By the nurses' standards for proper family behavior, giving out the phone number of the SICU is an egregious violation of the nurses' generous willingness to give information to the designated family member. The nurses have a practice of asking large families to designate one or two members to serve as the spokesperson for the entire family. This is the person who calls the SICU to ask about the patient's condition and then relays the information to the rest of the family and to friends. It keeps the nurses from having to come to the phone repeatedly during the day. Should a family disregard the nurses' request to have only the designated family members call, the nurses feel the family's actions as a slight of their precious time and hard work. These feelings often lead the nurses to feel under-involved with the family and thwart the likelihood of the nurses doing caring work with them.

Managing Real Feelings: Contending With Time And Identity

When the nurses' feelings are contradictory to the principal feeling rule to have regard for suffering, they often try to change them. In the previous section I described the nurses' feelings in their encounters with patients and families as place markers about their professional identities and their experience of time in the SICU. Following this understanding of the nurses' real feelings, efforts they make to manage their feelings are essentially attempts to modulate their temporal experience in the SICU or change the definition of their professional self. The following interview excerpt illustrates the complex interplay of time and professional identity as it relates to the nurses' feelings and their struggle to manage them.

> Lynn: Well I don't know if this is a bad thing, but I definitely think the bad thing about me is if I'm mad you can tell, if I'm frustrated and the patient is looking in my face. I can think of one example. I had a patient that had a very bad tolerance for pain. She had back surgery. We tried everything. We were bolusing [giving intravenously] her with morphine. We were doing everything possible to make her comfortable and obviously she was in a lot of pain. And for 12 hours I took care of this woman. I mean I had 2 other patients and her, and she was actually the lightest, the most stable patient. And I tried everything. I spoke to the family, I explained everything in detail, in detail, in detail, until I was blue in the face. And as the day went on I was very serious and composed, and by the 11th hour taking care of her I finally broke, because I was, she was so mean you know, because she was uncomfortable. But she was taking it out on me and I was so attentive to her. That finally broke me and I said – listen, I'm not going to take this anymore. So, in other words, sometimes you work and you do want to scream and yell at the patient, but you're not acting that way. Yes, that happens.

When the nurses' feelings are contrary to the principal feeling rule to have regard for suffering, they use two strategies to change their feelings or alter their display of feelings – ***seek a different perspective*** and ***create emotional distance.***

Seek a Different Perspective

The nurses are most likely to use the emotion management strategy of seeking a different perspective when they feel too little regard for a patients' or family member's suffering. The nurses' image of themselves as gentle caretakers of the patients' and family's emotions do not fit with feelings of anger and frustration towards the same people. These negative feelings signal to the nurses a distance from families and patients that is not consistent with the feeling rule of the SICU, making it difficult to do caring work. In the previous interview excerpt, the patient's rejection of Lynn's skill and effort to relieve her pain made Lynn feel badly about herself as a nurse. When the nurses are uncomfortable with their feelings, they may do "emotion work" to change them (Hochschild 1979; Thoits 1990). One of the strategies the nurses use to change their feelings is to seek a different perspective of the patient's situation.

> Mary: I think what I try to do, especially in a unit like this where the scenarios of what brought people in may be somewhat controversial to other people, and it may be a person who I think – oh, how could you like this person because other people may have a negative look on them . . . and I'm like, you know what, we don't know the whole story, we don't know the other side. So I try to look at it that way. I try to put them aside and say there has to be another side to this. Maybe I never want to find out about what it is. Maybe . . . maybe there's a history of drug abuse, maybe whatever the reason, not that I condone their actions or what they do, but I don't have the compassion either.

> Elizabeth: To me, that situation would be an elderly patient, when I said about the sedation or anesthesia, and they wake up completely confused or combative. And sometimes you get very agitated or aggravated because they are trying to hit you or kick you. But then you think, this is an elderly woman. You have to think about all she's gone through, the surgery, the anesthesia, the sedation. That's the problem that's causing this. And hopefully that will turn [my feelings].

> Pat: Sometimes I think you just don't get along with somebody right off the bat, either the patient or family. Sometimes instead of struggling with it you say to yourself – okay I'm not going to let this kind of ruin my day. I'm going to try to be more open-minded. If it's a prisoner I try to think to myself he's still a person, god knows what his history was, why he's here, I still have to take care of him.

The emotion management strategy of seeking a different perspective is essentially an attempt to empathize with the patient. Milligan and More (1994, 3) define empathy as, "a willingness and an ability to leave the security of one's own beliefs, feelings, and frame of reference at least briefly in order to approach the feelings, thoughts and world of another." Medical students in Smith's and Kleinman's (1989) study also used empathy as an emotion management strategy. Empathizing with a patient distracted the students from their feelings. Yet, by identifying with the patient's circumstances they also felt good about themselves as physicians-in-training. Like the medical students, the nurses' attempts to see the patient's behavior and circumstances from a different perspective is an effort to feel better about their professional self in the encounter.

Hochschild (1983) has observed that the experience of emotional dissonance is a strain for an individual and, therefore, motivates people to bring together real feelings and norms for feeling. Negative feelings towards patients are not consistent with the feeling rule to have regard for suffering. Feelings of anger, contempt or condescension set the nurses far apart from the patients and families for whom they are supposed to feel concern and compassion. This disconnect between their real feelings and the SICU's primary feeling rule induces them to seek a different perspective of the situation, thereby manipulating and preserving the ideal of themselves as nurses. As Clark (1990) reminds

us, efforts we make to change our emotions are attempts to generate feelings that put us in the places we prefer.

Create Emotional Distance

Individuals commonly attempt to control the cause of uncomfortable emotional experiences by "selective exposure" (Rosenberg 1990). Distancing themselves from patients and family members is a way for the nurses to manage both feelings of too much and too little regard for suffering. The nurses create emotional distance by *disconnecting*, *using humor* and *using medication*. Employing these strategies, the nurses do not change their feelings so much as try to lessen their intensity and attempt to manage the display of their feelings.

The SICU nurses acknowledge that they avoid patients and families who they dislike. Although they believe they attend adequately to the patient's physical needs, they are unlikely to linger in their rooms any longer than is necessary. However, as described in the previous section, it is not uncommon for the nurses to feel too much regard for a patient's or family's suffering. In this circumstance the nurses feel flooded by grief, anxiety or sorrow (Menzies Lyth 1988). I recall being a young nurse and feeling very distressed when I had to care for young men near my brothers' ages who had suffered paralyzing spinal cord injuries. In either case – feeling too emotionally involved, or not involved enough – the nurses create emotional distance to manage their feelings.

Disconnect

One of the implicit feeling rules of the ideology of science-based practice is to render the patient insentient. In this practice, the nurses disregards the patient's awareness, therefore, expressing little concern for the patient's emotional state. This feeling rule also functions effectively as an emotion management strategy for the nurses. Rendering the patient insentient frequently occurs during routine patient care tasks, such as receiving a post-operative patient from the recovery room. By emotionally disconnecting from the patient, the nurses can get through their physical care tasks quickly and stay on schedule with their work. This helps them feel like expert science-based practitioners. Emotional disconnection in the service of time can also be heard in the nurses' comments such as, "I'm just covering for lunch," and "I can't deal with her hair right now." Both remarks excuse the nurse from doing extra work and help her sustain a feeling of synchronicity as she goes through her day.

The nurses may also disconnect from a patient or family as a way to manage their own feelings. Mary reported to me that she had a very difficult time doing caring work with a patient or their family member if they reminded her of someone in her family. In these circumstances she found herself having to "step back and push away" because she felt, "I just can't do this. I have to keep that distance because this is too close." Maureen's father had died of a respiratory illness at St. Paul's a year before I interviewed her. Her inability to do caring work patients or family members in these situations is obvious:

> Maureen: I tend not to do well with a patient that is dying, really at the last hours with family and things. It's just a personal thing. I always see my father in the bed . . . especially if they can't breathe and things seem as if they were his . . . you know, that's when I have to worry about myself first at that point, just to maintain my composure.

Mary and Maureen were describing circumstances that caused them to feel over-involved with their patients. In the quote that follows, Elizabeth describes feeling under-involved with a patient, yet she uses the same strategy of creating emotional distance to manage her feelings.

> Elizabeth: You try to separate it if you can. For a patient who is under arrest, I mean sometimes they have a guard, a policeman here and sometimes they have done something bad – which has happened several times here – gunshot wounds or whatever, drug abuse. I think you are more cut and dry with them. I don't show as much emotion. You know I still take care of them but I won't be extra nice or go out of my way . . . you don't have to be their buddy and you don't have to like them.

Maureen had initially reported to me that she acted towards patients and families exactly as she felt. It seemed to me that she was talking about people for whom she felt a great deal of dislike. I gave her another example of a more subtle and common situation when a nurse simply feels that her and her patient's personalities differ. Like Elizabeth, Maureen did not believe she would change her emotions, but accept them and try to manage their display.

> Maureen: I guess that comes with routine socialization skills. If you don't feel like someone is being receptive to you then you're not going to be receptive to them. You will do what you need to do as far as a nurse for this patient but you might not . . . but I don't really think you're going to become a life long friend.

In another part of her interview, Maureen again describes how she manages her negative feelings towards a difficult patient by disconnecting emotionally.

> Maureen: Okay, getting a drug dependent, drug seeking person who is complaining of gallstones who doesn't have gallstones, seeking 150 mg. of Demerol [narcotic] every hour. Someone like that who comes in throwing things, nasty.
>
> Interviewer: So you would interact with them in one manner.
>
> Maureen: I wouldn't be as jovial with them. I would be straightforward, professional, polite and everything, but I wouldn't become – I feel like sometimes like I'm the buddy type, like I have a buddy system with the patient. Whereas when I'm with them I think you do need to do some limit setting and have a barrier. I feel it works better with them . . . and I think it works better for yourself too when you're taking care of them (laughs).

Notice that the nurses use language such as, "step back," "separate" and "push away" to describe how they handle their emotions. Froggatt (1998) studied the language hospice nurses used in their descriptions of caring for dying patients. Like the SICU nurses, these nurses often used metaphors that conceived the body as the container of emotions that must be controlled. In doing so, Froggatt points out that the nurses used language to disconnect from their emotions.

Another method the SICU nurses use to manage their emotions is to limit their exposure to patients and families through physical distance. For obvious reasons, this is easier to accomplish with family members. The ninety-minute break for P.M. care during visiting hours is a respite from the emotional burden of dealing with families. Lynn, one of the assistant head nurses on the unit, insists that all visitors leave the SICU during this time.

> Lynn: For us not to have visitors for an hour and a half releases a lot of tension because a lot of times the visitors spend more time at the desk and looking around the unit than they do in the patient's room . . . I'm serious, I don't avoid family and visitors, but for an hour and a half, I think it's sacred!

The nurses would recruit me to assist them gain emotional distance from family members. As I came on the unit one afternoon, Lynn announced she had a job for me.

She requested that I "occupy his [patient's] son for me, I'm not in the mood today." The nurses would also talk about avoiding visitors so they will not be "bombarded with questions." Physical distance from family members allowed the nurses to concentrate on the patient's needs alone.

Use humor

Using humor with patients and families helps the nurses create distance from patients and families by providing an alternate situational definition. Humor also operates as a social control mechanism in the SICU (Fine 1984).

One evening when Maureen and I were working together, she was very worried about a patient she had accidentally overdosed with an intravenous sedative medication. We were in the room next door to this patient's and Maureen kept asking me to look at the monitor through the window between the rooms to check if the patient's vital signs were normal. Every time Maureen heard an alarm at the central monitoring bank in the nurses' station, she would ask me to check on this patient. In a short time the effects of the over-sedation wore off and the patient was again so agitated that she required the sedative medication. Maureen conveyed how hardy the patient seemed to be as well as her own veiled relief by joking, "bitch, I couldn't kill her if I tried." Her humor was a way of managing her uncomfortable feelings about the mistake she made and the serious consequences the patient may have suffered. Her feigned indifference to the patient's well being provided her with needed emotional distance from the event. Maureen recruited me as a fellow nurse to re-define the situation in a way that lessened its significance as a potentially lethal mistake and diminished the threat to her competence as a nurse (Bosk 1986; Fine 1984; Hafferty 1988).

Feeling over-involved with a patient is particularly easy when a nurse's actions cause the patient harm or jeopardize their well being. Given the seriousness of the

patients' illnesses and the complexity of the technical care the nurses provide, this is a constant and real threat. I entered my feelings about this incident in my fieldnotes:

> There is really a lot of talking over the patient with Maureen and I. Both of her patients are very sedated and intubated [breathing tubes in windpipe]. As I write now it seems funny on the one hand [her comment] but it is very clear to me how serious this stuff is – taking care of these patients. Maureen and I have a discussion related to making errors and the huge potential to do that. Yet on the other hand we often treat and handle the patients in a very casual way like a hunk of meat – the generic body in the bed. We flip and turn, wash, etc., like we've done it thousands of times (we have!) and every once in awhile something like a mistake, that had the potential, or did cause harm to the patient, yanks you back to the reality of our work. I am often aware when I help other nurses that I don't want to be so serious about the [the fact that the] patient is ill, vulnerable, deserves great respect and care as we handle his or her body. This is very heavy stuff. It feels heavy to think and act like this, and work is a long day.

The nurses also use humor to manage patients' and family's feelings and behaviors (Fine 1984). In this way, humor operates as a form of social control. Always trying to negotiate time demands, the nurses try to change patients' and family's feelings to conform to the nurses' definition of manageable behavior. This definition is largely shaped by the amount of time the nurses have to do caring work. Controlling patients' and family's emotions through humor is an effort by the nurses to control their work processes. By re-defining the patient's and family's circumstances as befitting levity, the nurses hope to reduce their workload (Francis 1994). Hewison (1995) argues that nurses consistently use language to exert power in their interactions with patients. In the SICU, the nurses commonly joke with patients and family members, use an informal, cheerful manner and engage them in friendly banter. This is part of the feeling rule to have regard for suffering, but it also functions as an emotion management strategy.

The nurses' status in the SICU relative to the patient and family, bestows upon the nurse the role of, not only expert arbiter of the patient's physical state, but the patient's and family's emotions. The patient and family are, in effect, expected to comply with the

nurse's definition of their situation (Lawler 1993). For example, if the nurses act carefree and cheerful as they speak to a family about the patient's arrival from the operating room, the family may feel a sense of relief or reluctant to display their true fears and anxieties. In either case the nurses are relieved from having to do much caring work with the family.

Like the restaurant workers studied by Fine (1990), in the face of changing tempos and duration of activities in the SICU, the nurses try to exert control over what activities they can. Most commonly the nurses avoid doing caring work in order to complete patient care tasks. This is particularly true when family members are in need of emotional support. The SICU's tradition-based practice ideology requires the nurses to emotionally minister to families. However, the SICU's science-based practice ideology privileges technical work with patients and diminishes caring work as non-essential labor. Using humor with family members is one way to satisfy both demands of the nurses. By using humor the nurses can hope they provide families with some emotional support yet curtail the barrage of questions and requests they get from family members that creates extra work for the nurses.

The feeling rule of "undo it backstage" discussed in chapter five, also functions as an emotion management strategy. When the nurses undo their displays of emotion towards patients and families backstage, they commonly use humor. Although they do not direct their humor towards patients or family members, the nurses privately make jokes and sarcastic remarks at the expense of the patient or family. These behind the scenes uses of humor by the nurses allow them to vent frustration that might interfere with feeling or displaying regard for suffering. Sharing the humor also bonds the nurses together as a group. It is a way of collectively warding off the threatening selves that antagonistic families and unthankful patients are felt to thrust upon the nurses (Francis 1994). Using humor is also a timesaving method since the nurses feel less compelled to attend to the emotional suffering of "loonie" patients and "psycho" families.

Use medication

Using humor with patients and families is as a way for the nurses to manage their own emotions by controlling the emotions of those they care for. Administering sedative medications to patients similarly helps the nurses to manage both the patients' and family's feelings, as well as their own. The administration of potent sedatives to patients is standard practice in an intensive care unit. The nurses have a moderate amount of discretion about the dosage and administration time of sedative drugs. Narcotics and anti-psychotic medications control the severe agitation and delirium that patient's experience as a part of their illness and the treatments they must endure. This severe agitation is harmful to the patient. It can raise their blood pressure and heart rate to dangerously high levels. Agitation frequently prevents them from breathing in synchrony with the mechanical ventilator. This is known as, "bucking the vent." When agitated, patients tend to pull out life-sustaining tubes that help them breathe, deliver nutrition and infuse important medications. Contending with patients' agitation is a constant source of work for the nurses. It is one of the characteristics of a patient who is a "pain." Chambliss (1996, 36) observed that "nurses quickly learn that patients have to be managed, sometimes through physical or chemical restraint, for the nurse to get their work done."

Diane suggests that administering sedative medication to patients helps her manage her feelings because she does not have to attend to the patient.

> Just shut up and take the drugs [laughing a lot]. Maybe if I give you fifty of Demerol [a narcotic] you'll go to sleep for an hour or two. I definitely think that happens. Definitely. I do think I try to communicate with them when they're awake for awhile.

Diane also suggests to me that sedating the patient helps her manage the family's anxieties and, therefore, her feelings about families who create more work for her. Anxious family members are often hypervigilant about the patient's condition. They frequently summon

the nurses to check on monitor readouts or alarms they do not understand, but believe signal that the patient is in grave danger.

> Diane: Well, when the patient is more relaxed the visitors are more relaxed most of the time. Then when they come in and see someone more relaxed and comfortable, they're more relaxed and comfortable, and their role can be just sitting there and watching [the patient] instead of figuring out what they [patient] want at the same time. So does that make like a big excuse for the visitors for like drug abuse [laughs].

Although I never observed a situation when I believed, as a nurse, that one of the SICU nurses inappropriately medicated a patient to decrease her workload, sedating a patient certainly has that effect in many cases. As Diane suggested, there is a kind of chain reaction to the practice. If the patient is calm, the family is calm. Therefore, the nurse does not have to enter the patient's room as frequently to do caring work with the patient or family. Less work means the nurse has a greater chance of having a temporal experience of her day as the normal passage of time in the SICU. Calm patients and families and getting one's work done on time contributes to feeling like a "good nurse."

CHAPTER EIGHT

CONCLUSION

A few weeks before writing this final chapter I was reading a popular nursing journal and came upon the article, "Caring, the Essence of Nursing" (Wolf 2002). It gave me a sense of relief. There it was, one more paper with the words "care" and "essence" in the title. Nursing's ideology of care was alive and well. I felt reassured that my research was as topical now as when I began it several years ago.

The author of the article is a nursing scholar distinguished as a fellow in the American Academy of Nursing. In the article, she emphasizes the importance of constructing instruments to measure caring in an effort to substantiate its value in practice. She goes on to describe a tool she has developed to do this. Four of the five behaviors she describes as exemplifying caring are interpersonal skills such as respectful deference and attention to other's experiences. Like in so many articles I have read in nursing journals over the years, the author presents skill in managing the psychological needs of patients as paramount to the profession's ideology of care.

My research on the nursing profession over the last ten years were investigations into the nursing profession's conviction that "care" characterizes the basic nature of nurses' work. In my most recent work I wanted to know how an ideology of care informed nurses' actual care with patients and families in a surgical intensive care unit. My investigations lead me to conclude that nursing's ideology of care was of limited use to nurses as they went about their daily work. Although nursing elites have declared care to be the essence of nursing, this ideology failed to provide the SICU nurses with a set of

beliefs that corresponded to their full occupational identity and nature of their work experience. My research shows that it is not possible to separate nurses' caring work – both nurses' real feelings and the normative performance of caring work – from the cultural, social structural and situated contexts it occurs in. These elements create the nurses' "real world" and an ideology of care is inadequate to explain it.

One cannot generalize the SICU's nurses' experience to all nurses. The occupational label, "nursing," can no more describe the range of work nurses do than can "medicine" describe the work of all physicians. Each occupation includes many specialties whose work is carried out in varied practice settings. Different work cultures and organizational structures can be expected to create different normative beliefs and practices related to nurses' caring work. However, we can use the SICU at St. Paul's Hospital and the nurses' experiences to speculate about the relationship between the nursing profession's ideology of care and nurses' actual caring work with patients and family members.

Culture and Caring Work

In this work I located nurses' caring work within the belief and value systems that operated at St. Paul's Hospital and in the SICU. I found there were two workplace ideologies and caring work was different in each of them. Each sphere had normative systems for feeling and displaying care within these two ideologies.

The SICU nurses drew on an ideology of care to give meaning to their work, as did the nurses in other practice settings I explored in earlier research. Caring work, in fact, was part of the SICU's ideology of tradition-based practice. However, also like the

nurses in other settings, the SICU nurses had ambivalent feelings about their caring work. Although caring work was a part of their convictions about good nursing practice, the nurses found it difficult to detach the meaning and value of their caring work from a nineteenth century conception of nursing as an extension of women's domestic labor. This view of nursing considers attention to the emotional needs of patients and families as the natural and unskilled work of women. The SICU nurses regarded their caring work similarly. Caring work, in their words, required merely "heart," whereas expertise in intensive care nursing required them to have "brains." Nurses' ideologies constructed around these two kinds of work were tradition-based practice and science-based practice, respectively. Each practice had distinctive and contradictory normative beliefs about handling patients' and family's emotions. Tradition-based practice espoused the importance of caring work, while science-based practice marginalized it and directed the nurses to disregard patients' and family's emotional needs in favor of completing patient care tasks.

Nurses' ambivalence about their caring work was evidenced when I asked them what they thought about the nursing profession's declaration that care was the essence of nursing. Most of the nurses rejected this characterization because they did not believe it captured the skill aspect of their jobs. Care, as the essence of nursing, seemed to them a stereotypic and anachronistic representation of their work. Although the nurses performed caring work, to say that care was the essence and whole of their work was, for them, inconsistent with the professional identity they had of themselves.

Social Structure and Caring Work

The ideology of care was of limited use to the nurses because it obscured the reality that their caring work was structurally determined. In particular, time patterned the nurses' relations with patients and families. Both the nurses' subjective experience of time and the temporal organization of the SICU (e.g., length of visiting hours, nurse's work schedules and patient's length of stay in the SICU) influenced the nurses' caring work.

The SICU's status and reward structures also had an impact on caring work. Neither structure fully supported it. In comparison to other nurses in the hospital, the nurses derived prestige from their skill and knowledge as intensive care nurses, not their handling of patients' and family members' emotions. The nurses bitterly complained that their caring work was not sufficiently recognized or rewarded by hospital administration. Formal reprimands might be given to nurses for not completing important patient care tasks, but never for missing a chance to perform caring work.

Interestingly, my earlier research on an inpatient AIDS unit described a very different prestige and reward structure (Merkel 1994). AIDS nurses considered caring work central to their jobs. Early in the AIDS epidemic, this unit's patients were mostly gay men – many well known in the arts. The nurses gained prestige among other nurses and in the surrounding community because they were seen as pioneers caring for a fatally ill and stigmatized yet noted patient group. The arts community rewarded the nurses' work with high profile gifts such as theater tickets and personal visits to the unit. In contrast to the AIDS unit, the SICU's temporal, prestige and reward structures patterned caring work in a way that often thwarted the nurses' ability and motivation to emotionally support patients and family members.

Social Contexts and Caring Work

Nurses' caring work was also a context dependent social interaction. A symbolic interactionist perspective explains the nurses' real feelings and their efforts to manage them when their feelings deviated from the dominant emotion norm on the unit. Caring work with patients and families – both the nurses' real feelings and caring behaviors – varied according to the nurses' definition of the social situations they were in. It is clear that the nurses' framework for interpreting their social interactions and the nature of their role expectations was shaped primarily by two factors: their experience of social time in the SICU and the extent to which their professional identities as tradition-based and science-based practitioners were maintained during their interactions. The strategies the nurses used to align their actual feelings with the feeling norm to have regard for suffering were essentially efforts to modulate their experience of time and affirm their preferred professional identities. Therefore, caring work in the SICU varied from patient to patient, family to family and moment to moment.

In their variation, the interactions nurses had with patients or family members were evidence of the constant interplay of the nurses' feelings, structural forces operating in the SICU and competing normative beliefs about caring work. An ideology of care provided the nurses with a limited way to make sense of this experience. As a belief system about their role with patients and families, "caring, the essence of nursing" did not offer them an adequate mechanism for understanding expectations about their changing feelings and behaviors in a busy intensive care unit when, in one moment, an unstable patient arrived from the emergency room, an EKG alarm began to blare and an anxious family member called on the phone.

Is Care the Essence of Nursing?

Care did not fully describe the fundamental nature of the SICU nurses' work practices. However, the idea of care as the essence of nursing unites many nursing elites because they view it as a professionalizing strategy. Nursing scholars have fashioned this occupational persona for nursing as a way to gain professional status for nursing. I have summarized above the cultural, structural and contextual limitations this strategy has in terms of it serving as a rallying call for nurses "at the bedside" (to use the nurses' vernacular). Beyond these limitations, I believe an ideology of care poses other problems for nursing.

The ideological efforts of nursing to transform a "calling of care" into a "science of care" is a jurisdictional claim for control of a particular type of work couched in terms of exclusive possession of esoteric knowledge (Abbott 1988; Reverby 1987; Selander 1990). Jurisdictional claims are made to the public for a claim of cultural and social authority over a type of work. However, to be successful, nursing would have to demonstrate that caring work, over which they claim to have authority, is work qualitatively the same as diagnosing disease is for physicians and litigation is for lawyers. Nursing must prove and, more importantly, the public must accept nursing's claim that caring activities do not derive from common knowledge that women do naturally, but is learned and technical.

As a professionalizing strategy, caring work is also at odds with process models of professionalization emphasizing power and control. Efforts by nursing to "unpack the concept of care" in order to translate it into a "discourse of science" ignore the requirement of autonomous control over the content and terms of work seen as more salient to a claim for professional status (Elzinga 1990; Freidson 1970, 1986; Torstendahl

1990). Nursing is embedded in a highly complex and technical division of labor within hospitals, with physicians in higher positions of authority and prestige than most nurses. Medicine's professional dominance, by definition, constrains nursing's autonomy (Starr 1982). Therefore, claims that care is the essence of nursing reinforce the patriarchal nature of the division of labor in hospitals. As we have seen in Reverby's (1987) work, nursing's advancement and chance for autonomously controlling its future are thwarted by an ideology of care because it is inextricably linked to a female duty to care which locates nursing in a subordinate position to medicine.

As a description for nursing, caring plays into a "compassion trap" – the pervasive belief that women's primary social function is the provision of tenderness and compassion (Adams 1971). It is a trap, further argues Adams, because it ultimately undermines and misrepresents the role of women in our society. Thus the argument for professional status based on a definition of nursing as caring is weak because it is grounded in the oppressive notion of a division of labor between the sexes that assigns rational labor to men and emotional labor to women. As long as nursing is a predominately female occupation it will be difficult for it to escape this definition of its work. Therefore, I believe this is a misguided strategy. I disagree with Davis (1995) who sees nursing's project as not becoming a profession in the present (male) sense of the word, "but to challenge the gendered basis of the concept." She believes nursing is already doing this by creating a vision of nursing as caring. Davis suggests that if we could only change the definition of a profession, caring would fit the criteria. This approach is naïve because our culture's gendered assumptions about caring are deeply embedded in the social structure.

An alternative view is that nursing develop new strategies to build itself as a profession. White and Begun (1996) propose that one strategy nursing should undertake is to abandon its traditional efforts such as a focus on caring and focus instead on nursing as possessing skill and knowledge. They write:

> Purchasers of health care cannot put a price on caring. They can, however, put a price on skills and knowledge that contribute to patient outcomes. Nurses need to take their basket of goods to the market with a price tag. "Value-added" is an important commodity and what nurses contribute to improved quality and decreased costs must be measured and included in the price tag (White and Begun 1996, 83).

White's and Begun's suggestion sounds like it might appeal to the SICU nurses. Davis would probably argue that this is a male vision of a profession. However, White and Begun are suggesting fitting a professionalizing strategy firmly into healthcare's current social and economic climate, the very one that contributes to the SICU nurses' experience of their workplace. Nursing should not ignore the place of caring work in their practice, but a better strategy would be to incorporate the wide range of work nurses report.

Clearly, further research is needed to determine the meaning and relevancy of an ideology of care to nurses in the various specialties and see whether gender, race and backgrounds make a difference. For example, nurses in settings such as hospices, home care or extended care facilities may relate to an ideology of care differently than SICU nurses. My earlier study of AIDS nurses suggested that they located caring work more centrally in their jobs than did the SICU nurses. Yet the AIDS nurses also experienced ambiguity about how their caring work was valued, as did the SICU nurses, in the larger division of labor in the hospital. Furthermore, jobs are performed within organizational

structures that shape work in unique ways. These organizational conditions need to be clarified.

Today, there is a slight increase in the numbers of men coming into the profession. This is a ripe area for further study. My research was conducted on a unit with an all-female nursing staff. The only male nurse I interviewed for one of my earlier papers described caring work as an important part of his philosophy of providing quality nursing care (Merkel 1994). He talked about his relationship with patients as " a mother lion with her cubs." However, male nurses in a study by William's (1989) emphasized their male functions such as physical strength and different nurturing styles to distinguish their contributions to nursing from women's roles in the profession. William believes this was an effort by the men to specifically retain a masculine identity and distance themselves from a professional identity that is so closely identified with femininity.

All but one of the nurses in the SICU was White. The only African American nurse declined to be interviewed. The relationship between race and an ideology of care is also an important sphere of research. I know of only studies of African American nursing attendants, but they do not specifically address any links between race and caring work (Diamond 1996; Foner 1994).

A Contradictory Coupling

When thinking about the relationship between the nursing profession's ideology of care and the SICU's system of beliefs, values and norms, Chua's and Clegg's (1989) phrase, "contradictory coupling," is of interest. They use this term to describe the gap between senior nursing managers' ideology of managerialism and credentialism in a British

hospital, and the ward nurses' vocational ideals of nursing such as caring. Although the two groups had in common the fact that they were nurses, their actual work led them to define their experiences in very different ways. The American nursing profession's ideology of care and the SICU nurses' ideological convictions about their work may be seen as a similar contradictory coupling. For nursing elites, proclaiming caring as the essence and exclusive domain of nursing has been regarded as a way to garner the rewards of professional status. This research on SICU nurses shows how caring work, only part of their daily work, neglects their wide range of technical competence and demeans their standing as professionals.

APPENDIX

METHODOLOGY

Site Selection

I chose a surgical intensive care unit (SICU) in a medium sized (800 bed), urban, voluntary teaching hospital as my research site. I thought the hospital and an intensive care unit would be an excellent research sites because they provide a mix of work cultures. As a catholic hospital, St. Paul's epitomizes the values of compassion and care. Religious symbols are found everywhere in the hospital; crucifixes hang above every door, televisions in the patients' rooms broadcast daily masses from the hospital chapel and a main corridor on the second floor chronicles the lives of female saints who dedicated their lives to healing the sick. In contrast, the SICU is ornamented not by religious symbols, but by sophisticated looking equipment. I also chose the SICU for study because the layout of the unit provides good visual access to the nurses and their interactions with patients and visitors. The view from the nursing station, or a walk down the hall enabled me to see the nurses while they were in the patients' rooms.

Participant Observation

I engaged in one hundred and nine hours of participant observation on the day shift (8:00 A.M. to 8:00 P.M.) in the SICU over a one-year period. Within a shift I observed in four to twelve hour periods at different times in the shift and on different days of the week. As a participant observer I assisted the nurses with patient care as someone who functioned as a "high level" nurse's aide. I never retained primary responsibility for any of the patients or patient care tasks. However, because I am a nurse, I could assist the nurses

with such simple tasks as dressing changes, hooking up monitoring devices and troubleshooting alarms. The most common tasks I assisted with were giving baths, getting patients on and off stretchers and positioning them in their beds.

I wrote condensed field notes during my observation, trying to do so discretely. These were transcribed into full accounts of my field activity within twenty-four hours. My fieldnotes included analytical ideas and references as well as my personal impressions and feelings (Kleinman and Copp 1993; Lofland and Lofland 1995). To protect the anonymity of the nurses and hospital I entered the fieldnotes into my computer and protected the file with a password. All handwritten notes and hard copies of the fieldnotes were stored in my home.

Focused Interviews

I conducted focused interviews with eight of the ten nurses on the day shift. The interviews ranged from one to two hours in length. An interview schedule (appendix) was used and respondents were probed for specificity and depth (Merton, Fiske and Kendall 1990). I also asked the nurses to complete a fact sheet (appendix). One nurse refused to be interviewed and the other canceled two appointments and then seemed to avoid me on the unit. I took these actions to mean that she did not wish to be interviewed and I did not pursue her further.

As required by the Institutional Review Board of the hospital, I obtained informed consent from each nurse prior to their interview. All interviews were audiotaped and transcribed. Transcriptions were protected by a password on my computer; hard copies were retained in my home. My original plan was to conduct the interviews in the nurses'

homes knowing they would have little time at work and to allow them maximum privacy. However, after several canceled appointments, a nurse informed me that they would rather try to do them at work. One interview was conducted on a nurse's day off, the others during their meal breaks in my office or on the unit in the nurses' lounge, some in two sessions.

My original proposal also included group interviews but because I was not successful in conducting the individual interviews in the nurses' homes I knew I would not be able to get them in a group outside of the hospital. I incorporated some of the group interview questions into the individual interview schedule. I conducted informal group interviews when some of the nurses were together at the desk or in the lounge.

Documents

I used documents as a third source of data. I obtained the recruiting literature for the school of nursing and the department of nursing as well as the mission statement of the hospital from the administrative manual. I also read memos posted on bulletin boards in the SICU and was given a copy of the brochure offered to family members that explains an intensive care unit.

Data Analysis

I analyzed my fieldnotes and transcribed interviews using the initial and focused coding methods described by Lofland and Lofland (1995). Given my research question, I initially conceived of the coding categories as, caring work practices, beliefs, reward system and structural conditions. These were expanded and other categories added. I wrote notes that integrated my observations and theoretical concepts to elaborate certain

coding categories. I also used typologies to help me develop relationships between my data and emerging concepts as well as to reveal gaps and inconsistencies. (Hammersley and Atkinson 1992; Strauss 1987). I continually reviewed the scholarly literature as inferences were made from the data. This helped me to theoretically ground my emerging concepts. I left the field when I believed my analytical categories were saturated and I would gain little more from my observations.

Entry into the Field

Senior nursing management and the head nurse of the unit gave me permission to conduct my research in the SICU. Only a few of the nurses knew ahead of time that I was going to do observational research on the unit. Because I was a nurse familiar with intensive care units, I experienced little of the culture shock that many researchers do when entering the field. The routines of the SICU, sights and smells of very ill patients, medical and nursing slang, were all quite familiar to me. Therefore, I spent little time in the beginning of my fieldwork assimilating a new environment. However, because my research setting was a familiar one, I entered with preconceptions about nurses and the nature of caring work. I had thought little about this ahead of time but I believe my preconceptions and biases were subsequently revealed to me in the feelings I experienced towards the nurses, patients and families.

Since I was studying the SICU as a participant observer I wore a white scrubsuit similar to the other nurses. The scrubsuit, pants and top, is commonly associated with the garb worn by doctors and nurses in the operating room before they don the sterile gowns worn during the actual operation. Nurses in all of the intensive care units may wear either

a scrubsuit of white or navy or a traditional white nurse's uniform. I have worked at St. Paul's for the past fifteen years as both a clinical nurse specialist in neuroscience and staff education instructor. I have never worked in the SICU or had any direct responsibility for it. However, I knew all of the nurses on the day shift except one. I knew some nurses better than others and during the early part of my fieldwork, and with their permission, I would often follow one of them during their work. At the beginning of my fieldwork I was often questioned about my research. I would answer vaguely that I was studying nurses working with patients. Eventually I became friendlier with the other nurses although I felt the most comfortable with four nurses throughout the study. It was easy for me to join them and they would often beckon me into their patient rooms. I believe this was for diversion and friendship more than the desire to assist me with my research.

Because I was aware that my official role in the hospital was one that was regarded by some as having a higher status than the staff nurses in terms of clinical expertise, I tried to minimize status differences. I attempted to present myself as I honestly felt, as a nurse who did not have expertise caring for patients in the SICU. I often asked questions about diagnoses, surgical procedures and treatments. I believe this sort of role reversal helped me to assume the position of a pseudo-staff member. It cast the nurses in the role of teacher and expert and as such lessened the social distinctions between the nurses and myself. I also believe I was less of a researcher in their view since I am a nurse and was able to perform some nursing tasks along side them, discuss and understand medical issues and speak their nursing slang.

Yet, I believe that my supposed expert status as a master's prepared nurse and Ph.D. candidate was also recognized for its "exchange value." This also helped me to be

accepted by the nurses. Nine of the ten nurses were pursuing baccalaureate and master's degrees and were, therefore, fellow students, sometimes in need of assistance with schoolwork. Three nurses in particular would ask me to help them with school assignments. I also exchanged physical labor for the chance to observe the nurses. Much of what the nurses do with patients requires two people and they must wait until someone is free to help them. Often when I arrived on the unit a nurse would comment that she was glad to see me because they were so busy. The nurses would also jokingly tell one another that they were "hogging me" if I was working with one nurse and the other felt she could use my assistance. I also served as a "sounding board" for the nurses (Bosk 1979). They used me to complain about other nurses on the unit, the unfairness of their assignments that day, bothersome patients and visitors, and general conditions in the hospital. They used each other in the same way. Yet, I often got the impression that since I was ultimately an outsider they believed I was more objective about these matters and sided with their, as they saw it, obviously correct views.

On a few occasions I struggled with my role as a participant observer and what I believed were my ethical obligations to patients and family members. Although I assumed no direct responsibility for patient care, situations commonly presented themselves when I could have easily intervened without overstepping any institutional or legal prohibitions to do so. I am, after all, a nurse with skills, judgment and feelings. Circumstances that caused me to want to intervene were times when I thought a patient's basic care needs were not met, or the nurse did not adequately alleviate a family member's anxiety. I have included some of these episodes in this report of my research.

I still vividly remember the son of a patient who was obviously grief-stricken and anxious about his father's grave condition. The nurse he voiced his concerns to seemed oblivious to his emotional state. Initially I said nothing since I wanted to observe the situation. I also hesitated to intervene because I did not want the nurse to think that I was questioning her actions with the son. As in the other cases when I felt a strong need to intervene, I reached some internal position (guilt?) when I thought the patient's or family's suffering was so great that it would have been unethical for me not to have intervened. In the case of the anxious son, I made a small attempt to reassure him that the alarm he was hearing signaled nothing dangerous and we would attend to his father shortly. To this day I feel badly that I did not do more by taking him aside and exploring with him his feelings about his father's illness. This is what he needed. Unburdened by the overwhelming responsibility for the patients' technical care, unlike his nurse, I could perhaps hear this man's pain a bit better. Situations such as these would also leave me feeling angry and disappointed with the nurses.

Just as frequently, I identified with the nurses' feelings of frustration and disbelief when patients or visitors acted rudely towards them or expected the nurses to attend to petty (in our estimation) requests. I recall one afternoon when I could not believe the inconsiderateness a family showed us as we quickly pushed a sick post-op patient into her room. The family stopped the stretcher, started to talk to the patient and barraged the nurses and me with questions. I thought to myself, is this family kidding? We have really important things to do for this patient right now and answering questions is not one of them! In these moments I "went native" and viewed the situation entirely from the nurses'

perspective. I could feel my 1970s staff nurse feelings rise to the surface. I never acted on these feelings but I experienced them intensely.

Another feeling I encountered while working with the nurses was envy of their skill and status as seasoned ICU nurses. The immediate reward and satisfaction of caring for very sick patients was a seductive and heady experience. So much of what I did in my current job was administrative tasks. I would sometimes fantasize about quitting my job and "getting back to the bedside" to do "real nursing." A few of the nurses fueled my fantasy by telling me about a night position that was open on the unit and how great they thought I would do in the SICU. Perhaps this was also a measure of how well I was fitting into the field setting. Having read accounts of emotions and fieldwork, I knew to accept my feelings and try to use them as data (Kleinman and Copp 1994; Van Maanen 1988). I reasoned that since I was a nurse, the feelings I had during my fieldwork could be assumed to be similar to the nurses I studied, or at least arising from a similar frame of the situation (Goffman 1975). I would reflect on my feelings and then listen for the nurses to voice similar feelings, conflicts and motivations. For example, I wondered if the nurse's dismissal of the son's grief and focus on the technical aspects of the patient's care were a way for her to emotionally avoid the deep sadness and discomfort I experienced when I listened to him. I know I would rather not have felt so badly and guilty about the situation. I remember well being a staff nurse and feeling the tug of dealing with family members' emotions and the pressing need to get all of my patient care done by the end of my shift. When I heard the nurses express similar feelings during their workday or in their interviews, I knew my own feelings were another source of data.

INTERVIEW SCHEDULE

As you know, I have been spending the last several weeks observing on the unit. I would like to ask you some questions about yourself and your work. Before we begin, I would just like to verify the fact that you have signed consent to be interviewed and you understand that I am tape-recording the interview. Your identity in this interview will be anonymous and your responses kept confidential.

I would like to start with a few background questions.

1. What nursing school did you attend?
2. When did you graduate?
3. How would you describe the school's philosophy of patient care?
4. Why did you decide to become a nurse?
5. What units did you work on before you came to the SICU?
6. What made you want to work in the SICU?
7. What do you consider to be the most satisfying aspects of nursing?
8. What is the most frustrating part of nursing?
9. I asked you earlier about your school's philosophy of nursing, do you have a personal philosophy of nursing?

Now I have some questions about your practice in the SICU.

1. Do you think there is a specific way that a nurse should act with a patient?
2. Do you think there is a specific way that a nurse should act with family members?
3. You have just described to me how you think a nurse should act with a patient and family members, do you think there is a specific way you should feel towards a patient? How about with family members?
4. How do you suppose you got this certain notion that you should feel and act a specific way with patients and family members?

5. On this unit, how do you know when a patient needs emotional support?
6. How do you know when family members need emotional support?
7. If you believe a patient needs emotional support what do you do?
8. If you believe a family member needs emotional support what do you do?
9. Are you able to provide this emotional support all of the time?
10. (If not able to provide all the time) What would be the circumstances when you could not provide emotional support to patients?
11. (If not able to provide all the time) What would be the circumstances when you could not provide emotional support to family members?
12. How much of the total work you do caring for patients is spent giving them emotional support?
13. How much time do you spend emotionally supporting family members?
14. When you are providing emotional support to patients and family members, how does it make you feel?
15. What if you don't feel they ways you think you are supposed to feel with patients and family members, do you ever try to change the way you feel?
16. (If try to change) How do you do this?
17. How would you compare your experience of emotionally supporting patients and family members on this unit with other units you have worked on?
18. How consistent or different would you say that your way of providing emotional support to patients and family members from the other nurses on the unit?
19. (If different) Does it cause you any problems that your way of providing emotional support is different?

20. I want to ask you what you think your provision of emotional support to patients and family members means to other people.
    - What do you think it means to other nurses on the unit?
    - What do you think it means to physicians?
    - What do you think it means to nursing administration?
    - What do you think it means to hospital administration?

I want to ask you a few questions about things I have observed on the unit.

1. I notice that most of the nurses on the unit joke with the patients a lot, tease them in a friendly way. What do you think is going on when you do that?
2. I have also noticed that there are patients or family members you refer to as "cute" and others that you refer to as "pains." Can you describe "cute" and "pains" to me?
3. I notice that when the nurses are in a patient's room together, whether or not the patient is awake, you chat with each other quite a bit. I have been doing this with you also. What is your sense of what is going on when we do this?

We are almost done. I'd like to ask you a few questions about the nursing profession.

1. Are you aware of a movement in nursing that defines caring as the essence of nursing?
2. What are your thoughts about that – caring as the essence of nursing?
3. What do you think the essence of nursing is?
4. Do you think it is helpful or unhelpful to the nursing profession to define the essence of our work to other health professional and the public as caring?

Thanks so much for your help. I am also going to ask you to complete this brief questionnaire so I can get some statistics about the nurses on the unit.

NURSE'S FACT SHEET

1. Age _____
   _____
2. Religion:
   - Catholic _____
   - Protestant _____
   - Jewish _____
   - Other (please indicate) _____
     _____
3. Marital status:
   - Married _____
   - Never married _____
   - Divorced _____
4. Number of children _____
   _____
5. Basic nursing education
   - School _____
   - Degree _____
   - Year graduated _____

1. Additional education
   - Program _____
   - Degree _____
   - Year graduated _____

2. Additional education
   - Program _____
   - Degree _____
   - Year graduated _____

3. Years worked at St. Paul's Hospital _____

4. Years worked in the SICU _____

5. Previous experience
   - Unit/specialty _____
   - Years worked _____

11. Previous experience
    - Unit/specialty _____
    - Years worked _____

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