PERCEPTIONS OF CHANGE TO THE HOSPITAL NURSE'S ROLE: A GROUNDED THEORY

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Abstract

This investigation set out to explore the changes affecting the role of the hospital nurse from the perspectives of nurses and doctors working on, and patients receiving treatment in, hospital wards. The aim was to examine their perceptions through qualitative methodology using the systematic method of grounded theory.

Initially, eighteen nurses were interviewed, and through theoretical sampling, these were followed by interviews with seven doctors and then eight patients. All the nurses had been registered for a minimum of one year, and included general and specialist nurses. The doctors ranged from the newly qualified juniors to senior doctors with between fifteen and thirty years' experience, and worked in assorted specialties. The patients varied both in age and previous hospital experience, and these variations in all the groups provided both similarity and diversity of findings.

The data were collected and analysed separately for each group. Four constructs emerged from the nurses: *providing a service, drifting away from the patients, being ambitious and getting on* and *making choices.* Four constructs emerged from the doctors: *working together, retaining nursing, challenging medical power* and *defining the boundaries*, and three from the patients' data: *the changing healthcare environment, building relationships* and *responding to patients' needs.* The findings of each group were then compared to examine their similarities and differences and to provide a framework for the evolving theory. The results demonstrate that the perceptions of each group are subject to both internal and external influences affecting the health care context. Thus, the role of the hospital nurse is perceived as remaining the same in some areas, such as a need to retain the caring role for patients, whilst in others progressing towards technological change and overlapping with the roles of doctors. It is perceived as undergoing metamorphosis and changing as a consequence of external political pressure, societal influences and nurses own developing knowledge; at the same time the role retains traditional elements, where nurses build a therapeutic relationship with patients and respond to their needs. Thus, depending on the perceptions of specific factors affecting the health care context, these influences generate metamorphosis or stasis in the role of the hospital nurse.

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CHAPTER 1

INTRODUCTION AND INITIAL LITERATURE REVIEW

Introduction

This chapter sets the scene for the investigation by displaying for scrutiny the many issues that impinge on the role of the nurse. A brief rationale of the study is offered here, my personal background, and the influence of the historical and contemporary contexts. The following areas are discussed in some detail to illustrate the impact various issues have had on the role of the nurse over time. These include the focus of the study and the background of change from a historical and political perspective.

Focus of the study

This investigation focuses on the perceptions of hospital nurses' roles in the current climate of continuous change within the health care environment. Technological progression, professional and political influences, all contribute towards the increasing complexity of the nursing role. Some of the issues surrounding this investigation result from ongoing political legislation and the effect this has on the provision of nursing care at clinical level. However, the significance of how the role of the nurse is perceived by others who are in constant contact with nurses, such as doctors and patients as well as nurses themselves, is a vital part of the health care experience.

Nursing, as a role within healthcare, is central to the care of patients in hospital. Thus, the aim of this study is to examine how changes to the

hospital nurse's role are perceived by hospital nurses, doctors and patients within the current health care arena. This research dwells within the disciplines of nursing, medicine and sociology. It explores perceptions of the practice of the hospital nursing role and the ensuing relationships, which develop between nurses, doctors and patients within the social context of health care delivery.

Initially, the nurses' perspectives are explored to understand and gain insight into the meaning the changes have to individual nurses, and to identify the significant elements of their role as they see it. Nurses need to respond to many challenges. The intrinsic effects of government legislation on the boundaries between the traditional roles of medicine and nursing with their consequent effect on patient care, and the willingness of nurses to meet those challenges, are explored. Nurses work closely with doctors in the care of the patients, particularly in the hospital setting; therefore doctors' perceptions of the nurse's role could significantly influence their work situations. Consequently, doctors' perspectives are examined to study the effects their perceptions may have on the nurse's role. Patients, as the recipients of health care, may have different perspectives again of the nurse's role. This may depend on personal or a relative's experience, the influence of the media or their own personal expectations. Therefore, their perceptions are explored to establish through their thoughts and feelings, which issues concerning nurses' roles are significant to them.

Grounded theory methodology is used as the vehicle for this investigation, as according to Glaser and Strauss (1967, renewed ed. 1995, p. 5),

> *"...grounded theory is derived from data and then illustrated by characteristic examples of data".*

This thesis is laid out in an attempt to conform to this ideal. The chapters exploring the perceptions of the nurses, doctors and patients endeavour to lead the reader through the story in order to demonstrate the theoretical ideas that originate as a process in the context of social interaction. Thus, this is an emergent study that seeks to explore the perceptions of each of the three groups, in order to provide a picture of the demands influencing and changing the nurse's role in the hospital environment.

Development of the study

In order to place the investigation within context it is necessary to follow some of the political background to my post at the time the study was started. My personal background was that of a registered general nurse with experience in a range of clinical areas such as medicine, surgery, gynaecology and orthopaedics. I had also briefly worked in the private sector, and at the time of the study had been a sister on a general surgical ward for two years, working clinically as a senior nurse. During this period there had been a great deal of media attention paid to the plight of junior doctors and the long hours which they worked without any appreciable break. Concerns were raised that they were not able to competently assess and treat patients under these circumstances. Their conditions were investigated by a government committee for the Department of Health (D.o.H.) chaired by Sir Kenneth Calman, and as a result of their report (D.o.H. 1991), the

government set in motion moves to improve the living and working conditions of junior doctors, and reduce the long hours which they worked. At approximately the same time, the United Kingdom Central Council for Nurses, Midwives and Health Visitors (U.K.C.C.) published guidelines for nurses called the Scope of Professional Practice (U.K.C.C.1992a), which encouraged nurses to expand their current role providing they were competent to do so. Following on from the results of the report by Calman, the Department of Health set up a study lasting two years looking for ways in which the hours of junior doctors could be reduced, and more importantly, who would be able to carry out many of the tasks currently undertaken by junior doctors. Not surprisingly, the study found that nurses were the most ideally placed staff, and the results were published in a paper, which became known as the Greenhalgh Report (Greenhalgh et al. 1994). As an outcome of these reports (D.o.H.1991, Greenhalgh et al. 1994), the government ordered each Area Health Authority to establish a Regional Task Force in order to organise the management of the recommended changes. Resources were made available by the government to implement strategies to reduce junior doctors' hours and improve their working conditions. Although the majority of these were usually restricted to medical proposals or solutions such as extra doctors, some Trusts chose to implement posts to develop teaching programmes for those nursing staff that would be willing and able to undertake tasks normally restricted to junior doctors. As a result, I was appointed to such a post, the purpose of which was to develop the skills of nurses in order to reduce the junior doctors' workload. It was during this time that I became interested in the wide variety of opinions from staff and

patients regarding the changes to the nurse's role, and the original impetus for this study developed from observing their different views. Although the nurses were aware of the decreasing amount of available time for practising new skills, many were prepared to give up their own time to learn. In my post at that time I worked clinically, teaching nurses practical skills such as how to take blood samples, cannulate patients (insert a needle into a vein to administer fluids to patients unable to take them orally) and how to record an electrocardiogram (heart trace). Thus, through my role as a clinical nurse with the responsibility to implement training and facilitate these changes, I was ideally placed to listen to different perceptions and beliefs. Junior doctors were pleased that nurses were to take over some of the more 'basic' skills, thus reducing the doctors' hours and within the health care field the accepted nursing position was one of altruism that nurses should do this to improve patient care. However, some concerns were raised by both doctors and nurses regarding the boundaries of the role and possible losses and gains to both professions, and the consequent effect on patients. The issues were many and varied, and in view of the current health care climate were an area which appeared to need further exploration and investigation.

Therefore, in order to assess the proposed field of study I began by examining the literature surrounding the role of the nurse and the possible impact of any changes, with a view to using grounded theory methodology as a process of investigation. The purpose of using this method is to develop theory through rigorous systematic qualitative enquiry. Strauss and Corbin (1998, p.40) stress the necessity "to frame a research question in a manner that will provide the flexibility and freedom to explore the phenomenon in

depth". Thus, the properties that develop from data analyses in grounded theory methodology drive the systematic comparison of two or more phenomena under varying conditions. Theoretical comparisons are based on previous experience, relevant literature and sensitivity to the phenomenon under study, and during the research process questions become progressively more focussed as relationships between the data evolve. This method therefore contained components that were particularly appropriate for its use in exploring the perceptions of individuals in each group and comparing their views. The rationale for the selection of grounded theory is discussed in further detail in Chapter 2.

One of the canons of a grounded theory study is that the literature review is intentionally incomplete, as the literature should not direct the investigation but identify a gap in knowledge (Glaser and Strauss 1967). Accordingly, Strauss and Corbin (1998), advise that the purpose of a grounded theory study is discovery, and that the evolution of categories must come from within the data itself, and not from previous literature, although once categories have been identified, the literature may be sampled to enhance the evidence of relationships provided by the primary data. Therefore, literature of all types, technical and nontechnical, may be used during all stages of the research process. The following description of related literature on the current role of the nurse provides, as recommended by Morse (2001), Strauss and Corbin (1998), and Chenitz and Swanson (1986), an initial exploration of the type and scope of previous research in this area. Thus, the relevant professional and political issues are included in order to illustrate the

organisational influences over time on the role of the nurse, and rationalize the developments and constraints perceived as part of the nurse's role. However, in order to further illustrate the changes, it is necessary to describe some of the pertinent background historical and current issues surrounding the role of the nurse.

The initial literature review relates to the current changes and previous research regarding the effects and implications for the changes to the nurse's role. Further relevant literature will become part of the data, as is usual in grounded theory research, and be incorporated into the data analysis.

The role of the nurse in a time of change

The role of the nurse has, not surprisingly, been linked to changes in our society and undergoing change for several centuries. Over a period of many years, particularly in the 19th and 20th centuries, much has been written about nursing itself and the various different aspects and expectations of what constitutes the nursing role. Issues relating to the definition of this role, and also what is excluded by it, have been addressed from many viewpoints, by defining specific roles such as the ward sister, and from the perspectives of those who endeavour to answer the question from both within and outside the profession (Taylor 1992, Ashworth et al. 1992, Buckingham and Adams 2000, Lane 2000, Royal College of Nursing (R.C.N.) 2003a). According to these authors, the role of the nurse encompasses multiple functions and responsibilities, and is portrayed from various perspectives in the literature. Taylor's (1992) review compared assorted images of the nurse; as an ordinary person carrying out an extraordinary role, as inherently

understanding their role with patients and promoting independence and self care, and sharing the same goals with patients to attain well-being and health. However, much of the literature in her review presented these roles as implicit and accepted rather than defining them as explicit characteristics. A phenomenological study by Ashworth et al. (1992) examined the participation which takes place between nurses and patients as part of the caring element of the nurse's role. They found that this was based on the central ideal of nursing as caring, enhancing human dignity, mutual trust, and shared decision-making between nurses and patients. Buckingham and Adams (2000) demonstrate the significance of making nurses' expertise more visible through their decision-making processes, in particular by positively exhibiting the similarities of these courses of action between the different professions. However, from an occupational perspective, Lane (2000) focuses on the constraints on the role of the nurse, indicating that as the majority of nurses are female their role is frequently affected by family responsibilities thus limiting their career progression. Indeed, although the Royal College of Nursing (2003a) attempts to identify exactly what nursing is, it appears to experience similar difficulties in offering a succinct definition, with this document presenting details over several pages in order to encompass the complexity of the subject. Thus, as the nursing role continues to evolve in different directions, attempting to define it becomes ever more complex.

Nursing reforms have been subject to influences from all quarters, not least from the social changes continuously taking place. Nursing, however, is not

practised in isolation and many of these issues will overlap or be interwoven with each other. Literature regarding the role of the nurse deals with a variety of issues, and as would be expected is generally linked to patient care or working conditions and environment. Political guidelines such as the Patients Charter (D.o.H. 1991/5) can raise patients' expectations of nursing manpower and ability and the consequent provision of nursing care. However, Webb and Hope (1994) who explored the qualities that patients wanted in their nurses identified that overall patients preferred warm and friendly nurses who were sympathetic to their needs, ensured they had relief from pain and gave them the information they needed regarding their condition. Although the authors acknowledged some under representation of ethnic and older patients, these merits were acknowledged by patients from across the social spectrum. Indeed, these were fundamental expectations and part of the unique role of nursing which recognizes the concerns of the individual.

Nurses expect and are expected to treat patients as individuals, and the ideal of individualised care offers choice by allowing patients to choose when aspects of care are performed. However, an ethnographic study by Wakes and Easton (1999) questioned whether it was possible in the current health care climate to plan and carry this out. Their findings suggest that nurses were not always able to offer choice to patients as their care needs to fit into the ward routine and is influenced by the pressures of the overall workload to be completed within the shift. Further, multiple interruptions while attempting to care for a patient, such as doctors' rounds, supervising students and

responding to telephone calls, often prevent nurses from offering more freedom of choice.

Ethical and moral issues for nurses in hospital settings continue to intensify with many philosophical issues surrounding current nursing practice. Areas regarding abortion, infanticide and euthanasia remain strong emotional and political concerns, and Begley (1998) examines the moral principles which can challenge assumptions made by nurses in moral decision-making. According to Begley, the doctrine of acts and omissions implies we are less responsible for omissions rather than our acts. To allow something to occur, such as withholding antibiotics in a terminally ill patient is therefore deemed more morally acceptable than committing an action to end that life through an overdose of analgesics. Issues such as these can cause conflict for nurses and as Kelly (1999) found in her study of newly qualified nurses, preservation of moral integrity often resulted in moral distress. She suggests that occasionally, disparity between the learning environment during training and the real world of nursing practice can leave nurses unprepared for the ethical and moral issues which they experience in hospital wards. Indeed, as technology progresses the roles of both doctors and nurses are influenced by the complexity of procedures, possible legal and ethical problems and their consequences. Mann (1992) raises these as particular issues in areas of critical care, where technology is used to support and prolong life, and humane nursing care may appear as secondary to technological interventions. However, as Burnard and Sandelowski (2001, p. 374) suggest, "The problem of technology for nurses may thus lie less in

technology itself than in the choices we and our patients make about what is humane, natural, and dignified care."

The role of the hospital nurse continues to expand and in some areas can overlap the boundaries of other professions. Baumann et al. (1998) debate the issues which arise with the extension of nursing boundaries and consequent overlap with the functions normally performed by doctors. They discuss whether the roles of doctors and nurses are mutually exclusive, and suggest that instead of following the medical 'cure' model or the nursing 'care' model, these models should provide end points on a continuum of care for the patient. The convergence of both roles therefore provides a focus for decision-making that includes the patients and their families to the mutual benefit of all. They do however emphasise that 'caring' is an elusive concept and not as readily quantifiable as curative measures. Nonetheless, Webb (1996) defines numerous characteristics associated with the caring role, including knowledge, skill, honesty, patience, empathy, compassion and respect, all of which need to be integrated into both a caring and a curative purpose.

With increasing emphasis on patient choice and treatment options, patients expect to be given adequate information. Improvements in strategies for pain relief such as patient-controlled analgesia, where patients administer small doses of a drug, usually morphine, through a specially designed device into a vein when they feel they need it, emphasise the need for appropriate information. Chumbley et al. (2002) found patients using these devices

particularly wanted to know about the drugs used, their side effects and to be reassured that they were safe. Patients also require specific information when they are discharged from the hospital environment, and Driscoll (2000) identified many positive aspects of providing this to both patients and carers. Relevant information enabled them to cope, decreased their anxiety and ensured fewer medical problems as patients knew and understood what to expect.

Thus in order to provide information, nurses require the appropriate level of education, knowledge and skills. Nursing education continues to evolve, and consequently nurses seek to advance their practice as health care increases in complexity (Sidani and Irvine1999). In their evaluation of advanced practice in the acute care setting, these authors identified a multifaceted relationship between various factors affecting the role functions of nurses, particularly those with a practitioner role. Nursing roles sensitive to the needs of the patient were interdependent with the roles of others, such as doctors, patients and the organisation for which they worked. Indeed, Woods (1999) claims that situational variables influence the process and outcome of role transition to advanced practice. Although many of these influential variables are exerted through organisational governance, they are not necessarily seen as negative but rather as reaching a state of compromise in practice.

The role of the nurse as presented by these authors is diverse, interdependent with other professions, subject to organisational and professional influences, and regularly exposed to moral and ethical

dilemmas. They demonstrate that nurses are frequently expected to portray an ideal of others' expectations of their role by attempting to meet the needs of those in the health care environment.

However, there appears to be a deficiency of literature and research regarding the 'real' role of the nurse as opposed to the 'ideal', as in studying the reality of the role rather than what is expected from it. Indeed, Warren and Harris (1998) debate the monastic basis of nursing where obedience to authority, silence and duty were core values and formed the vocational nature of the nurse's role. Thus, to enter into nursing as an occupation involves acquiring the attributes and characteristics which identify with the expectations of that role. Bradby (1990) who examined four cohorts of nursing students, described this experience as a status passage as the students underwent the transition into their role as nurses. Further, a study in Australia by Lawrence et al. (1996) examined nurses' representations of the positive and negative features of nursing, although current literature tends towards studies in areas such as skill mix and manpower resources. Research in these areas seeks not only to maintain quality, but also to contain costs (Procter 1992, Chang and Twinn 1995), particularly within the current ever changing climate of health care since the setting up of government targets. This continues with successive governments attempting to provide an optimum level of health care within finite resources (Webster 2002, Ham 2004).

However, the role of the nurse and nursing as a discipline has been undergoing change since Florence Nightingale set out in Principles for Caring

for the sick in the 1860's (Skretkowicz 1992). Indeed, the most significant issue in recent years was that of the 'extended role', which allowed nurses to extend their skills beyond those acquired during their basic training for registration. In 1977, it had been officially recognised by the existing government that nurses were capable of learning extra specific skills (Department of Health and Social Security (D.H.S.S.) 1977). These were usually taught by a doctor who agreed to sign a certificate of competence which allowed the nurse to practise this particular skill and became recognised as an 'extended' part of the nurse's role. This, in addition to developing generic skills and continuing with their normal duties, allowed nurses to develop their individual roles within any specialist area in which they worked. This practice continued for many years, with nurses developing skills in numerous different areas of practice, and with nursing competence usually assessed and agreed by a member of the medical profession.

The momentum of change in the health care environment continued to gather speed, and with the new 'Scope of Professional Practice' guidelines (U.K.C.C. 1992a), the term 'extended role', relating to all additional skills for which certificates of competence had been required, was no longer appropriate. Future acquisition of additional skills for ensuring dynamic practice would now 'expand' the nurse's role beyond the limiting parameters defined by the 'extended' role (Bowman 1995). Hence, these additional skills would be included in nurses' recognised roles, expanding the 'scope' of previously accepted practice, provided that nurses had attained the competence and knowledge to perform them. Certification was no longer mandatory nor was competence assessed by the relevant doctor, and

increasing emphasis was placed on individual accountability and the legal significance of role expansion (Hunt and Wainwright 1993). Thus, obtaining expanded skills was legitimised by the Scope of Professional Practice guidelines (U.K.C.C. 1992a) and removed from the jurisdiction of the medical profession. Registered nurses were expected to learn extra skills, to determine their own competency and to be accountable for maintaining safe practice.

Those in authority assumed tacit acceptance and implementation by nurses of these changes, and the study by Land et al. (1996) identified an overwhelmingly positive response by heads of nursing to directing further professional development in their areas. In many clinical fields however, nurses were already overstretched, with few extra resources available to implement change. This led to the morale of nurses becoming dangerously low, due in part to nurses attempting to achieve their ideal role of being "all things to all people". Indeed, the results of a nationwide nursing snapshot week run by the Nursing Standard (1996), which asked nurses to document their experiences for one week, identified many cases of frustration. Furthermore, a study by Green (1996), who examined the ward sister's role, recognised the need for explicit boundaries within the autonomy of the nursing role, setting it within the framework of the organisation as a provider and employer of services. Thus, in order to place this investigation within an identifiable theoretical context, the impact of organisational changes within the N.H.S. are briefly discussed here.

Following the implementation of the Salmon Committee report in 1966 (Ministry of Health 1966), nursing as an occupation in the United Kingdom underwent organisational change. More management grades were introduced, and the nursing officer replaced the role and title of matron. Further reorganisation in 1974, and again in 1982 (Hugman 1991), saw nurses entering management through area, regional and district health authorities. However, with the inception of N.H.S.Trusts management was again separated from nursing, thus reducing the power of nurses in the decision-making process (Cook 1993). In the directorate structure now in place in many Trusts nurse management is frequently devolved to clinical directors, usually doctors who are hospital consultants. The agenda created by the internal market through the White Paper 'Working for Patients' (D.o.H. 1989), ensured that hospital consultants would be directly involved in the management of hospital resources, including staff. Health policy in the United Kingdom is governed by available resources and the successful management of those resources (N.H.S.E. 1993). Indeed, Ham (1993, p.255) suggests that, "the future of health care will be driven as much by politics as by reason". Nurses themselves are crucial to that successful management (Dyson 1994). Consequently, how they are perceived within a changing climate of health care, their role in working with other disciplines and the financial constraints imposed at strategic level, affects not only their own positions but also the care they deliver to their patients.

Over the last decade, many radical changes have taken place which impact on the roles of those working within the health care environment, particularly

nurses (Shaw 1993). Indeed, nursing has been described by Dr.Jonathan Miller as the "greatest leap in medical science in the 20th Century" (Neubauer 1995), a view which is supported by many nurses. The advent of Project 2000, seen as a more appropriate and academic method of training student nurses, coupled with a widening in parameters of skills expected from trained nurses, signalled a move away from the traditional role of the nurse as the 'doctor's handmaiden' (Sweet and Norman 1995), to that of autonomous and accountable practitioner (Nolan 1995). General opinion among nurses, however, suggests that this has not been without cost, both to the nurse's professional role, and to them personally (Short 1995, Bradshaw 1995). Indeed, the debate as to whether nurses need to be an "all degree" profession continues to be discussed, as the Royal College of Nursing in its major policy document Quality Education for Quality Care, advocates an all graduate entry to nursing (R.C.N. 2002). Nursing academics support this stance, and although the Nursing and Midwifery Council (N.M.C.), previously the U.K.C.C., recognises the need for a skilled and competent profession, they warn against excluding those who want to go into nursing via other routes such as progression through the starting levels of healthcare assistants (Dinsdale 2002). The issues surrounding the role of the nurse are complex, frequently abstract and for some, difficult to define or verbalise. However, nurses are becoming increasingly aware of the significance of the changes directed at the current health care climate and the effects these have on their role (Quinn 1992, East and Robinson 1994, D.o.H.2000).

The health care environment is in a state of perpetual change. As a consequence, nursing and the nursing role are similarly affected. Many diverse aspects have influenced the role, such as the need for nurses to be able to prescribe family planning aids (Tyler and Hicks 2001), perform endoscopy investigations (Pathmakanthan et al. 2001), and the creation of a new professional nurse at Masters level (Gerrish et al. 2003). Government legislation continually seeks to improve patient care, with documents such as the "Patients Charter" informing the public by setting standards which impact on the way that care is delivered (D.o.H.1991/95). The Patients Charter standard that all patients would have a 'named nurse', who would be a trained nurse responsible for their care throughout their stay, affected both the organisation of the ward and the team structure of nursing within it. This standard encouraged wards to develop the concept of primary nursing where individual nurses would be responsible and accountable for the care of a specific group of patients as the nurse 'named' to look after them (Wright 1990, Melville 1995). Indeed, as the manifestos of each successive government attempt to influence the structure of nursing within the N.H.S., the return of the role of the modern matron has been included as part of the current government's plan for N.H.S. hospitals (D.o.H. 2000).

Professionally, the nurses' own governing body, the United Kingdom Central Council (U.K.C.C.) for Nurses, Midwives and Health Visitors (U.K.C.C. 1992a, 1992b, 1996), defines the boundaries of nursing responsibilities and updates professional guidelines for nurses on a regular basis. Indeed, the U.K.C.C. itself was updated in April 2002, to become the Nursing and

Midwifery Council (N.M.C.). Over the last decade the immense changes in all areas surrounding health care, from such examples as the discovery of new drugs, advances in disease control and genetics, to a continuing reorganisation in the way the health care needs of the changing population are met, have a consequent impact on the roles of nurses. The boundaries of the nurse's role continue to expand and extend in order to accommodate these developments. Thus, the expectations of both patients and staff in all areas of health care are raised as a result of current National Health Service (N.H.S.) reforms (D.o.H. 2000, D.o.H. 1989, National Health Service Management Executive (N.H.S.M.E.) 1990, Bradshaw 1995). However, the most notable impact on the nurse's role in recent years, and one which continues to affect it, has been the continuing government directive to reduce junior doctors' hours. Indeed, the European Working Time Directive from the Council of the European Union 93/104/EC (D.o.H. 1996) lays down minimum requirements for working hours, annual leave and periods of rest. Its purpose is to protect the health and safety of those working in the European Union. Although this took effect in British law in 1998 as the Working Time Regulations, as a special case junior doctors were exempt until 2004.

Junior doctors have traditionally worked long hours, often at the risk to their own health, and at times to the well - being of patients in their care. However, in 2002, in line with the New Deal (N.H.S.M.E. 1991) and the Eurpopean Working Time Directive coming into force for doctors in 2004, the Department of Health (D.o.H), National Assembly for Wales (N.A.W), N.H.S. Confederation (N.H.S.C), and British Medical Association (B.M.A.) together issued guidelines for the implementation of working patterns for junior

doctors (D.o.H. 2002). The new hours and working practices make a significant impact on the coverage of medical services by doctors in training, as junior doctors are no longer able to spend long periods in their working environment. Their hours will further reduce in August 2007 to an interim 56 hour week, and again in August 2009 to 48 hours. Thus changes within the health services as a result of this appear set to continue.

Changes within the National Health Service

Although briefly mentioned previously, a broader account of the earlier issues surrounding junior doctors, their reduced working times and the implications for other professionals, is discussed here. In 1991, with growing national concern over the living and working conditions of junior doctors in training, the N.H.S.M.E. set out specific requirements, which became known as the 'New Deal' (N.H.S.M.E. 1991). Included within the appendices of this report were suggestions for 'making the best of the skills of nurses and midwives', by extending nursing practice to incorporate duties traditionally viewed as medical tasks. Media coverage of the long hours worked by junior doctors without a break, with photographs of exhausted doctors in the national press, had significantly raised public awareness and concern, both for junior doctors and the patients they were treating (Walby et al. 1994). It became a matter of paramount national importance therefore, to find alternative staff to carry out junior doctors' tasks, thereby reducing their working hours. The tacit acceptance within the health care arena that nurses can and will absorb changes and extra skills into their workload, was highlighted by the Greenhalgh report (Greenhalgh et al. 1994). As previously stated, this report

was the outcome of a study commissioned in 1992 by the Department of Health, in order to identify ways in which the hours worked by junior doctors could be reduced, and their working conditions in general improved. The most notable recommendation of the Greenhalgh report (1994), and one which would potentially have the greater impact on the current nursing role, was, that nurses were ideally placed to take on many of the tasks currently performed by junior doctors. This recommendation sought to provide alternative, and less costly, arrangements for many of the duties currently performed by overworked junior doctors, and would require nurses to expand their role to learn and practice many new skills. However, although new roles were developed for nurses as a result, the broader consequences to the culture of nursing as a whole and the personal and professional identity of the individual nurse's role did not appear to have been considered.

The working world provides an individual with a major means of personal and cultural identity. The culture within which nurses function influences their role, and can ultimately affect their whole philosophy of care (Wright 1989). Indeed, the recent document from the Royal College of Nursing (2003a), "Defining Nursing", attempts to describe in its 38 pages what nursing is, and what it means to different groups of nurses, both nationally and internationally. However, it is extremely difficult to produce a definitive statement due to the complexity of the role. The majority of nurses continue to be female, although the percentage of men commencing nurse training is increasing (Mac Dougall 1997). Thus, through the impact of gender the cultural feminine traditions persist, with nurturing and caring attributes

considered fundamental to the role of the nurse. Indeed, although more women are entering medicine, the traditional gender bias between the professions continues to thrive. Achterberg (1990), writing on the role of women as healers throughout history, states that women were initially revered for their knowledge of healing and then condemned for it, as the scientific development of knowledge of the human anatomy became restricted to the domain of male medical men. Socially and historically, there has been general acceptance that aspects of the feminine role include deference to the masculine (Gherardi 1995), and to understand the role of the nurse from different perspectives, it is necessary here to explore the theoretical basis of an individual's role.

The role of the individual

An individual's role is socially influenced and subject to defined attributes and behaviours. However, it comprises many interaction processes in relation to others and incorporates experiences gained from early childhood (Abercrombie et al. 1988). The early work of the sociologist Mead (1934) identified that we lay a foundation for a sense of self by relating to significant others, internalising and taking as our own the attitudes and values of those important to us, thus seeing ourselves as we are seen by others. According to Biddle and Thomas (1966) our roles are defined for us as we occupy a particular position in a social relationship. Engaging in that role shapes the behaviour and status attached to it, and the knowledge and values required to perform specific parts of it. Thus, role norms are the expected set of behaviours for people holding a particular role and status. They regulate

dress, demeanour, action and expression. This helps an individual to take on a role, and be perceived by others as fitting that role. Nurses' uniforms still retain the aura of service, depicting nurses in a subordinate role (Muff 1988). A more contemporary mode of dress may have replaced the original uniforms, but a demeanour of servitude continues to be expected from nurses. Although this is changing through media coverage and real life documentaries, perceptions of their role by society continue to be reflected as female and secondary in the health care arena (Wyatt and Langridge 1996). Social roles and personal roles are closely linked, and although behaviour is linked to society it does not determine it. According to Joseph (1994) role identities for nurses are closely connected to their status as women, and the ideology of caring perpetuated by the image of Florence Nightingale. Although it may be argued that the role of 'modern' women in the 21st century has experienced a shift in emphasis away from the traditional female role of caring and nurturing, this remains part of the expected responsibilities for the majority.

Until the late 20th century, the role of women in society was largely determined by their biological function. The differences in the reproductive role of men and women, with women responsible for giving birth to, nurturing and caring for the young, and men as protectors, led to the natural dominance of the male over female. Women were constrained in the workplace by the social influences of the family culture, and the practical and political influences of available childcare (Crompton 1997). Indeed, until fairly recently, the expectations for women were that employment served the

purpose of filling the gap between school and marriage, and that higher education for women was misplaced. This issue has only recently been addressed in the last two decades with the introduction of nursery education and after school care (Department for Education and Employment (D.f.E.E.) 2001). Indeed, government policies continue to impact particularly on the role of working women and their contribution to the changing workforce, with flexible working hours becoming more acceptable to employers (Department of Trade and Industry (D.T.I.) 2003). For many nurses, however, these changes do not always appear to correspond with available employment.

The influence of change

Nursing developments have been constrained by financial, political and cultural boundaries and, although currently stimulated by the need to find a means of filling the manpower gap left by the reduction in junior doctors' hours, appear to align with political strategy rather than patient need. Some changes can be attributed to the rise of the feminist movement, and others to a slowly evolving process of equal opportunities implemented by political policy (Davies 1995). Change itself can be implemented through several strategies, with Lewins' model of change (1951) advocated for changing nursing practice by authors such as Wright (1987). This involves the process of unfreezing, moving and refreezing, in order that any change is stabilised. In 1976, Bellis et al. developed three strategies for change, the power-coercive, where those in positions of authority can command and control the process, rational-empirical, which assumes people will make rational decisions on the information presented to them, and the normative-re-

educative approach, which is participative and challenges attitudes and beliefs. There are positive and negative components to all of these strategies, with their application appropriate in some circumstances but not others. For example, the power-coercive strategy may be appropriate for organisational change, but it can provoke resistance, the rational-empirical assumes that individuals will be rational, and the normative-re-educative technique can be lengthy as there may be difficulty in changing long held attitudes and beliefs. Thus, different strategies may be required at different levels of the organisation, with changes to the nurse's role implemented according to the most effective method for their accomplishment.

The role of the nurse is continually subject to change, depending on the social, political and medical developments within society. It is heavily influenced by the demands on services and the political agenda of current successive governments. This brief background to the investigation has established the complexity of the subject, and the literature demonstrates the multiple influences on the nurse's role. From the earliest periods, the role has been dominated by both internal and external factors. The social role of women has had a major impact on the direction in which the nurse's role has developed. As the perceived weaker sex, and their role as carer within the family, women were seen as dependent on male support, with a naturally occurring order of male dominance in Western culture. This was typically reflected in organisations with men as leaders and women as led, and was perpetuated in health care with Florence Nightingale in the 1860s establishing the nurse's role as that of follower of medical orders, which

emphasised the difference between doctors' and nurses' roles (Skretkowicz 1992). During the mid 20th century, nurses were permitted to expand into medical fields only with the consent of and under the control of doctors. This is illustrated by the example of extending the nurse's role to allow them to give intravenous drugs, which, previously under the aegis of medicine, became a convenient task to devolve to nurses. Expansion of the nurse's role also fell under the jurisdiction of the government, who saw nurses as an acceptable and available instrument to satisfy any breach in the medical workforce (McCartney et al. 1999, Rosen and Mountford 2002). However, Hewison (1999) argues that if nurses became skilled public speakers with an appreciation of the policy-making processes, they would be more able to influence its implementation.

Further areas of devolvement and development have evolved as a direct result of the Greenhalgh report (Greenhalgh et al. 1994), and the political implications surrounding the reduction in junior doctors' hours. The nurse's role has been managed politically and socially, and developments appear at times to be encouraged for the convenience of other professions working in health care. Indeed, Colyer (2004, p.406) claims there has been a 'strong political imperative' to develop the roles of non-medical personnel in the last fifteen years. However, these roles are constrained by systems of governance (D.o.H. 1998) and are now managerially led rather than directed by doctors, although nurses continue to strive to develop their practice to advanced levels (Daly and Carnwell 2003). Further, the evidence highlights areas of nursing development sanctioned by the nurses' own regulatory

body, the Nursing and Midwifery Council (N.M.C., formerly the U.K.C.C.), such as the Scope of Professional Practice (U.K.C.C. 1992a), and nurse training continues to diversify in order to attempt to maintain a comparable standard with other professions (D.H.S.S. 1998, R.C.N.2001). Reports from conferences such as those on the development of professional roles in East Lothian (Watson 1997), emphasise the extent to which nursing roles can and will develop (Wilson-Barnett 1997). Indeed, Tye (1997) exploring the professional issues surrounding development in a major Accident and Emergency Department, underlines the shift in role boundaries and the potential legal and professional conflicts which may result from developments in this area. Both outside the nursing profession and sometimes within it, the nurse's role continues to be viewed as subordinate to that of medicine, fostering a culture of deference to doctors (Dopson and Waddington 1996, Harrison and Ahmed 2000). According to a cross-national study by Degeling et al. (2000), this appears to have been implicitly promoted by successive governments, as their ability to provide both nurse education and nurse staffing became more difficult during the 1960's and 1970's. Further Bradshaw (2000) in her historical examination of British nurses shows the traditional nurse had a clearly defined purpose and developments to the role remained within limited boundaries. Much of the literature, however, suggests that the role of the nurse is responsive to change rather than initiating it.

Implications for change in the healthcare environment at any level impact on the care of the patient. Doctors tend to direct the role of the nurse rather

than understand it, thus investigation regarding the role of the nurse from the perceptions of doctors is scarce. Little appears to have been written since Stein's (1967) notable paper on the disparity of power between the professions representing the nurse as the doctor's handmaiden. Indeed, it is rare for a nurse to interview doctors, and Chapple (1997) warns that those who do so must be well prepared, as doctors expect a nurse interviewer to have a wide knowledge of the subject base and a beneficial rationale for the study and the methodology.

From the nursing perspective, much has been written regarding the physical and psychosocial care of patients, including nursing models which form the basis for assessment of patients (Williams 1998, McCaughan and Parahoo 2000). This is implicitly understood as an integral part of nursing care, although Wimpenny (2002) suggests that the term model is outdated and confuses the purpose of the assessment. However, how patients often perceive the true role of the nurse appears to be obscured by the multifaceted issues surrounding their hospital care. Indeed, Warren (1995), who studied the emotional experience of patients in hospital, found patients preferred nurses who were kind and approachable. This highlights therefore an area for exploration which could have an impact on the future healthcare environment and care that patients receive.

In conclusion, therefore, this chapter lays the foundation for the study and the literature very briefly reflects the myriad issues surrounding nurses' roles. The salient points from this overview highlight the change process for nurses

as effected by successive governments. The role of the nurse from the perspectives of doctors appears to have been approached only from the viewpoint of delegation, that is, those roles which could be delegated to nurses. How doctors perceive the true role of the nurse appears as yet unexplored. Although relationships between the two disciplines have been examined, these have tended towards a nursing perspective rather than doctors' views. Furthermore, nurses' roles appear to have been directed according to particular professional issues.

The majority of available information appears to deal with the external issues, those which mould and shape the nurse's role from without, both professionally and politically. The perceptions of the nurse's role from the perspectives of doctors and nurses who work within the health care environment and the patients who receive their services, are areas which appear to have undergone little enquiry. Moreover, in recent years service provision in health care has remained a leading issue, thus perceptions of the role of those that provide the majority of that care to patients, the nurses, appears to be an area of investigation waiting to be explored. In my own professional experience I noticed a disparity between the proposed direction in the development of the nurse's role, and what was happening in the 'real' world of acute hospitals. This raised questions for which there currently appear to be no answers. Some of the issues were nebulous and would require meticulous exploration. It was my intention to explore these issues from individuals' perspectives, to examine their feelings and thoughts in depth, and to gain an understanding of how they felt about these influences

on health care. Consequently, through examining various methodologies, my decision to use grounded theory methodology developed both from the wish to explore each groups' perceptions in depth, and from its unrestrictive, yet systematic nature. The reasons and explanation for this are given in the next chapter.

CHAPTER 2

THE RESEARCH PROCESS

Introduction

The aim of the qualitative researcher is to enter the worlds and represent the experiences of those whom they study. Nurses, by the very nature of their profession, deal constantly with their own and others' feelings (Crowe 2000). I wished to understand how it felt to be involved in the changes which were taking place in the nursing profession and outside it, and what it meant to the participants from their perspectives. I chose to explore the roles of nurses from the viewpoint of those who would be directly affected by the changes, nurses themselves, the doctors with whom they worked, and the patients who would be the recipients of changing nursing care. It was essential not to restrict the participants' perspectives, but to enable them to freely offer their views and feelings (Silverman 2001), and detailed examination of the complexity of these views would be better served by qualitative analysis. Thus, the choice of a qualitative methodology whereby the data closely portrays the richness of the participants' experiences through their own interpretation clearly appeared as the obvious strategy (Holloway 1997). This would enable me to examine the interaction and social relationships. Simons (1995), addressing the question of research design, observed that attempts to understand the social world through interviews and qualitative methodology are a convincing and valuable approach. From all perspectives, this afforded the exploration of issues which may have been too complex to raise by quantitative methods. The qualitative interview

process enables the participants to discuss their feelings, and to direct which issues are explored in depth (Kvale 1996). In order to probe the relevant issues through a systematic and orderly technique, I required a specific qualitative methodology which examined interaction holistically within a social context. Social life is affected by our ability to act or imagine ourselves in other roles, and symbolic interactionism studies the relationship between ourselves and society (Abercrombie et al. 1988, Strauss and Corbin 1998). Thus, in order to apply a suitable focus for interpretation and analysis which considered all the phenomena, grounded theory offered a process by which to examine and record the participants' views (Baker et al. 1992, Wimpenny and Gass 2000, Glaser 2001). The following aim and objectives endeavour to position the investigation within appropriate boundaries.

Aim and Objectives

Strauss and Corbin (1998) state that the original research question is broad and open-ended, and tends to become more specific as the issues relating to the area under investigation emerge. Thus, although explicit objectives cannot be stated at the beginning of the study, these can be related to the process as the investigation evolves. The following aim and objectives are based on the grounded theory methodology advocated by Strauss and Corbin (1998).

Aim:

The overall aim of this study is to explore through the methodology of grounded theory, the perceptions of nurses, doctors and patients regarding the changes affecting the role of the nurse in the hospital environment.

Objectives:

To interview nurses, doctors and patients separately to explore their understanding of the changes to the role of the hospital nurse.

To explore evolving hypotheses systematically against incoming data through consistent theoretical sampling.

To discuss and analyse the findings of the three groups in relation to the emerging theory.

To evaluate the potential implications of the results within the current hospital context.

The selection of grounded theory

Grounded theory has its origins in symbolic interactionism which studies the relationship between the self and society. The contribution of symbolic interactionist theory to grounded theory affirms that the investigator needs to enter the worlds of the participants or actors being studied, and observe their interpretation of the actions taking place. The early posthumous work of the sociologist, George Herbert Mead (1934) envisioned society as a process of communication between its members through the use of symbols and an exchange of gestures, with the self-emerging as a process of that social interaction. He claims that through role taking, the self conducts an internal conversation, with the individual anticipating the effect of their communication on others. This assumes that a person's actions are based on what those actions mean to them, and originate from that person's social interaction with others (Blumer 1969). Indeed Blumer (1969) views human beings as proactive rather than reactive, constructing social action rather than

responding to it. Sheldon (1988) supports this view and maintains that the personal interpretation of the meaning of natural events rests with the individual who has the experience. Thus, the participants' reactions to events would be studied from their different perspectives, but within the social context of a hospital, through their actions and interactions with each other. Interaction and individual interpretation of events are part of hospital culture, and as identified by Bowman's (1995) study of nurses from an educationalist perspective, frequently highlight a disparity in accounts of the same incidents. Grounded theory is a systematic approach, the aim being to generate an explanatory theory from the data rather than using an existing theoretical framework to accommodate the collected information (Glaser and Strauss 1967, Strauss and Corbin 1998). However, the flexibility of this approach allows participants to communicate their values, attitudes and beliefs through frank discussion with the interviewer, rather than through structured responses (Denzin and Lincoln 1998). The purpose of using grounded theory is to explain the social processes in a particular situation by identifying a core process and the contributory processes linking it to form an explanatory framework. Further details are discussed within the data collection and analysis, and the discussion concerning the later divergent grounded theory approaches of Glaser and Strauss are included in my reflective section.

Ethical and access issues

Prior to the interviews, it was necessary to gain the consent of all those involved, both the organisation and the participants. Initially, consent was

requested and obtained from the appropriate Nursing and Medical Directors and the Local Research Ethics Committee to conduct the investigation in the selected areas (appendix 2). Hospital managers, and where appropriate, ward sisters gave their consent for their staff to be interviewed. In order to ensure that my chosen methodology was understood by the Ethics Committee members, I sought the support of the nurse member who had knowledge of qualitative methods as my advocate, and endeavoured to make my proposal as clear as possible to other members who were unfamiliar with the canons of qualitative research. Then, as the investigation progressed, permission to approach a group of doctors was again sought and granted by the Local Research Ethics Committee. As further progression identified the need for the views of patients, a full research protocol was again submitted to the Local Research Ethics Committee, and permission was granted to proceed.

At the start of this study, in my then current role working in training and development, I had already explored whether registered nurses would be keen to take on extra roles, by means of a very simple questionnaire which does not form part of the present study. The results showed that nurses were keen to expand their role but they voiced many concerns. Their own perceptions of what it would mean raised many issues, and the impetus for this study evolved partly as a result. My intention was to identify the factors, which were most significant to the participants, and to compare the similarities and variations between them. Letters were sent out to registered nurses of different grades (Nursing and Midwifery Negotiating Council

(N.M.S.N.C.) 1988), from an E grade staff nurse with at least one year's post-registration experience, who at that grade would be expected to understand the implications of change, to a senior nurse at grade H, who would be expected to implement change, explaining the study and requesting volunteers (appendix 1). Patton (2002) suggests the nature and personal characteristics of such a sample supports the choice of methodology, which as expert nurses are "information rich", and from whom one may learn a great deal about the issues central to the purpose of the research. The subject is also of interest to and affects many nurses, and according to Fontana and Frey (1994) identifies numerous abstract concepts of the effects of change, which are not easily definable through other methods of research.

As the investigation progressed however, it became clear that the influence of the medical profession played a definitive part in shaping the changing role of the nurse. Wicks' (1998) study supports this, and although her research was based in an Australian hospital, the similarities identified between the different priorities of nurses and doctors are generalisable and would appear to be international, particularly in the developed world. It also became apparent that I would need to interview members of the medical profession in order to better understand the nature of this influence. Again a purposive sample of doctors was selected by sending letters requesting volunteers to different grades from pre-registration house officer up to consultant specialist. This was a more difficult group to access, as nursing research is not always viewed as important by the medical profession, particularly if it is qualitative (Webb 1984). Indeed, Stevenson and Beech (1998), in their dealings with

local research ethics committees, suggest that due to the high ratio of doctors as members of these committees, qualitative researchers are required to conform to the perceived language of quantitative scientific objectivity in order to gain approval. However, although quantitative analysis does not depend on subjectivity, it is neither value free nor neutral.

The analysis of data from both groups led me to question how all the changes taking place in the caring professions affected those for whom they cared. This, in turn, directed me towards approaching a sample of patients who would be willing to discuss how they saw the changes in the nurse's role. Information letters and a request for patient volunteers were sent to all wards in medical and surgical specialities (appendix 1). I informed the ward sisters and consultants of these wards of the nature of the study, reiterating that patients would volunteer, and that there would be no pressure exerted on them to take part. They could ignore the requests, distributed in the ward dayrooms if they wished, although I was very keen to capture their views and hoped this would not be the case.

The personal nature of the qualitative interview, frequently carried out on an individual basis, highlights the obligations of the interviewer. Kvale (1996, p.109) states, "An interview enquiry is a moral enterprise", and nurses involved in research have a moral duty to respect and protect the interests of the participants. Those interviewed in or having to access the health setting, especially patients in hospital, are particularly vulnerable, and ethical codes and guidelines stress the ethical issues within the research process. Thus,

any decisions taken must be justified with these in mind (Fontana and Frey 1994). The philosophy of qualitative research is to discover what the participants think and know, with the aim of contributing knowledge to enhance the human condition (Rubin and Rubin 1995). Research is judged on its scientific value, and the competence of the researcher (The Royal College of Nursing (R.C.N.) 1998). Prior experience in the research field must be compatible with the proposed investigation, and I had carried out two previous investigations using grounded theory methodology and by interviewing patients. Personal integrity is based on "honesty, fairness, knowledge and experience" (Kvale 1996, p.117), and in the qualitative interview the researcher is the main instrument for obtaining data. However, I found that during one of the interviews with the patients, I became aware that the individual I was interviewing had personal problems that they found difficult to resolve. Ethically, I was not in a position to offer advice about her problems, but I could suggest an alternative service which may possibly have been able to help. A similar episode occurred during one of the nurse's interviews, and during another interview a patient became very breathless and although he protested, I had a moral duty to stop the interview to enable him to recover. Incidents such as these emphasise the need for the researcher to have the ability and sensitivity to deal with ethical and practical issues which could arise during an interview.

There is always a cost to the participants, whether in time, energy or access to their private thoughts, and perhaps in other ways. Some participants find the interview a positive experience, a reciprocal exchange of giving information by

being listened to and receiving the researcher's full attention. Indeed, with almost all my interviews with the patients, I found that I was welcomed into their homes and offered tea, and introduced to any family members. It sometimes required a great deal of tact to explain that the interview required only the participant, rather than any other family members. Kvale (1996), however, cautions the interviewer of the dangers inherent in the seductive nature of the personal interview, leading to disclosure of information the participant may later regret. Acknowledging this, I therefore reassured the participants that anything they wished to withdraw would not be used in the research. I also offered each person the opportunity to have a summary of the research on completion, and all agreed that they would like this.

The issue of human rights and their relationship to the generation of knowledge is a major ethical dilemma in qualitative research, requiring a balance between the risks and benefits. Nursing as a discipline is committed to humanistic and scientific growth. However, both the participants and the information they disclose during the process of the investigation must be protected. These two areas, the protection of the participants, and access to them through the 'gatekeepers', need to be considered during the research process (Holloway 1997). Sample selection in qualitative research has a pronounced effect on the fundamental quality of the research, and in the initial stages of a grounded theory study the selection of a purposive sample is necessary to provide the ultimate amount of data, with theoretical sampling following later. Glaser (1978) refers to this as a calculated decision considered in advance of the study, as the investigator approaches sample

groups where the possibility of obtaining relevant data is maximised. A purposive sample enables the selection of participants with a common focus of experience, as in being, working with or being cared for by, a nurse (Weiss 1994). Within that sample, the data sampling is unfocussed in order to capture a wide range of ideas from the participants. As these are analysed, theoretical sampling develops through pursuing themes and concepts emerging from the ongoing data analysis, and controls the direction of the data collection in order to explore these further (Goulding 2002). This type of sampling is not planned at the start of the study but continues throughout by choosing relevant participants and ideas (Holloway and Wheeler 2002).

The use of grounded theory dictates that the number of participants to be interviewed will be defined by the saturation of the data (Glaser 1978), and Carr (1994) acknowledges the quantitative argument that the small-scale sample in qualitative research could be viewed as a weakness. However, the strength of this approach lies with the in depth nature and analysis required to define and explain the phenomenon under study, and the richness of the data captured through the use of 'thick description' (Geertz 1973). Thick description describes the context of the experience, conveys the intentions, gives the reasons for the experience and displays that experience as a process, capturing and communicating those conditions which enable the reader to understand the interpretations of the writer (Patton 2002). Thus, it is analytical in that it describes in detail the participants' views of their world. It enables the reader to follow their thoughts and emotions, and elicits understanding of both the internal and external impact of significant issues.

The informed consent of the participants refers to their voluntary agreement to engage in the research. This can present problems for the qualitative researcher, particularly with grounded theory where informing the participants of the nature of the study is constrained by the need to obtain the participants' own views of the subject under investigation. Thus, the information given to each of the three groups was varied according to their consent needs, with information letters tailored to each specific group, and with each group of participants given as much information as was possible within the constraints of the methodological intricacies. For all participants, the issue of informed consent is one of ongoing participation, with the individual's right to privacy and confidentiality remaining constant throughout the study. As the participants were my source of information and their behaviour was to be studied, my relationship with them was pivotal for access to the data (Weiss 1994, Cutliffe 2000). In qualitative research, however, the area of informed consent may be considered more difficult, as progression within the interview explores the ideas and concerns that emerge from the data (Kvale 1996). I informed all the participants at the beginning of the interview that they could withdraw at any time, and the patients were assured there would be no detrimental effect on their treatment. All the participants were interested in what I had so far discovered, and at the end of the interview I gave them further details with a brief overview of the results at that time.

Complete confidentiality cannot be achieved in qualitative inquiry, as the researcher quotes from the words and feelings of the participants, however, I

informed all participants that the data would remain anonymous, and as confidential as the study permitted with the use of the interviews. Personal information divulged during the course of the interview would not be disclosed other than in the context of final data analysis, and single letters were substituted for names.

Population and sample

The following tables present the participants' details, and show the variety of specialties, wards and areas of practice from which they were selected. They comprise the details of eighteen nurses, seven doctors and eight patients.

		NURSES		
Code letter	**Age m/f**	**Current Specialty**	**Career level**	**Years in current post**
A	36 F	General surgery	Senior sister/ Clinical specialist	4
B	41 F	Care of the elderly	Senior sister/ Clinical specialist	5
C	38 F	Intensive/critical care	Senior sister/ Clinical specialist	10
D	41 F	Cancer care	Specialist nurse	10
E	42 F	Endocrinology	Specialist nurse	5
F	43M	Head and Neck department	Charge nurse	4
G	45M	Research and Development	Charge nurse	2
H	32 F	Acute general medicine	Ward sister	3
I	38 F	Care of the elderly	Ward sister	6
J	38 F	Renal medicine	Ward sister	2
K	30 F	Haematology	Ward sister	4
L	32 F	General surgery	Senior staff nurse	8
M	34 F	Female surgery	Ward sister	5
N	48 F	General surgery and medicine	Clinic staff nurse	8
O	50 F	General surgery and medicine	Departmental sister	20

P		Withdrew		
Q	48 F	Infection control	Specialist nurse	12
R	38 F	Orthopaedics	Ward sister	9
S	32 F	Cardiac medicine	Ward sister	3

Table 1. Population and Sample: Nurses; n = 18

		DOCTORS		
Code letter	**Age/ m/f**	**Current Specialty**	**Career level**	**Years in current post**
T	50 M	General and breast surgery	Consultant	10
U	42 M	Trauma and surgery	Registrar specialist	13
V	36 M	Surgery and urology	Registrar on rotation	5
W	25 M	Colo-rectal surgery	Junior House officer	1
X	40 M	Breast and vascular surgery	Registrar on rotation	5
Y	24 F	Surgery/urology	Junior House officer	1
Z	25 F	Vascular surgery	Junior House officer	1

Table 2. Population and Sample: Doctors; n = 7

		PATIENTS			
Code letter	**Age M/F**	**In patient ward specialty**	**Previous in-patient hospital experience**	**Length of current stay**	**Occupation**
A	74 M	General surgery	Yes	21 days	Priest
B	34 F	General surgery	Yes	4 days	Health worker
C	76 M	Vascular surgery	Yes	28 days	Council worker
D	69 F	Acute medicine	Yes	15 days	Housewife
E	59 M	Colo-rectal surgery	Yes	19 days	Government officer
F	39 F	Head and neck surgery	Yes	5 days	Government officer
G	72 M	Cardiac medicine	Yes	10days	Fireman
H	65 M	Urology	Yes	7 days	Teacher

Table 3. Population and Sample: Patients; n = 8

Interviewing nurses

The ethical issues surrounding interviewing one's peers is emphasised by Platt (1981), who advised that the boundaries of the research process might be different when interviewing colleagues working in the same environment. There may be certain expectations or constraints experienced within the interview relationship. It is important therefore, to ensure that a relationship of trust and ethical sensitivity relating to any disclosure exists both during and after the interviews have taken place (Rubin and Rubin 1995). Permission had been gained from the Director of Nursing to approach nurses working at several different hospitals within an acute Trust. However, Kvale (1996, p.112), states, "institutional consent may imply a subtle pressure on employees to participate". It was important therefore to ensure that participants felt no coercion to cooperate with the investigation. This was assured by requesting volunteers through the distribution of information sheets to various groups of nurses, thus allowing participants to reply by letter only if they wished to take part. Eighteen nurses participated in the study, and each participant's confidentiality was protected by changing names to letters, and omitting any identifying features. No information regarding any identifiable findings was given to anyone, although, as Platt (1981) also found, due to the nature of the health care environment, other staff members became interested in their colleagues' responses.

Interviewing doctors

The doctors' interviews were governed by the same principles as those of nurses and patients. Confidentiality, anonymity, and informed consent remain

constant for all groups. I received permission from the Medical Director (medical equivalent of nursing director) to write to the doctors informing them of the study and inviting their participation. Fontana and Frey (1998) emphasise the importance of finding an insider to facilitate access to the group under investigation, and I was fortunate that a senior consultant was supportive of the study, encouraging his colleagues to volunteer. As previously stated, a group of doctors from all grades were selected to receive a letter requesting volunteers to take part in the study, and seven doctors were interviewed. I had some concerns regarding my ability to conceal their identity when writing the results, as they were a more easily identifiable group due to their gender and practising area of expertise, such as medicine or surgery. However, this was accomplished through the same method as that of the nurses, by using only letters and their position of junior doctor, registrar or consultant. Chapple (1997) in her study with general practitioners accepts that doctors are an elite group, and as such, she encountered difficulties in disguising their identity. However, my problems were not those of an elite group, but that their specialism could lead to identification. This was addressed by describing their speciality in broad terms .

Interviewing patients

Initially, I had concerns regarding the inherent imbalance of power between nurses and patients, in favour of the nurse. This places a moral obligation on those nurses who undertake research, as the relationship between nurse and patient is underpinned by trust, and patients have a right to make a free choice with no duress or coercion used to persuade them to take part (R.C.N. 1998).

Due to their vulnerability within the hospital environment, obtaining permission to approach the patient participants was more complex, and potential barriers needed to be addressed. I had gained ethical approval from the Local Research Ethics Committee, with written permission from the Nursing and Medical Directors of the Trusts to conduct the study. However, Rose (2000) identifies several factors affecting access to participants, particularly when involving entry through other staff who may not be so enthusiastic about the investigation. Although it is a nurse's duty to protect vulnerable patients, this cannot include taking the decision to exclude them on their behalf. Therefore, in order to facilitate this process, I saw each of the ward sisters personally to give them a brief overview of what was involved and to seek their permission to distribute the information letters in their ward dayrooms, and also to seek their cooperation in collecting the letters from patient volunteers. However, I was aware of the ethical dilemma posed by interviewing patients from the ward on which I worked, comprising a large number of men undergoing surgery. One concern was that patients would feel obliged to take part, and then tell me what they thought I wanted to hear. Another, that their treatment would be favourably influenced by taking part, contravening the principle of justice (R.C.N.1998). Nevertheless, to exclude a sample of male surgical patients would possibly exclude a significantly articulate group who would enjoy participating in the investigation. My responsibility therefore was to ensure that if any of this group volunteered to take part, their choice was informed and freely made, and that they understood there would be no preferential treatment. I made no reference to the study, unless directly asked, and the information leaflets and letters of consent were made available in the ward

dayroom for patients to read and return to me via the internal post, should they choose to take part. This was the same procedure which would apply throughout all the areas where patients were invited to participate, and eight patients took part in the investigation.

The interview relationship

Weiss (1994) presents the interview relationship as a research partnership between interviewer and participant, where knowledge of particular issues relevant to the study is gained. By its very nature, the process of qualitative research cannot be viewed as neutral or objective, as the research approach is influenced by the status, gender and the personal culture of the researcher (Denzin and Lincoln 1998). I was aware that my status would be regarded differently by each of the three groups. As a nurse, I was a peer of nurse participants, and hopefully this would present a positive effect on my access to their feelings. When interviewing doctors, particularly senior ones who were male, and thus part of a traditionally influential group, my researcher role could be subtly influenced by the power relationship between medicine and nursing (Snelgrove and Hughes 2000). Denzin's (1989) suggestion that the hierarchical relationship between interviewer and participant is typically in favour of the interviewer did not appear to apply in this situation, and during the interviews I emphasised the research rather than my nursing role. I was sensitive to the knowledge that doctors in senior positions, and with whom I worked, were prepared to share their thoughts with me. Again, I referred to Chapple (1997) who stresses the importance of meticulous preparation when

interviewing doctors, whose time is always limited, and I ensured that as far as possible I would be able to answer any questions they might ask.

The interview relationship was once again different when interviewing patients. Wilde (1992) describes the 'luggage' nurse researchers take with them as part of their current occupational role. She suggests that it is extremely difficult to separate one's usual method of interaction from the research interview, and cites several areas which could inhibit the interview, such as premature summarising and reflection. The humanistic nature of nursing, providing comfort, and acknowledging unspoken needs (Crowe 2000), can predispose to an interview where participants, as patients, have been unable to voice their true opinion, because the researcher as nurse, pre-empts the replies. This was indeed a danger to guard against, and on one occasion when the participant was rather tense, led to a discussion of her family rather than the role of the nurse until she felt at ease to continue. Kvale (1996) states that the interaction in an interview is not just reciprocal, but that there is a "definite asymmetry of power" (p.126). This could have presented a moral difficulty in my position as a nurse interviewing patients, but was circumvented by emphasising the respect and need for the participants' own thoughts and feelings, and their value to the investigation. I did this by explaining the importance of their thoughts to the study, that their opinions were a valuable contribution to the investigation, and that although I had my own ideas, they would not be disclosed at that point. The challenge was to expand my understanding of the participants' worlds, and to share the definitions of their interpretations using the interaction between the participants and myself to

construct knowledge of their environment. The meanings they derived from their social interaction must be observed from the context of that interaction (Baker et al. 1992), that is, I needed their own thoughts as patients who were observing nurses within the health care environment, to understand their perceptions of any changes. I ensured that I did not wear my uniform when interviewing and the majority of the patients' interviews took place in their own homes. By using the interview as a means of social enquiry, and myself, the researcher as the tool of enquiry, I attempted to develop and clarify the participant's thoughts and feelings through our conversations. This exchange was determined by questions and answers between us, as proposed by Wilde (1992), and reflected the significant personal social processes the participants used to define their reality and understanding of the changes taking place, for example the limited time of the doctors but perceived unlimited time of the nurses.

One of the canons of grounded theory is the unique relationship which exists between the researcher and the participants. Cutliffe (2000) describes the researcher as the most sensitive instrument available to analyse individual meanings. I remained aware that my own views could influence the participants, and endeavoured to remain objective when pursuing a train of thought from them. However, establishing a rapport with the participants is significant in eliciting sensitive information, with the need to build a harmonious relationship to allow for disclosure of thoughts and feelings. This promotes a unique intimacy shared during the interview process, which I found

encouraged the participants to feel comfortable in revealing their views, as identified by Sorrell and Redmond (1995).

Weiss (1994) assumes that unbiased researchers cannot exist, as they are present in every stage of the study. As the basis for the study was founded on my own experiences, and my role in the research one of exploring the many issues pertinent to the participants, I would indeed be present at each stage. Keddy et al. (1996) describes the grounded theorist as living with the data, as they permeate our own values and intuitions. The relationship between myself as researcher and the participants, and consequently the data, cannot be discounted. Indeed, Steier (1991) suggests there is a process of construction between the participants and the investigator and sees research as an intervention, while Simmons (1995), posits the researcher as an active member of the participants' worlds. However, the methodological dilemma described by Lofland and Lofland (1995) of the need to naturally possess an understanding of the area under study while distancing oneself from it in order to better understand the underlying issues, highlights the instrumental role of the researcher.

Janesick (2000) claims that qualitative research can never be value or bias free, therefore as the instrument of enquiry, the researcher's subjectivity needs to be addressed. My own role as a nurse gave me particular insight into many of the issues which concern nurses. Working with doctors, and caring for patients also contributed to my knowledge of areas for discussion regarding the current changes, although I was aware of a possible disparity in the focus

between these groups and myself. Recognition of these potential biases, and awareness of my own inclusion in the social context under investigation, and thus the research process, enabled me to monitor myself by keeping a reflective diary.

Data collection

The interview data were collected between 1998 and 2002. As suggested by Strauss and Corbin (1998), the original sample of nurses were revisited in 2000 by reviewing their transcripts in order to confirm that their data remained meaningful. Data from the literature continued to be collected until 2004. The nurses' and doctors' interviews were carried out in several different areas such as an unoccupied isolation unit, a counselling room, or an empty office early in the morning or late at night. All the participants were offered the opportunity to have the interview conducted in their own homes if they wished, although due to the wide geographical, mainly rural, area from which they came, it was generally decided that it would be more convenient to carry this out in the work setting. All but one of the patients preferred to be interviewed in their own homes.

The demands of grounded theory are that data collection and analysis continue together, as collection, analysis and theory stand in a reciprocal relationship to each other (Strauss and Corbin 1998). Indeed, they suggest (p.46), that there should be a 'fluid and skilful application' rather than a rigid adherence research procedures. Fontana and Frey (1998) suggest that an unstructured group interview may be used to initially explore the

appropriateness of the chosen methodological technique. Consequently, the first interview with nurses comprised three clinical nurse specialists together, and as 'information-rich' (Blumer 1967) served the valuable purpose of identifying many significant issues. Subsequently, each interview was carried out individually. All of the participants, regardless of which group they were in, were asked to tell me about how they saw the changing role of the hospital nurse, thus allowing them to follow their own individual agenda. Each interview was recorded on tape, and occasionally a few points, such as hand movements or grimaces were recorded by notes. Tape recorders however discrete, remind the participants that there is a record of their conversation and can be the cause of constraints in the interview (Weiss 1994). Indeed, it is a common understanding among qualitative researchers that when the tape machine is switched off at the end of the interview, pertinent data are revealed which have not been recorded (Weiss 1994, Kvale 1996). In these circumstances, I asked the participants for permission to use the information, and if granted made notes of the relevant issues. Using a tape recorder can make it easier to respond and direct the issues for discussion. It also captures the "vividness of speech..." (Weiss 1994, p.54), the nuances and complexities of which would be lost through other methods. Transcribing recordings verbatim allows participants' comments to be examined and quoted in the results, and the richness of the data promotes the discovery of issues important to the participants (Silverman 2002).

Coding the data

There are several coding procedures relevant to data analysis in grounded theory methodology. Microanalysis of the data, according to Strauss and Corbin (1998) involves both open and axial coding. The initial process of open coding identifies many concepts, their properties and dimensions in the data. Axial coding is the procedure by which data are systematically regrouped after the initial open coding. This is conducted by making new connections between categories through a combination of inductive and deductive thinking in relation to the causal conditions or variables of a phenomenon, the context, intervening conditions, any actions and the consequences of these actions. Thus, the participants' actions and interactions are analysed within the cultural and historical context of a hospital. Selective coding is the process through which these categories are then refined and integrated. This integration is the result of the researcher's immersion in the data and consequent recognition of the emerging theoretical concepts. Theoretical comparisons increase researcher sensitivity by raising questions regarding the emerging theory and drive the further collection of data through theoretical sampling. Indeed, according to Kuzel (1992, p.41), "who and what comes next, depends on who and what came before".

Theoretical sampling

Theoretical sampling is the systematic collection of data driven by evolving concepts and maximises the opportunities for the comparison of differences and similarities (Strauss and Corbin 1998). Its cumulative effect enables the categories to become denser and focuses the direction of further data. Thus, the issues raised during participants' interviews were used to guide the

exploration of subsequent areas, grounding the theory in the data. Theoretical samplings with nurses produced similar findings in that group, although gender differences were reflected in senior nurses with long clinical experience, and doctors and patients were asked to develop concepts raised by nurses and by themselves. However, although I endeavoured to reflect gender, speciality, experience and length of hospital stay, there will have been limitations in the sample. This is discussed in Chapter 6. Theoretical sampling allowed me the opportunity of pursuing the issues which were important to the participants, and collecting data by developing questions related to their particular perspectives. The literature was examined together with the data, to explore, to confirm or to disconfirm the emerging theoretical ideas, and to describe and explain the social processes taking place from the participants' perspectives (Strauss and Corbin 1998). Thus, the emerging theory remains conceptually dense, reflecting the relationships and interactions embedded in the data. As the data were collected from participants from each group, they were compared with previously collected information relevant to that group. According to Strauss and Corbin (1994) the emerging theory is grounded in the information which develops from the beliefs and behaviour of the participants in the investigation, thus representing the creative and interpretive nature of their worlds. At this stage the data analysis for each sample group remained separate within each set of data, although analysis of the initial data from the nurses had provided the thrust for further investigation. The collection of further data were guided by the ongoing analysis, driving the process of theoretical sampling, by following the theoretical insights into the emerging theory. Theoretical sampling

directed the inclusion of doctors and patients in the study, due to the impact of these two groups on the nurses' data. Data saturation was indicated by the repetition of previously collected data, which confirmed the information originally obtained, and the interviews with each of the three groups continued until no new significant concepts were identified.

Issues of validity and reliability

The question of validity and reliability relates to measurements used more frequently in quantitative research. However, the ability of the researcher to demonstrate the integrity of the investigation is crucial when considering the value of the results. Data are usually collected in the participants' own setting (Meadows and Morse 2001), with the investigator learning about their world, and the results are thus seen as highly valid. Nonetheless, Mason (2002) maintains that within the holistic context of a qualitative study, the validity and reliability, or criteria for rigour, will be influenced by the participants, the method of data collection, researcher status, and the social context where data are collected. Qualitative researchers try to describe the situation in its totality to capture the validity of their interpretation and thus include all data relevant to the context in which they are collected (Glaser and Strauss 1967, Strauss and Corbin 1998, Glaser 2001, Mason 2002). Therefore, my observations and data collected through my field notes, as well as the interviews, describing how the participants react in different environments and their relationships with others, are portrayed in the analysis in order to illustrate the significance of the setting.

Sandelowski (1986, p.29), states that, "Every human experience is viewed as unique, and truth is viewed as relative". The truth value of a qualitative investigation relates to the lived experiences of the participants taking part, and is therefore subjective in nature. They provide an inside perspective of the situation, by describing their own thoughts and ideas. Excerpts from interviews provided evidence and examples of participants' lives and experiences. They facilitated understanding of significant issues, promoting identification with them (Weiss 1994). Reliability refers to the consistency of the investigation, and whether it can be repeated and the results replicated. Much of the data in qualitative research depend on the unique relationship between the investigator and the participants, and it is well recognised that this very uniqueness poses problems in replicating a study, unless it is possible to reconstruct the original strategies (Le Compte and Goetz 1982, Morse et al. 2001). In order to make these strategies explicit and to demonstrate the consistency of the investigation, I have described in detail the course of the research to show how data are produced and collected. Contained within this description are all the components relating to the study, such as my memos and field notes, in addition to the data collected through the interviews. This enables other readers to follow and understand the process of the research, in order to evaluate its worth. Guba and Lincoln (1985) state that credibility, where the participants taking part in the study recognise their experiences in the descriptions, known as 'member checks', is more appropriate as the criterion for evaluating the truth. I attempted to confirm the intended meaning of the data by asking the participants to check a brief summary of the transcript of their interview in order to gain clarification. The credibility of the

investigation is also maintained when other researchers recognise the experience from the written interpretation, through the peer review. According to Duffy (1985), this increases the reliability of a grounded theory investigation. Koch (1994) proposes that by other researchers reading the investigation, evaluating the data, and consistently following the 'audit trail' of the theory, the credibility of the investigation will be sustained. Four other researchers continued to read the investigation as it developed, questioned my links and provided me with feedback, and have understood the process I followed. My supervisors challenged my findings during the process, enabling me to explore and explain the data. Holloway and Wheeler (2002) maintain that as well as credibility, transferability, - how the findings could be transferred to a larger group, dependability, - where the credibility of the study is sustained through auditing of the process externally, and confirmability - where data are directly correlated with their sources, are required to substantiate the trustworthiness of a qualitative study. These terms describe the degree to which the investigator has made the method and interpretation of events explicit, demonstrating their authenticity by analysing the findings, and concluding that the final results are a genuine account of the investigation. To achieve this, I have described the research process in detail, and constantly reviewed data for identification of personal bias. The analysis of the data, and the results of the investigation have been documented with quotations from all the participants who were interviewed, with my field notes, memos and personal reflections of any relevant experiences during the study, thus establishing that the findings have evolved from the personal perceptions and experiences of the participants and their world (Sandelowski 1994). Indeed, Goulding (2002)

states that the process of grounded theory itself strives towards verification through the saturation of data.

The extent to which the theoretical constructs of the study can be applied elsewhere is often difficult to achieve in qualitative research. However, within the health care culture, researchers working in similar environments in other geographical areas are frequently able to identify with the images portrayed through detailed description of the participants' experiences. Transferability refers to the ability to transfer the findings to a similar context, as others recognise the significant issues raised in the analysis. The overall culture within health care is generally recognisable, and the nursing press frequently acts as a medium for disseminating information. However, explicit and detailed description of the research process and results enables these to be acknowledged and identified by those working in the health care environment, thus validating the credibility of the research (Denzin and Lincoln 2000).

Data analysis

The interviews from all participants have been transcribed verbatim. The tape recordings of the initial interviews of each separate group were coded in detail, and the transcriptions were examined line by line, to identify similarities in the data, as suggested by Glaser and Strauss (1967). This intense coding produced an immense amount of written text for analysis, and justifies the claims of many grounded theorists that the researcher is an instrument of the research process and needs to interact with the data (Morse 1994, Denzin and Lincoln 2000). The initial interviews of nurses alone produced more than

1,300 different codes, emphasising, to me, the variety and intensity of the many issues affecting the changing role of the nurse. Indeed, Morse (1994) suggests that the area of interest for a study provides only a 'conceptual template', from which a qualitative inquiry develops. By immersing myself in the data from the beginning of the study, both metaphorically and literally, as each of these codes was listed on separate pieces of paper, patterns and relationships between these codes started to emerge, and were grouped together into categories. These codes and categories provided a basis for further interviews; the transcriptions were examined and coded to constantly compare subsequent data with the data previously collected. Codes which were considered particularly appropriate were those using the participants' own words, known as 'in vivo' codes (Strauss and Corbin 1998). For example 'providing a service' was used to describe what the participants did, and also developed as a category, to describe other issues relating to the nurse's role. This concurrent process of data collection and analysis enabled themes or concepts to become evident by comparing how frequently similar codes occurred, and to develop the advancing theory (Stern 1980). During this time, as more interviews were completed, I collected detailed memos 'in the field', informally observing relevant interaction and behaviour on the ward. I was also approached by nurses not taking part in the study, voicing their views on the effects of the current changes, and gained informal permission from them, should it appear relevant to the study to use this data in my analysis. My belief is that this information will add richness to the data in the analysis by attempting to capture the real experiences taking place in the working environment, congruent with the qualitative worldview of Burns and Grove

(1999) that there is no single reality, although distinct patterns can be uncovered.

As Swanson (2001) suggests, the questions asked change slightly according to the data collected previously, in order to align with grounded theory methodology. Thus, a focussed relationship develops between the themes to form categories. By identifying connections between them, these were merged together under broader headings to develop the major constructs (Strauss and Corbin 1998). A framework is therefore built up inductively from the data, which is then tested and refined. Stern (1980) claims that concurrent, selective sampling of existing literature may further expand the developing theory. Consequently in order to integrate relevant literature into the construction of the emerging theory, I carried out a comprehensive literature search, both manually and by computer, parallel to the data analysis. The literature served to extend the boundaries of my own knowledge as 'researcher as instrument' in the research process and analysis, and to clarify many of the emerging issues. My own awareness of the nursing culture, and my professional experience, described by Strauss and Corbin (1990) as theoretical sensitivity to the research context, enabled me to establish a rapport with the participants which may otherwise have been difficult to initiate. It further enabled the actions and interactions of the subjects under study, through grounded theory analysis, to be understood. Evidence of this will therefore be included in the analysis of the data through my field notes and memos.

This process was repeated when I collected and analysed the data from all groups of participants. As grounded theory methodology develops theory inductively, and the findings are described from the perspectives of the participants rather than the researcher, I made a conscious decision to initially keep the data from the three groups separate, so that the concepts which developed from each group of participants, would demonstrate the views of that group. During the interviews their subjective experiences and the issues relating to those experiences in the empirical world, were explored in depth. However, as the study progressed it became apparent that there were many similarities at a conceptual level, thus the conclusions are presented as a culmination of the data from all three groups.

One of the major decisions in data reduction in grounded theory involves how much of the data to include in the description. According to Patton (2002) there needs to be sufficient description and quotations to enable the reader to enter into the thoughts and feelings of those represented, and to understand the context in which they take place, which Geertz in 1973 described as "thick description". Thus, thick description does not simply indicate what that person is feeling, but presents their emotions, actions, the significance of the events and illuminates interactions and social relationships. According to Janesick (2000), describing in depth the participants' experiences serves toward providing evidence of the validity of the study, by recounting their perceptions of specific issues. The selected quotes from the data express the ideas of all the participants thus forming a pattern of ideas. However, in order to provide a basis for analysis, it is necessary to achieve a balance between description

and interpretation. Grounded theory therefore demonstrates the links between cause and effect (Goulding 2002). Consequently, my choice of grounded theory originated from the idea that this methodology allowed for the participants' views to be explored in depth. According to Glaser (2002), the development of a grounded theory from description to conceptualisation and abstraction, gives the theory explanatory power by representing the data from its earliest analysis. My familiarity with the social context of the health care setting, and my understanding of working practices on the wards, was an advantage which helped me to relate to each of the three groups, albeit in different ways. Thus, my own role as the research instrument may have been perceived differently by each group, as an active or passive member of the participant's environment, depending on their own position as nurses, doctors or patients. I was particularly conscious of the ethical issues concerning the patients as a vulnerable group, and I ensured that any questions were given as full an explanation as possible within the confines of the study.

Qualitative methodology operates on the premise that the researcher represents and interprets the reality of the participants (Mason 2002), and its principal limitations are discussed in this chapter. From the perspective of grounded theory an extensive literature review is not advised at the start of the study, but rather as concurrent to data collection in order to minimise previous influences. Data collection is driven by the direction of the emerging themes potentially limiting the openness of the data. Nonetheless, grounded theory encourages the exploration of negative cases, where the participants do not follow the expected trail of reasoning, and data are collected which support an

alternative perspective of the study. These help to clarify the meaning of the patterns and define the limits (Strauss and Corbin 1998). Johnson et al. (2001) propose that modification increases rigour. Indeed, they quote the conflict between Glaser and Strauss in the 1990's as evidence that there is no purist form of grounded theory, and propose that the qualitative research traditions, including grounded theory, are products of negotiating the social reality of the participants and are therefore flexible in their interpretation. However, the acquisition of any data contribute to the study, whether they are formally included in the analysis or add to the background concepts to explain a line of reasoning or participants' perspectives.

Having studied the arguments supporting both computer and manual analysis (Morison and Moir 1998) and the interactions required between the researcher and the data to define meaning (Denzin and Lincoln 2000), I chose manual analysis as more appropriate for understanding the social mechanisms and processes of the participants. However, manual analysis in grounded theory requires the commitment of a large amount of time and space, in order to capture relevant themes and ideas from the data. Although many authors discuss the method of analysis in detail (Strauss and Corbin 1998, Denzin and Lincoln 1998, Schreiber and Stern 2001), the practical details of writing out all the codes, categories and constructs are frequently omitted. The advantage of this however, is that interaction between myself as the research tool and the data take place at a creative level which it may not have been possible to achieve in the same manner if I used computer analysis. Although the number of participants in a grounded

theory sample is smaller, the richness of the method produces a vast amount of data. Indeed, supporters of the quantitative paradigm tend to criticise grounded theory for its small sample numbers, which may be viewed as limiting the generalisability of the results. However, the lateral and in depth thinking promoted by this technique repudiates this argument through applying the substantial dimensions of the method to collection and analysis of the data. Thus, although the findings cannot necessarily be generalised, the theory or theoretical ideas can be. Indeed, Haig (1995) maintains that grounded theory as a scientific method is the most comprehensive methodology available in qualitative research, contributing to the richness of the data and explaining the results of a social enquiry. I have attempted to clarify in detail the methodology of grounded theory, so that the reader can follow the particular elements of this process. However, Morse (2001) warns that the domain of validity can be threatened by simplistic portrayal of complex issues, although the process of linking concepts and interactions validates and increases the utilisation of the original concepts. Indeed, the social interactionist nature of this method presents as particularly relevant to the issues surrounding the role of the nurse, allowing me to uncover the layers of impressions and insights of all three groups. Therefore, I initially started the investigation by interviewing nurses and their findings are presented and discussed in the next chapter.

CHAPTER 3

NURSES' PERCEPTIONS OF THEIR ROLE

Introduction

This chapter demonstrates and discusses the findings of the interviews with the nurse participants. Nurses were the first group to be interviewed, and this was due in part to my own professional background and also that they appeared the easiest group to approach. Table 1 is repeated here to reiterate the relevant information pertaining to each participant.

		NURSES		
Code letter	**Age m/f**	**Current Specialty**	**Career level**	**Years in current post**
A	36 F	General surgery	Senior sister/ Clinical specialist	4
B	41 F	Care of the elderly	Senior sister/ Clinical specialist	5
C	38 F	Intensive/critical care	Senior sister/ Clinical specialist	10
D	41 F	Cancer care	Specialist nurse	10
E	42 F	Endocrinology	Specialist nurse	5
F	43M	Head and Neck department	Charge nurse	4
G	45M	Research and Development	Charge nurse	2
H	32 F	Acute general medicine	Ward sister	3
I	38 F	Care of the elderly	Ward sister	6
J	38 F	Renal medicine	Ward sister	2
K	30 F	Haematology	Ward sister	4
L	32 F	General surgery	Senior staff nurse	8
M	34 F	Female surgery	Ward sister	5
N	48 F	General surgery and medicine	Clinic staff nurse	8
O	50 F	General surgery and medicine	Departmental sister	20
P		Withdrew		
Q	48 F	Infection control	Specialist nurse	12
R	38 F	Orthopaedics	Ward sister	9
S	32 F	Cardiac medicine	Ward sister	3

Table 1. Population and Sample: Nurses; n = 18

Eighteen nurses were selected for interview after replying to the letter requesting volunteers. The first interview consisted of three senior nurses interviewed together as a small group in order to obtain a feel for significant issues, as suggested by Fontana and Frey (1998), and the remaining fifteen were interviewed individually. They were selected from several different grades, worked in various specialities such as medicine, surgery, and orthopaedics, and specialist roles such as breast care and infection control, and both male and female nurses took part. They are identified by job title as follows: S., for female sisters, C/N., for male charge nurses (equivalent level of sister), C.N.S., for Clinical Nurse Specialists, Sp. Nurse, for Specialist Nurses and S/N., for Staff Nurses.

Each tape-recorded interview took approximately one hour, and, as described in the previous chapter, all interviews were transcribed verbatim. The transcriptions of the initial interviews were coded in detail, and were examined line by line, to identify similarities in the data. From the coding and comparisons of the data, four major constructs evolved.

The major constructs

Four major constructs evolved through constant comparison of the data. These are: 1) *providing a service*, 2) *being ambitious and getting on*, 3) *drifting away from the patients*, and 4) *making choices*. Throughout the data analysis there appeared an underlying feeling of moving forward. This is represented by Figure 1.

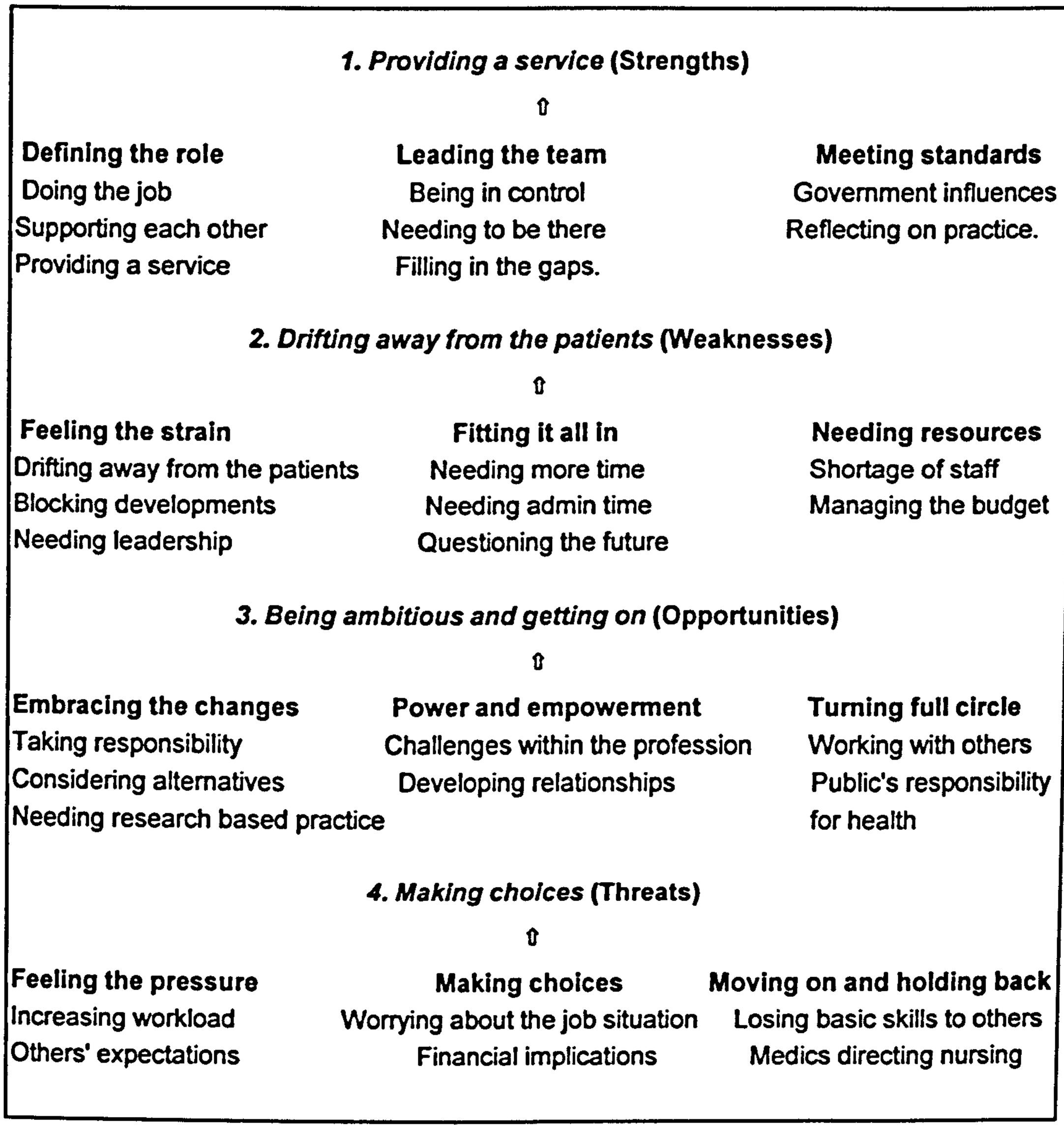

Figure 1. Categories forming the four major constructs developed from nurses' perceptions.

The constructs are not linear, but interlink with and relate to one another, identifying the equal significance of each within the theoretical framework. They further understanding of how the participants developed their practical skills but were cautious about the reasons and where this would lead in the future. The development of the category, 'moving on and holding back' was particularly influenced by this underlying feeling of the need for cautious development within the nursing role. Indeed, the constructs themselves

developed inductively as strengths, weaknesses, opportunities and threats. The analysis demonstrated, however, that the nursing role was constantly developing, that nurses perceived they were progressing regardless of all the influences, as displayed in Figure 2. The influence of the medical profession, however, and the areas surrounding it, on the practice of the nursing role was an issue which was highly significant in nurses' perceptions.

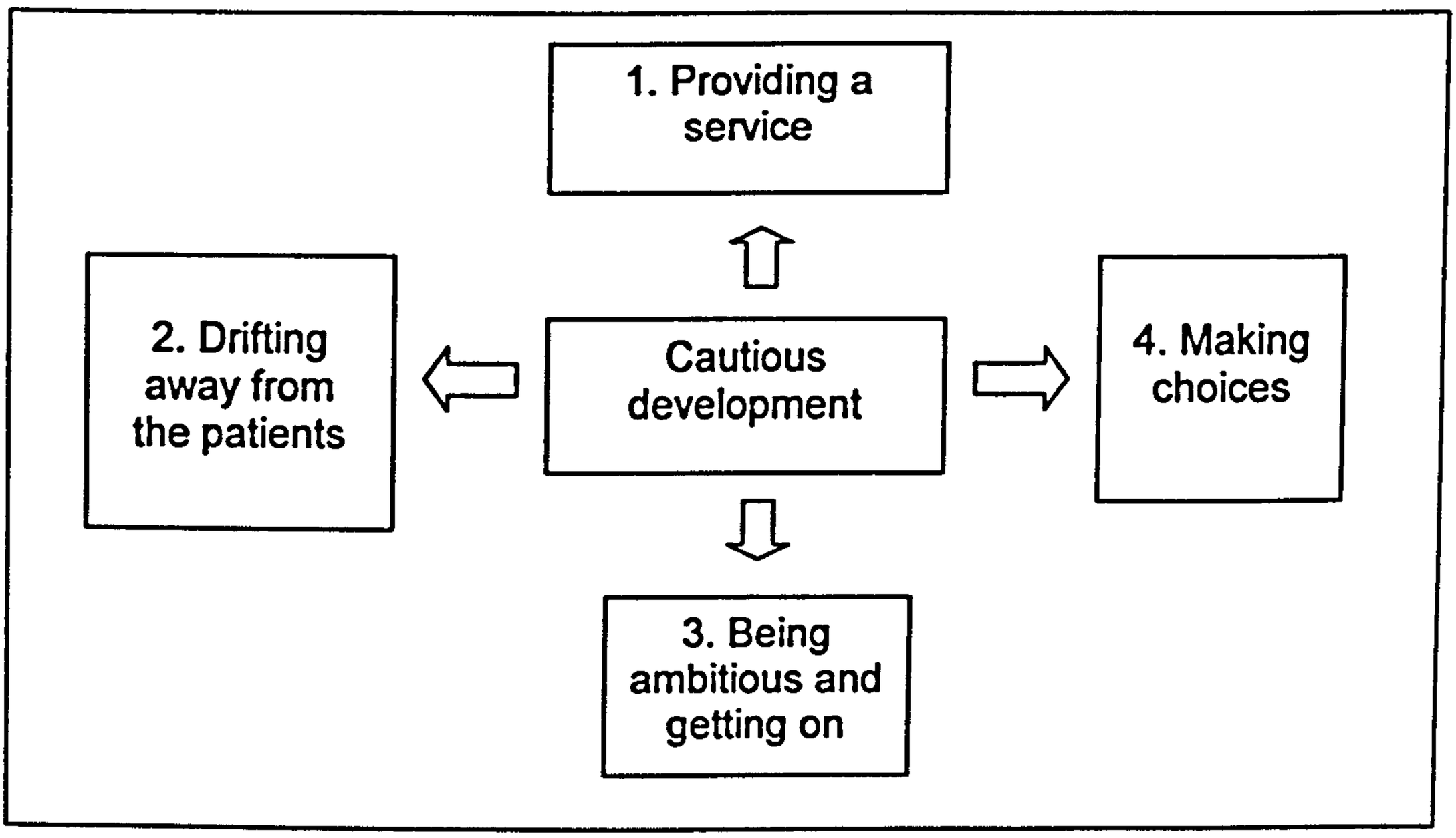

Figure 2. Diagrammatic representation of the framework of nurses' perceptions.

Overview of the theoretical framework: the four major constructs

1. Providing a service

Nursing is traditionally and historically concerned with providing a service, both to the patient and to the organisation, and the nursing role is an integral part of the health service in this country. For the nurses, service provision was seen as a strong part of the nursing role. Nurses recognised that the

definition of their role included providing a service to the patients, and involved doing the job, supporting each other and leading the team. The effects of governmental influences and the political agenda, meant that they were constantly aware of the need to meet the standards set both by the nursing profession itself and outside agencies such as the District or Strategic Health Authority.

2. Drifting away from the patients

This was seen as a weaker part of the nurse's role. Some nurses found there was a significant lack of resources such as time, money and staff. Fitting it all in became a high priority, needing a lot of energy and commitment from those in a more senior position. This led to questioning the future of the nurse's role, and in some instances, blocking development.

3. Being ambitious and getting on

Several nurses saw this as an opportunity to develop, were happy to embrace the changes, and expand their role accordingly. The opportunities presented by expanding their role was for some, a chance to develop themselves and their own role appropriately. The challenges within the nursing profession, the need for research-based practice, and empowerment through developing effective relationships with their managers, presented as opportunities for positive change.

4. Making choices

Some nurses saw the changes as a threat to the nursing position of caring for the patient. Outside pressures such as the government's medical agenda for improving junior doctors' working conditions, were viewed by some as threatening the very essence of the nursing role. Not only did they feel that the medics were directing nursing, but also that they were losing some parts of their role to others such as support workers and nursing auxiliaries.

Each of these four major constructs contained within them the factors which identified how the participants wished to move forward in their role, but were cautious about the changes. Caution was expressed both positively and negatively by holding back, however, the participants recognised that changes would take place nonetheless. Their concerns were balanced with their aspirations to develop and expand what they did in order to benefit the patients that they nursed. These issues identify the reciprocal relationship of each of the four constructs, as previously demonstrated by figure 2. Each construct is discussed separately to illustrate the inherent relationships between the categories they contain.

1. Providing a service

When asked about their professional role, nurses elaborated on its functions, their own and others' expectations, and the way this had changed over time. To understand the role of the nurse, it is necessary here to explain some of the fundamental elements which influence the formation of that role before examining the changes that affect it. Each professional group has a particular role which its members have been afforded by society or have developed through their own individual construction and socialisation. Thus, in order to understand the concept of role in relation to nursing, I will discuss the conceptual basis of role learning, as to examine this role it is necessary to know how it is learnt.

Learning the role: socialisation into nursing

Socialisation is the process through which, from a very early age, individuals learn about their society and their own place within it. Primary socialisation usually takes place within the family where individuals learn the values of their culture and its norms and rules. Secondary socialisation occurs when individuals enter the wider world, in particular an occupation where they need to learn the boundaries and constraints of other occupational roles (Joseph 1991). People learn to take their roles by internalising the normative expectations of that role, thus becoming committed to them and making them their own. In this process, individuals take on or reject certain aspects of their role, choosing those elements which they see as necessary or desirable. Different people are sensitive to different conditions, which affect their own abilities and preferences for a particular role. To become a nurse

requires a lengthy induction into that role through education, training and knowledge of competencies and ethical principles. Howkins and Ewens (1999) who examined the professional socialisation of student nurses in the community setting found that students continually reappraised their role as they gained greater understanding of its purpose. Learners' ideas are shaped through a system of rewards and restrictions, in order to achieve the desired goal of competent practitioner. Thus, the formal role within a profession is defined by that profession, includes the functions assigned to that role and is shaped by the position of the role holder. Conversely, the informal role is the role taken by individuals, driven partly by their personalities and preferences and partly in response to the expectations of their own group, and their clients and colleagues. Mead (1934) spoke of the concepts of the 'I' and the 'me'; the 'I' is the creative and individual aspect of self, while the 'me' is that which is influenced by others. This attempts to achieve a balance between tensions by reducing anxieties and meeting emotional needs.

Role making and role taking

The concept of role taking was also introduced by the sociologist Mead (1934), and is generally accepted as the originator of symbolic interactionism (Porter 1998). Mead's essentially philosophical focus was the human self, and our ability to think reflexively and evaluate our own thoughts. Goffman (1959) uses the metaphor of drama to explain how the person - the self - is performing a role, how everyday interaction is influenced through social meaning. The social actor performs the role partly following the dramatists'

words and expectations but also bringing to it his or her own interpretations. By presenting a mask in the public arena, impressions and meanings are conveyed to others to confirm the individual's real or ideal identity. Through using this interaction as the medium for information exchange, the actor's social role and the audience's expectations are brought together, establishing the credibility and attributes of an expected role. Further, Goffman (1959) distinguishes between appearance and manner, with appearance often regularised within a culture ritualistically informing others of their status. Manner, however, strives to explain to others how the role is performed, and the expected norms associated with that particular role. Thus, Goffman's (1959) perspective on the presentation of self in society provides a framework which could be employed in any discussion of role. Individuals in work situations present themselves to others by performing a role, and others seek to obtain information about them to help define the situation and to meet reciprocal expectations. However, the expectation from doctors that nurses will behave in a particular - possibly subservient - manner, and from patients that nurses will behave with an angelic demeanour, is sometimes inconsistent with perceptions of the nurse as autonomous and confident. According to psychologists such as Gross (1987), understanding human behaviour depends on regarding it as social in nature. The interaction which takes place in the presence of others influences our behaviour, and indeed, even the way in which we behave in private has been affected by social contact. Human behaviour tends to be participative and our actions are based on the perceptions we have of others and their behaviour. This was strongly emphasised by those nurses attempting to define their role to me,

and included their expectations of themselves. The norms of a person's particular role regulate dress, demeanour and expression, and help an individual to take on a role and be perceived by others as fitting that role. Goffman (1959, p. 13) describes these as "sign vehicles", which allow others to acquire information about the individual. Thus, the nurse's role requires that they wear a particular style of uniform, from which others assume they have the knowledge, skills and expertise to carry out that role. Conforming to the group norms gives individuals a sense of identification with others defining the boundaries of, or inclusion in the group. Goffman (1961) suggests that the organisation of our society holds that any individual who possesses certain social characteristics has a moral right to expect to be treated in a certain way. Nurses have within their role specific expectations of themselves, while patients, other professionals and the organisation in which they work, might have somewhat different expectations.

Defining the role

The previous section establishes the multifactorial elements contained within a role, and demonstrates that these are subject to many influences. Initially, most participants tried to give a definitive description, however, this only served to identify the complexity of their role, and as the interviews progressed, this complexity was explored in greater depth. A variety of functions were perceived as contributing to the larger role, and this depended on the individual's place in the organisational structure. An organisation is a macro social entity, an establishment with its own cultural norms and social principles frequently embodied in professional codes of practice and quality

management. The organisation defines the roles of those required to function within it, driving individuals to internalise idealised social values. One of the related theoretical statements of symbolic interactionism is that feelings about ourselves and our behaviour are influenced by labels we attach to individuals, and according to Porter (1998, p. 87) " an act only becomes symbolic if there is a shared meaning to it." Attaching a label of doctor, nurse or patient to a person immediately projects an image of a particular role and status applying to that person. Individuals are required by society to play and perform particular roles, and one of the key concepts of role theory is that of status position, - that a position an individual occupies in a society's structure can be achieved or ascribed, with specific behavioural expectations attached (Handy 1985). Behaviour, feelings and attitudes are a function of reference group influence, and an individual's self-perception is largely guided by the evaluation of others. Nurses operate in the public domain, nearly always on view to patients and other staff, with their own self-image constantly interacting with the expectations and perceptions of those for whom and with whom they work. Indeed, the post modernist notion of self-concept, according to Schreiber and Stern (2001), concurs with the position of symbolic interactionism in that we continually reconstruct our meanings about the world in which we function. Creating and recreating meaning within a local context is the basis for the understanding of action and interaction in grounded theory. Indeed, to perform a role in any setting requires action and interaction, and within the health care field all performers are observing or being observed, exposing private actions to the public gaze. The impact of this exposure whether physical or psychological, has been a

constant element of a patient's vulnerability, with maintaining privacy and dignity at all times an integral part of a nurse's role (N.M.C. 2002).

Participants revealed many similar aspects. All agreed that the nurse's role had multiple facets, and that it was continually changing over time. Many of the more senior nurses such as ward sisters and clinical nurse leaders, who had a clinical role and organisational managerial responsibilities, identified some of the difficulties with this complexity. Although the role was deemed difficult and many of the changes added other dimensions to their roles, nurses with a higher level of specific clinical expertise believed their skills were being used in the correct manner.

> *I think sometimes the clinical nurse specialist (sister/ward leader) is an impossible role with a busy ward, and trying to dash off to this and that meeting, but I also feel very firmly that clinical people should be doing what we are doing.* (Nurse J.,S.)

This view is supported by Schaefer's (1991) investigation of clinical nurse specialist practice in an American hospital, which demonstrates the significance of the presence of these senior nurses in the clinical area as enhancing the quality of care, and also their own clinical credibility. The dual nature of the clinical leader/senior nurse role was emphasised by the participants in a senior position, and displayed by the way the workload was allocated on the wards. Patient allocation, where a number of patients are allocated to a particular team of nurses, was the preferred method of nursing on most of the wards. The aim was that as far as possible within the constraints of staff numbers and skills, the same group of nurses looked after the same patients on consecutive shifts. In order to maintain this continuity for the more junior staff nurses, the senior nurse/ward sister would move to

different groups on a shift-by-shift basis to fill in the gaps left by days off or sickness. This meant that their clinical role and senior nurse role could be difficult to combine at times, and effective care could depend on defining where one part of the role ended and the other began.

> *...when I'm looking after a patient I want to be totally committed to them because there is nothing worse than a nurse flipping in and out of the curtains all the time...* (Nurse C., S/C.N.S.)

Recognition by other staff of the complexities of the senior role helped some to combine this role effectively, or otherwise, depending on the workload. The allocation of patients was carried out by trained staff on the previous shift, by identifying gaps in staffing - frequently more than one -, and distributing the patient dependency geographically and fairly across the ward.

> *There's one staff nurse that consistently, when she organises the care, gives me four or five heavily dependent patients - the sort you can't leave...or they'll give you people that are isolated in a cubicle so that if there's a phone call you're stuck, and I think that person is trying to make a point. They're trying to say, you know, we've to work hard, 'you' should be looking after patients. There's one person that does that, but there are other people that appreciate that (you have other commitments), they give you two patients (that are) fairly light.* (Nurse B., S/C.N.S.)

Procter (1992), examined subjectivity and objectivity in relation to measuring the nursing workload, and suggested that objective measurement was difficult, and that nurses based their judgement on being able to achieve a certain level of care. The fundamental issues for the nurses centred on the multiple facets that constituted their own personal creation of their role. The complex nature of this was extremely difficult to define succinctly. There appears to be a plethora of definitions, with, nearly always for nurses, the patient as the focus. Thus, the centrality of the patient's role is inextricably linked to the nurse's role. The data reveal the nurses' attempts to perform

according to their professional ideology, and to implement their professional role in accordance with their personal view of its purpose. Bradby's (1990) report on the transition into the occupational role of a nurse, describes how role identity is gained through the divesting of personal identity. She examined four cohorts of nurses to discover the reality of their experiences, and found that it took between six and ten months before identification with the nursing role took place. Service provision operates through each member of an organisation carrying out their own particular role in relation to what is expected of them. However, the role of the nurse consists of multiple facets across a broad range of abilities, including carer, teacher, counsellor and competent practitioner, and is interlinked with their own professional and personal identity.

Personal and professional identity

According to Secrest (2003), who studied how students experience professionalism, professional identity is closely linked to personal identity and socialisation into a role. Thus, professional identity provides a cohesive association with the norms of working as a nurse, and developed strength as the nurse became more experienced. The senior nurses that I interviewed demonstrated this by raising issues which had a more strategic influence, and identifying their roles with the expectations of the organisation. However, the following comments show that for them, professional and personal identity are closely linked. The nurses felt that professionally ,

> *they (nurses) are there to look after the patients.* (Nurse R. S.),

but were sometimes unsure of:

> *whether our actual personal strengths can carry us through (the workload).* (Nurse O. S)

Personal identity is formed from a very young age, through the development of the concept of self. According to Berger and Luckman (1966, 1991) the structure of society and interaction with others influences our personal development of identity. Personal identity contributes to the role of professional identity, as those personal beliefs and values are frequently transferred into the professional role. This was highlighted by Florence Nightingales' demands that a nurse was of high moral character (Holliday and Parker 1997), and indeed, to deviate from this in the service of others was regarded as reprehensible then and remains so now. Nurses who overstep these boundaries are remembered with revulsion, particularly if this includes children (Kendrick and Taylor 2000). The moral structure of nursing particularly since the late 1800's, instils its professional identity with developing ethical values. Current moral and ethical dilemmas in health care relate to expectations and change in our society, with life being prolonged technologically, or terminated according to value judgements by health care personnel or the patients' family (Watkinson 1995, Erlen and Sereika 1997).

Professional identity, according to Fagermoen (1997), develops through the internalisation of the beliefs and values contained within nursing practice. The data from her study revealed the altruistic nature of nursing, with human dignity as a core value. Taylor (1997) affirms that ideology in nursing encompasses the humanistic values necessary to care for patients. Professionals require a framework by which to identify their role in society

with their public image of commitment promoting professional status. Nurses' own perceptions provide a more private view, with their personal identity projecting their feelings and values into their professional persona. Fagermoen (1997) offers nursing practice as a means of self-presentation by nurses, enabling them to actualise their own values. Further, Mordecai (1996) discusses the role of personal identity on the commitment to moral action, with the individual's expression of self-identity as a good person. He explores the reasoning behind the moral choice to act in a certain way, and maintains that people act according to the values they consider essential to their personal identity. He concludes that actions are thus motivated through their symbolic meanings to the individual and anchored in our personal identity. Cooper (1990) exploring the rebuilding of self-identity and esteem in mental health patients, confirms that our identity needs positive reinforcement to maintain a sense of reality. Indeed Pask (2003), reviewing moral agency in nursing supports the belief by nurses that their work is intrinsically beneficial to their patients. Thus, professional identity, personal identity and socialisation into a role are interlinked and affect the individual's view of their own reality. This is essentially true in the analysis of the nurses' perceptions, in that each participant displays their own personal view of their role. Providing a service to patients therefore includes the nurses' personal values and furnishes them with a medium to perform their moral obligations as part of their role. This is highlighted through nurses' attempts to give patients their full attention during simple tasks such as assisting with hygiene needs, and again with nurses' reluctance to leave many of their duties unfinished, thus remaining on the wards when their shift has finished.

Education

The nurses identified that the professional service part of their role included keeping up to date with current education and research. Competence in nursing is measurable, but there are different levels, usually gauged through novice to expert, according to Benner's (1984) framework. The senior nurses acknowledged the obligation to keep themselves informed, and to educate their staff. Practical nursing is taught by example, following instructions from a more experienced or expert colleague. For many of the specialist nurses, this also included their role in teaching their patients and carers how to cope, for instance with giving insulin in the case of diabetics, or administering medication to those with Parkinson's disease or epilepsy. As they see themselves as autonomous nurses it was essential that their knowledge base is congruent with their practice and the patients' needs for information.

The nurses working on the wards were required to have a broader knowledge base, but nonetheless, one which would ensure safe practice. One of the nurses who described post-registration education as "crucial" highlighted the problem of those nurses who had previously gained a nursing qualification some years in the past. Many of these suffered from educational inertia and needed to be inspired to breach the gap between theory and practice. Therefore, the nurses identified the need to support and encourage these staff to develop their knowledge. The nurse's role incorporated the skills of simple counselling, in order to allow team members to relieve their tensions and receive feedback. All nurses felt responsible for

and contributed to the quality of care, this was influenced by the knowledge and skills of the ward team, and the example set by the ward leader.

Teaching through standards of good practice and enabling other staff to follow examples of senior nurses has long been recognised as significant in nursing (Ogier 1982). One senior nurse who worked with older patients with complex medical conditions was especially aware of this,

> *I think that when I give direct care I don't do that in isolation, so it can influence other people and - just my attitude rubs off onto other people as well...so there is an element of ...kind of teaching by role model alone, I'm particularly conscious of it.* (Nurse I., S)

The participants identified the educational part of their role as a significant element in continuing development and change, regardless of their role in the organisation. Hogston's study (1995) of nurses' perceptions of continuing professional education, and its effect on nursing practice, identified the educational process as a fundamental element of the professional role. Education is linked to quality of patient care, and application of learning enhances the professional development of the role. As patients became more informed about their disease and also more aware of their rights within health care, the participants noted that education of both patients and staff became an increasingly meaningful part of their role. Indeed, the recent recognition in this country of the European Convention on Human Rights has ramifications for a significant impact on health care through issues such as consent and right to treatment (Dimond 1999). Nurses as teachers of others, both staff and patients, are an important part of providing professional services. The senior nurses viewed themselves as role models, as did the specialist nurses. Patients, their relatives and carers were taught how to

manage their disease either through medication or being given the choice of alternative treatments. The specialist nurses also had the responsibility for setting up support groups for patients with specific diseases. This enabled the patients to discuss their illness with people in similar position, and to learn about new treatments, or what to expect and how to cope with the course of their disease. This required the nurses to gain an in depth knowledge of their subject and give pertinent advice to their patients. Some specialist nurses found that public awareness, in particular for diabetes and heart disease, and the current process of screening patients for these diseases, led to an increased need for education, which affected and changed priorities within their role.

> *...it's an educative role because people with diabetes have to look after it themselves, and therefore they have to have a lot of information given to them over time.*

And

> *We also teach carers, that's quite an important role for me because I do the paediatric side, but there are also some adults who are also looked after by carers, very elderly people, and (those with) learning difficulties.* (Nurse E., Sp.nurse)

The specialist nurses were conscious of their wider role. This involved supporting patients with a particular disease, particularly those with a concomitant disability, and encouraging them to deal with their illness independently by taking control. Another of the specialist nurses commented,

> *I do see that is what my role is all about, about change within the service, within people, for the benefit of the service and the patients...because we actually serve the whole population, and that involves all sorts of things, teaching, groups, liaising with professionals.* (Nurse D., Sp.nurse)

Specialist nurses have a unique role in health care, and Nurse D. had spent many years in her particular area of expertise. She had seen many developments and changes and her role had expanded to accommodate these. Specialist nurses are required to have a higher level of knowledge regarding their speciality, and have the implicit responsibility to maintain and improve their service (Mc Sharry 1995, Wallace and Gough1995). The specialist nurses that I interviewed were all conscious of the service requirements of their role, possibly because they experienced a greater autonomy with regard to their practice. Although their role was equally as complex as those of the ward sisters, and the ward sister/clinical leaders, it was of a different complexity. Their responsibility and accountability to one or two particular consultants with whom they worked allowed their role to be defined within specific boundaries, within the confines of required service needs. On the wards or in other departments, however, the nurses were answerable to numerous consultants and senior nurses, and were required to have a working knowledge of most medical conditions with which the patients were likely to be admitted into their area. This was emphasised by the comments of a sister working on a general ward, who described the educational part of the role as,

> *Crucial, not only for quality of care, but for P.R.E.P (post registration education and practice) and nurse training. They need to reach the theory/practice gap and encourage people who haven't done anything for years to get moving, and I think to have people who actually do clinical work as teaching...it's probably the best way to tackle that.* (Nurse K., S)

Changes in the methods of nurse training today differ markedly from the 1960's traditionalist era. Nurses now have to reach an academic standard throughout their studentship, which is largely supernumerary, and conducted

and organised through a University background with the last of the old style schools of nursing integrated into higher education in 1995 (Burke 2003). This current education of student nurses is aimed at producing a knowledgeable competent registered nurse, fit to perform and understand the reasons for conducting procedures. This is in contrast to the traditional training where nurses learnt by copying those slightly higher in the hierarchy than themselves. Although the expectations from this training were that nurses would learn by imitation, knowledge for the rationale underpinning practice was not considered significant. Nurses then were not expected to have the same high level of expertise and responsibility which they now require to accommodate the contemporary provision of service in health care. The divergence between training and education continues, with task-orientated learning becoming associated with the untrained assistant, and theoretical knowledge and understanding preserving the core of registered nurse education. Thus, the image of the nurse continues to change, and the traditional and historical background to this image is described here to clarify the impact of this on modern nurses' roles.

Traditional images

The image of the nurse has traditionally been one of a caring, nurturing, subservient female. This image promoted the perception of unquestioning obedience, of a vocation and of following orders, which persisted for decades. However, this image is changing along with the requirements of the role itself, and those functions which nurses are now required to perform. One of the specialist nurses had worked in

community and industrial nursing for some years after training, returning to hospital nursing in the 1980's. She felt that when nurses began to question what they did, it signalled the beginning of the changes for nurses.

> *...(The changes started in the) early 80's in hospital and...the change was really just so dramatic, you know people <u>did</u> answer back and question...* (Nurse Q., Sp.nurse)

The influence of social change for women with the arrival of feminist theory in the 1970s, acted as an impetus for women in general to examine their role, and raised many questions for nurses within their working environment. However, it appeared to devalue some aspects of nursing work, namely the practical skills needed to care for patients, which were afforded low status. Indeed, in 1991, Lawler's study of the social framework necessary for the skills of caring for the body in nursing work, and the hidden nursing care, emphasised the sentiments that nursing work is 'dirty work' and consequently regarded as low value. Bjork (1995), who analysed perceptions of nursing over 30 years, highlighted the paradox of developing intuitive and embodied knowledge through nursing practice and devaluing the importance of practical skills. This dilemma was expressed by the same participant, who was concerned over the quality of personal care now given to patients.

> *...the other thing you really notice is that when we trained (in 1960s) you had time to do a lot of the basic stuff that nurses obviously aren't doing now, that has been passed down to health care assistants...But I don't feel the transition has actually been accomplished yet...so I feel that a lot of the basic stuff is not being done by anybody. And I wouldn't want to move nurses back to ...scrubbing out bedpans and all the awful things we had to do, but I do think some of the basic stuff actually is...it should be able to go alongside the more technical stuff.* (Nurse Q., Sp.nurse)

Fagermoen's (1997) survey of several hundred nurses, searching for the meaning of professional identity in nursing practice, supports this

participant's statement. The results of her survey and consequent six qualitative interviews, underlined the need for nurses both to care for patients through practical skills, and for intellectual stimulation through the cognitive aspects of nursing work. Scott (1995) maintains that nurses have duties and responsibilities defined within their role, and consequent demands on that role are changing traditional boundaries with increasing speed, - sentiments

echoed by this participant,

> *There are a lot of demands on the role of the nurse, externally and internally, which are making the role change obviously very quickly,...the role of the nurse has always had to change, but maybe not as much as the pace is demanding at the moment, and patients demand that the role changes,...you know, society is demanding as well as national and political agendas..*
> (Nurse H., S)

One of my memos written at the time of a national public service strike

highlighted a patient's general comment about nursing being an altruistic profession, as he asked me if I would ever go on strike for more pay. This made me wonder if nurses would be compelled to strike in the future, and whether the public's perceptions of them would change if they did. As society changes and successive governments strive to address the needs of health care users and workers, the traditional nurse training has been modified to suit. Several nurses identified the changes in nurses' training as having an effect on their current role. Those who had trained some time in the past felt that the role had improved.

> *...when I was trained - I started my training in '65 - so it's a hell of a time ago, I mean they did just train us then didn't they? (laughs)...I really often think that you could have sort of taught trained monkeys actually to do what we did, because you were actually told this is the way to do it, you were watched while you practised doing it, and then you were let loose to do it...I think in a way we were almost discouraged from questioning what you did, why you did it...and was there actually anything else, and nowadays it's got*

> *to have changed because of the difference in the training alone.*
> (Nurse Q., Sp.nurse)

Ford and Walsh (1994, p.7) in their discussion of the rituals of nursing practice, define training as "characterised by the ability to perform tasks correctly and efficiently; it is about obedience, the prompt carrying out of orders and it can be performed cheaply for large numbers of trainees in the workplace". The fundamental difference between being trained to perform a task, and educated to carry it out, lies with the understanding and rationale for the necessity for its accomplishment. Challenging practice can only be achieved through cognitive skills and a flexible enquiring mind. Benner's framework (1984) identifies the development of an expert practitioner from a novice nurse, through education and understanding of the complexities of nursing practice. This method of transmitting skills continues today, through the mentorship and preceptorship system which has been set in place to support student and newly qualified nurses. Mentorship is associated with a wide variety of occupational settings, particularly in social services, nursing, teaching and the police force. According to Morton-Cooper and Palmer (2000), it provides a method of career development and socialisation, supporting the individual through the learning process of a particular discipline. The relationship is one of empowerment, encouraging individuals to learn through a process of application and support. However, Smith-Blair et al. (1999), studied the effects of organisational change through the introduction of new roles, and identified a constant need for role clarity from all members of staff involved. This need to make the role change explicit to other members of the ward team was explained by Titchen and Binnie (1992) when introducing team nursing on a medical ward. Through describing some

of the difficulties with the devolution of authority from the ward sister to other registered nurses, both practical and educational skills were recognised as valuable ingredients.

Defining the role was linked positively with "doing the job", as part of providing a service involved the practicalities of working. The participants explained how they functioned professionally, and described what they felt they were employed to do. Traditional hierarchical roles and rules were seen as changing due to changing responsibilities. Senior nurses who worked in departments rather than ward areas identified the multiple responsibilities which went with the job.

> *I see it as being responsible for the day to day running, ...to identify appropriate staff allocated to those clinics for hands on nursing, whether they're trained or untrained...I seem to be the first line manager for the Unit, and to liaise with the medical records departments, pharmacy and all the other services.* (Nurse O., S)

She did however, comment nostalgically on her personal view of her role and how it had changed over many years of service, and her sense of frustration was evident.

> *...from the minute I first drew breath I wanted to be a nurse, I wanted to be a 'hands on nurse'. I like the way 'hands on' nursing used to be. Now, to me, what I'm doing isn't nursing. I'm the bank manager, I'm the audit accountant, facilitator and just once in a while, a nurse. (Nurse O., S)*

Being able to organise all the multiple issues relevant for a patient's treatment frequently became part of the nurse's role, in order to accommodate both the patients and the medical staff. The changes taking place in practice on the wards, however, required the nurses to take responsibility for their own workload, and to make decisions for the patients

they were nursing. The 'structure, process and outcome framework' of the nursing process (Clott and Tierney 1993) enabled nurses to assess when patients were fit for discharge for example, and to put their plans into action. This again highlights a significant need for knowledge in this changing role. Newly qualified nurses need a period of preceptorship with another more senior nurse to guide and support them until they are deemed competent to act autonomously. In turn, this provided confidence in their own ability to make clinical decisions. Several participants frequently highlighted the changing nature of the job in practical terms, as this charge nurse (male equivalent of ward sister) commented,

> *It's (the role) changed from where the sister was given all the information regarding the ward, and specifically patients, to where now each member of staff has their own number of patients that they look after and they nurse, so the sister in that respect isn't as involved in holding all the knowledge and then dishing it out when they feel like it.* (Nurse F., C/N.)

However, the changing nature of doing the job was at times difficult, with one unit leader/ward sister observing how junior staff experienced problems with accepting the responsibility for planning patient care,

> *I expect a registered nurse to be able to prioritise, to be able to assess the patient, find what needs to be done and implement that care in the appropriate manner that's in the best interests of the patient. I think that it is taking registered nurses quite a long time to come to terms, especially the more junior registered nurses, from how much that is a changing role from the era where there was a ward sister, head of the ward, who said to the nurses you are looking after 'Mr or Mrs so and so', and maybe this and this has been done this morning...individual nurses are now expected to be on time, nurse, and have their own decision - making process... (Nurse J., S.)*

A higher level of clinical expertise was identified as a necessary stopgap in situations where patients needed input from other disciplines which may not be readily available.

> *You seem to dabble in a bit of everything...depending on what you've done and what experience you've got through your nursing. I mean, I've done Intensive Care (nursing), so if we need physio (therapy) on poorly patients...then I do it, I don't call physios (therapists) in at the weekend, but that's unfair because some of the other staff can't do that...* (Nurse R., S.)

Nurses are frequently seen as a 'jack of all trades'. Cody (1996) writes that nurses are 'drowning in eclecticism', suggesting that the theoretical underpinning of nursing knowledge has been borrowed from other, more scientific, disciplines. However, the move to continuing higher education, and the expanding theoretical knowledge base of nursing practice, is seen by nurse theorists to validate the individuality of the art and science of nursing care (Benner 1984). Nonetheless, theoretical education alone is inadequate as a basis for the practice of nursing, and competency -based outcomes for newly qualified nurses are requisites of pre-registration nursing programmes (U.K.C.C. 2001).

The art and science of nursing

Part of the art of nursing is being able to provide care for a patient, and providing the background for care to take place was viewed as an essential and enjoyable part of doing the job,

> *I suppose one of the more satisfying parts of the role is to give direct care, care for patients, and really getting close and getting involved with what that patient needs and wants. I then try to make it happen for them.* (Nurse I., S.)

The debate concerning the nature of nursing as an art or a science continues unresolved. Darbyshire (1999) argues for the fundamental importance of overcoming this divide if nursing is to continue to develop. According to Peplau (1987) the art of nursing involves the use of 'self', to build a

therapeutic and trusting relationship with patients. The significance of that relationship and the contribution of both art and science to nursing are emphasised by Artless and Richmond (2000) in their description of the care environments of orthopaedic patients undergoing rehabilitation. They combine art and science with nursing knowledge, by demonstrating the need for empathy, a scientific evidence base and the knowledge to apply it. For the nurse participants, relationships with patients and physical closeness were a satisfying part of the role. They found giving direct care, actually carrying out a series of actions to provide comfort and dignity to the patient was very rewarding. Closeness with patients appears to be a unique part of nursing which at first glance may not appear to require any special knowledge. However communication and interpersonal skills are central to this process, together with an ability to understand human actions and reactions. This part of the role emphasised the essence of nursing, the understanding and answering of patients' needs at an instinctive level, although Oakley (1993) argues that basic caring could be carried out by anyone, and does not require any special skills. However, theories of caring propounded by Watson (1985), Roach (1984), Leininger (1991), and Boykin and Schoenhofer (1993), support the value to patients of the physical performance of caring, and the use of cognitive skills which enhance the caring encounter between nurses and patients.

Teaching junior doctors

In the N.H.S., nurses work within a culture of social organisation where their roles are perceived differently by different individuals. One of the significant issues raised was the part of doing the job which now involves teaching

junior doctors. This has long been implicitly understood by both the medical and nursing professions, but never formally acknowledged. Anecdotal evidence suggests that most senior nurses informally assess the capabilities of new junior doctors starting work in their ward or department, and the twice yearly intake of new juniors is viewed with some trepidation until it is discovered whether they are proficient and safe. Junior doctors were sometimes advised by their superiors to listen to the senior nurses, and approach them for advice, but a lack of formal recognition for this was confusing for both nurses and doctors. Indeed, my field notes at the time of one set of junior doctors' induction records that a 'ward sister has informed the junior doctors that the nurses are not medical auxiliaries, but professionals in their own right. They will advise the doctors but not clear up after them'. This part of doing the job raised numerous issues for many of the participants, particularly those at ward level whom it most affected, as part of providing the service also involved taking over some of the junior doctor's tasks, which required further knowledge and training. One nurse felt this enhanced understanding between doctors and nurses of each other's roles, but although nurses may perform doctors' roles, the doctors did not perform nurses' roles in return. Delegation of doctors' roles to nurses poses the question which of these roles is suitable for nurses to do, and appeared more acceptable to some of the younger sisters.

> *I think we are beginning to get an overlap in the (nurse's and doctor's) role with the clinical practice things. We can do some of the same tasks, which perhaps enhances our understanding of each other's role slightly, not fully, but it can make it slightly better, and I think that will progress.* (Nurse K.S.)

Many nurses raised a cautionary note however, that if nurses took over junior doctors' tasks, where would the doctors gain their experience in the future? Evidence of this deficit was already beginning to be exhibited in the working environment. Some doctors lacked the expertise to carry out simple procedures such as giving intravenous antibiotic medications - drugs given directly into a vein. This also had the consequent effect of increased prescribing of intravenous antibiotics by doctors who no longer had the time consuming task of administering them, and also of the continuation of intravenous antibiotics when they could have been given orally. However, McKee et al. (1992) pointed out that although greater professional independence for nurses may result from adopting many of the junior doctors' tasks, there was a danger that the medical profession could see this as a challenge to their own professional status unless their own role was redefined. There was also a risk that doctors could redirect the more mundane medical tasks onto nurses.

Supporting each other

Endeavouring to perform all these components of their roles magnified the nurses' fundamental need for support in maintaining their professional function. They identified peer support as a significant issue, and supporting each other was an integral part of the role. Support was needed both from within and outside the working environment, and was seen as necessary to the majority of the participants and their staff.

> *I think it's quite important that you do establish a network with the senior nurses and that you do actually keep in contact with them, because then you get a feel for what's happening, and then if you*

> *get a problem or a new issue you don't really know how to resolve, you can brainstorm with people.* (Nurse J., S.)

Harrison et al. (1995) studied the function of support in a normal life transition, of women either returning to work or retiring. They discovered that women preferred support by those experiencing a similar state, and emphasised the need for support to be reciprocal and to share a common bond with peers. Support was highlighted as a favourable influence on service provision,

> *We need public support, we need social support, because at the end of the day that is the service we are here to provide.* (Nurse H.,S)

Gould et al. (2001) examined the factors affecting the performance of clinical nurse managers (ward sister level). They established that effective support within the organisation was one of the main factors encouraging retention, both of themselves and their staff. This participant, painting a clear picture of a common situation on a busy ward, described the understanding of the need for supporting their staff,

> *I think its really important that the key people are senior nurses...they need to have a clear understanding of what the day to day running of the service is like, and what the pressures and the stresses imposed upon their nurses are...like on the late shift on a Friday night when there's two people off sick and there's no bank nurses on the ward... you need a senior nurse to be able to remember what it's like or to be actively practising...*(Nurse J., S.)

Having experienced this situation herself led this nurse to understand the position her staff were in, and to offer support in this setting. Keeping in regular contact with colleagues from previous employment and networking with peers facilitated peer support. This enabled the nurses to discuss ideas with each other, taking advantage of each other's knowledge, expertise and experience to reach a solution for problems. According to Williams et al.

(2001) who examined senior nursing roles, stakeholders also recognise the crucial function of support in enabling staff to carry out their job. Indeed, the data display that the nurses found support from their peers essential. Support in health care is understood to improve self-esteem, job satisfaction and feelings of value in the workplace. Clinical supervision for nurses is support which is officially recognised as providing a forum for nurses to discuss clinical practice issues in a confidential setting and encourage them to gain more knowledge through key aspects of reflection (U.K.C.C. 1996). These include feedback and challenge in an atmosphere of support. However, Fowler and Chevannes (1998), claim that reflection is not a necessary component of clinical supervision, although they recognise that reflection in practice can provide professional support. There are different kinds of support, and different needs for support according to the situations in which we find ourselves. The role of the nurse is emotionally demanding at times dealing with distressing and painful experiences. Stoter (1997 p.4) writes that "good staff support is not an optional extra", and indicates that staff relationships are important to maintain staff morale. The nurses in the study had no formal means of support, but tended to use either colleagues from a previous workplace, or their current peers. Lack of support from their own junior staff was highlighted when they were allocated dependent patients who needed more nursing interventions. Need for support is also necessary when the workload is repetitive or exhausting and not just in high drama areas such as accident and emergency or intensive care units. Shortages of staff contribute to low morale and influence the quality of patient care, and the nurses identified their supportive role in helping students in a learning

environment. Randle's (2003) study explores the experiences of student nurses throughout their three-year pre-registration programme. She found that the students' self esteem was damaged by the manner in which they were treated during some of their clinical placements on the wards. Unfavourable comparison of their behaviour and comments towards them had the effect of lowering their self-esteem and devaluing themselves. The conclusions she reached illustrate that negative practices taking place in their socialisation, such as bullying, influence the development of their interpersonal relationships and consequently the quality of care they give. However, although data collected from the nurses did not identify bullying, they did relate to a lack of support from their senior managers. I asked this participant about her own support from other sources, and she described her need to access support from outside her current workplace,

> *The other route for professional support and backup is obviously those nurses that you have worked with in the past who are at the same level. I have a lot of friends who are now senior nurses; if I really have an issue I can ring up one of those...* (Nurse J., S.)

Professional bodies such as the U.K.C.C. (later the N.M.C.) and R.C.N. were not seen as particularly supportive as their guidelines were, of necessity with such a varied profession, fairly broad. However, the current climate of health care emphasises a customer focus, with senior nurses responsible not only for supporting their staff but also for leading their staff in the provision of care for their patients, developing improvements and implementing professional legislation.

Leading the team

Leadership in nursing is an issue which permeates through all the strata of the profession, and within nursing it is customary to be a leader and to be led. 'Leading the team' emerged as a valuable aspect of nursing care within the current organisational structure, with the necessary educational systems in place to develop personally and professionally. Leaders with personal high standards will expect the same of their staff, however, the nurses noted that the service, and consequently their own role, is becoming ever more diverse and more difficult to manage. To the participants, leadership implied developing others through firstly educating themselves.

> *...Recently I've done the Advanced Life Support (A.L.S.) Course, and I'm keen to develop those sorts of things on the ward and indeed send others on the A.L.S. course as well. I don't think it will be long before nurses will be leading arrests (cardio-pulmonary resuscitation) and doctors won't be taking part in quite the same way that they do, as a result of A.L.S. courses.* (Nurse S., S.)

Changes nationally have resulted in the focus of nursing leadership concentrating on developing and training new leaders for the future to provide a better service to patients. In 1997, the R.C.N. completed a three year project into the role of the ward leader and senior nurse, in order to explore the relationship between effective leadership and good quality care. The results of the project demonstrated the influence of senior nurses on direct patient care, through developing their expertise and imparting their skills to other members of the ward team. Increasing personal knowledge, and disseminating this to the ward team served part of the leadership role. Leadership skills are a pre-requisite of any nursing role, and are key to successful nursing management (Brewer 2003). Weber (1947) in the early 1900's used the term charisma to describe the capacity certain individuals

have to influence others to follow them. Donnelly (2003) however writes that one of the myths of leadership is that leaders must possess charisma. She claims expert knowledge is more a pre-requisite of nursing leadership than charisma, as leaders need the knowledge to deliver the care for the service they manage and charisma can encourage dependency. Nonetheless, the organisational context in which the leader operates can influence their ability to encourage followers. Thus, in the context of health care, nurses are expected to follow the ward leader, but may not always identify with their vision. Leadership unfolded as meaningful to the nurses, who sought to be the leaders in their areas. According to Christian and Norman (1998) who explored leadership skills in twenty-eight Nursing Development Units, several elements appear to be central to the clinical leader role. As well as managing change, these include establishing a focus for staff, communicating well and encouraging staff development. It was found, however, that leadership skills were constrained by the hierarchy of the organisation, and that nurses needed to be able to act on their own authority. The tenets of leadership, whether on the ward, or in a specialist role, were primary components of all nurses' roles. Leadership is included in most nursing job descriptions, with the expectation that the post holder will be the identifiable lead in any practice changes. Part of the leadership role involves acting as a role model, and also as a mentor, empowering members of the team to make their own decisions. The nurses identified their different levels of obligation as leaders, with responsibility to the patients and staff, nurses and doctors, managers and the profession. Leadership also involves recognising the qualities of others, enabling them to feel valued and

respected members of the team. Teamwork was seen as cascading from the ward leader down to other members of staff, but it was also important to work together,

> *I've had meetings with all the trained staff and I've told them if I find things that aren't done, or what I think they should be responsible or accountable for, then I shall start picking them up for it. But also, in turn, I expect them to pick up the members in their team, because it's no good if it's only me trying to do it.* (Nurse R., S.)

Indeed, McCormack and Hopkins (1995) proposed a 'collegial relationship' model incorporating the components of reflective practice and clinical supervision as a method of sustaining the role development of potential leaders and improving their effectiveness amongst their staff. Leadership from the senior nurses was decisive in determining the quality of care to the patients, as is the importance of relationships between colleagues striving for the same goal. Johansson et al. (1994) who examined the effects on work satisfaction and quality of care in changes in a surgical department described this as the 'we-spirit', a crucial component in effective management. Leadership brought with it differing levels of responsibility, and many felt that the ward sister's role was that of:

> *...clinical leader - right in the middle of management in terms of sort of hospital nursing, to those below them and those above them, responsible to their nursing leaders. Then they also have a responsibility to the service managers as well, then there's the responsibility to the doctors as well to ensure their things are carried out properly.* (Nurse S., S.)

The hierarchy of nursing has traditional and historical roots, and is linked to the prevailing social context and the role of women in society at any given time. The structure was originally formalised by Florence Nightingale, who was herself a highly educated aristocrat born into wealth and political

influence, and thus in a position to effect change (Dossey 2000). Although historical arguments suggest health reforms during that period were not hers alone, she has come to be epitomised as the focus of nursing care. In her Notes on Nursing revised by Skretkowicz (1992), which was first published in early 1860, Nightingale explicitly writes to illuminate the plight of the sick of that time. That this book has become a classic text, and many of its values still hold true nearly 150 years later, can be taken either as a fundamental vulnerability of basic human needs, or an exposure of the shortcomings which continue in nursing today. Indeed, Holliday and Parker (1997) analysing the influences on Nightingale's life, suggest that her professional ideals could still give current direction to the discipline. Nightingales' notes (Skretkowicz 1992) describe being "in charge" as ensuring that others as well as oneself carry out all allotted duties, and it is not the role of the person in charge to do everything themselves. Hierarchy in nursing is traditional, setting out the rules and regulations needed to enforce the structured organisation of roles required in the care of the patient. This implies an external locus of control, where individuals feel they have little control over events that take place. Indeed, Degeling et al. (2000) who examined the cultural differences in nurses in England and Australia, found that the identity of nursing in the respective countries influenced their professional ideologies and strategies, and the nurses experienced more control over some parts of their role than others.

Most wards have a particular culture, one which sometimes can attract or discourage staff, and this is significantly influenced by the qualities of the

ward leader. Lewis (1990) proposes that the ward sister is the professional gatekeeper of nursing functions, determining the actions of the staff. According to Doherty (2003) the Government's modernisation agenda formulated through the N.H.S. plan (D.o.H. 2000) provides an opportunity for ward sisters and senior nurses to review what their role will be in the future. For many of the nurse participants, the leadership role incorporated the demand to support the teams' needs, and to 'be there' for their staff was viewed as an important purpose.

> *...you have to have the opportunity to enable your team to let off steam if they need to, to come to you for support. If they come to you for support, you need to provide it, you need to have an effective team that works well together. You need to actively work on building that team, identifying people's strong points and utilising them within the team so that nurses feel valued, feel supported, and if they do feel valued and supported, they will work very hard and very long for you.* (Nurse J., S.)

She reflected the views of many participants with this comment,

> *You are team leader for your team, and therefore they all look to you, expect you to be 100% there all the time for them deal with all the problems...* (Nurse J., S)

However, the continuing diversity of service provision caused problems in some areas, resulting in many nurses feeling a lack of control.

> *You know, you can only do so much, and when you are trying to do ten different things, you're losing track on maybe one or two, and yes, it feels exactly like that, it feels as if everything is just quietly slipping away and out of control, and we have to fight harder and harder to keep it under control.* (Nurse O., S.)

This participant was also concerned about being able to keep patients at the heart of nursing care,

> *I agree the service has to develop, but I just wonder if it's spreading so diversely that it's actually losing its point, its focus, which at the end of the day is the patient as far as I'm concerned.* (Nurse O., S.)

Senior nurses are expected to have a higher level of knowledge and ability than those they lead, and with a move towards an all graduate profession, the role of the nurse was affected both by internal and external influences. Indeed, in an attempt to describe what exactly nursing should encompass, the government has introduced its 'Essence of Care' programme, (D.o.H. 2001) whereby specific basic standards of nursing care can be monitored and measured. These include, among others, the basics of privacy and dignity, and are deemed significant by both staff and patients.

Standards of care

The participants felt that providing a service was linked to providing good quality care, considered to be the ultimate aim of all health care professionals. Standards of care are set both locally and nationally, and nurses are required to work to both. The nurse's role was affected by government influences such as the "Patients Charter" (1995), which raised patients' expectations of the service, and recently updated to "Your guide to the NHS" (2001), the publication in 2000 of the N.H.S. Plan (D.o.H.2000), and continuing monitoring of health care provision by the Commission for Health Improvement (2003). If these expectations were not met, this added to the administrative part of their role when patients raised issues relating to their hospital experiences.

> *...I think patients generally now are far more aware of what their rights are, and even to some extent we are encouraged to view their opinions, especially the negative ones. I mean, more and more patients are inclined to write and complain, and that is fine because you need to know what the problems are, but some of them are very trivial and that does take an awful lot of time up.* (Nurse L., S/N.)

Emerging health care reform constantly changes the context in which health care is delivered. Restructuring of the management of the N.H.S. to accommodate the principles of the internal market had a significant impact on the practice of nursing. As more hospitals attained Trust status, the service they provided in different areas was examined in detail. Service providers came under close scrutiny both locally and nationally, and continued to have their annual performance targets rated in the N.H.S. Performance Guide (D.o.H. 1995/6), with all Trusts being measured against quality benchmarks in accordance with the Commission for Health Improvement. In recent years, service provision in health care has been a leading issue on the political agenda, with the parties both in government and in opposition highlighting their own specific programmes for improvement. Nurses are responsible for providing more than half of the workforce in the N.H.S. (Wyatt and Langridge 1996), indeed nursing manpower and the mix of skills required is a subject of ongoing debate, particularly in the continuing effort to manage resources effectively (R.C.N. 2003). Assessing the standard of the service provided is part of the continuing national agenda, and usually evaluated by means of a patient questionnaire (Pontin and Webb 1995). Most participants recognised that standards were continually improving. One of the charge nurses interviewed felt that nursing developments to improve standards were normally taking place, but that now it was being formalised politically,

> *...It was already happening within hospitals, primary nursing was already happening,...(the government) just identified what they thought was excellence within nursing and what we should be striving for...they looked for centres of excellence where they could actually ask everyone to achieve at this sort of level really.* (Nurse F., C/N.)

Most of the nurses identified a heavy workload and the dependency of the patients as a prejudicial factor to the service they provided. The dependency refers to how much nursing time is required to be spent performing a range of care tasks for a particular patient. Workload and dependency have remained the conventional accepted practice for measuring the number of nurses and skills that are required to care for patients. However, there appears to be no system of measurement for the invisible functions of nursing, such as comforting and reassurance, those areas which are so important to both staff and patients. The issues of workload and dependency are areas which have a significant impact on the role of the nurse. Waters and Andelo (2003) wrote that nurses need to adopt the right implements for assessing the skill mix of staff on the ward, and discussed the advantages and disadvantages of five skill mix tools. Several different methods were explored in the review, but the acuity-quality method, although complex, allows for the total of nurses to be matched to ward activity rather than number of beds. Further, Adams and Bond (2003a) explored the relationship between ward environments, numbers of staff and the way nursing care is practised. Their data were collected from 100 acute hospital wards, and findings confirmed that a higher number of staff had a direct impact on ward organisational structure and a positive effect on multi-disciplinary working. They established that the lower the nurse to bed ratio, the more hierarchical is the ward organisation. However, although more nurses to beds demonstrated that a more devolved method of working, such as primary nursing, led to an increased level of job satisfaction, this did not promote innovative practice. The second part of Adams and Bond's (2003 b) paper explored the relationship between grade

mix and staff stability. They found that staff stability was significant in promoting innovative developments, and that higher standards related to a stable workforce regardless of grading. Quality of care is an important component of the nurse's role and part of maintaining high standards. The data portray that this was implicit and expected as part of the nurses' service to patients, and that the boundaries of their knowledge needed to expand in order to meet both public and professional expectations of these standards. Excellence in nursing practice is pursued in health care from both national and local levels. There are political, personal and professional drivers for staff to maintain their competence and continually seek to improve their standards of care. In sustaining this improvement, practice must be based on evidence, requiring staff to acquire the skills and knowledge necessary to challenge existing rituals, assess the evidence and plan and implement change. Sleep et al. (2002), who conducted several multi-disciplinary learning workshops in order to promote evidence-based health practice, point out that in order to inform and improve decision-making, education and knowledge are required to learn skills to assess the evidence.

Accounts from the nurses raised several important issues relating to their role of providing a satisfactory service to patients. Addressing the effects of change to the role highlights its complexity. The numerous functions expected of it presented difficulties for nurses who undertook to define it, and encompassed many of their daily tasks. The nurses took their obligations and responsibilities seriously, and emphasised the benefits of continuing education throughout the nursing career. This was perceived as significant

for improving quality, providing effective role models, maintaining high standards of care and promoting productive change. A higher level of knowledge was needed for those who were required to teach patients and junior staff, and education was seen as crucial in closing the theory-practice gap. Some nurses stepped across professional boundaries to fill the void left when care would normally be provided by other professions allied to medicine. One example of this was the nurse who had gained a knowledge of physiotherapy when working in the Intensive Care Unit, and used this knowledge when there was no-one else available at the weekend. In addition, education and knowledge were essential to those who were leaders, in order to develop themselves and their teams personally and professionally. Comprehension of the political agenda and its influence on nursing practice was likewise becoming a necessity. Support from both peers and from above managerially was valued, and imperative to successful functioning within the role.

According to national and professional bodies, nurses are expected to base their practice on research and evidence (N.M.C. 2002). Clinical governance (1998), a framework for continuous improvement where the quality of care is monitored through local and national standards, requires that nurses continue to develop professionally, and indeed this is supported by professional organisations such as the R.C.N. and N.M.C. Thus education and knowledge are accepted as, and understood to be, an integral part of the nurse's role, and a necessary part of developing practice both from a legal and moral perspective (U.K.C.C. 1999, N.M.C. 2002). By attempting to

provide a quality service, however, some nurses felt their role was becoming fragmented, and moving away from direct patient care. This is discussed in the next construct.

2. Drifting away from the patients

Drifting away from the patients describes the reasons which the participants gave for the disappearance of parts of their role, caused by changes in the role itself, with more time spent managing instead of in direct contact with patients. They described the strain under which this placed them, while trying to fit all functions into their workload, and the need for adequate resources to function effectively. This section describes the participants' feelings of fatalism, particularly from the more senior nurses, that they were being overtaken by events.

Feeling the strain

This category underlines the issues nurses described as preventing them from delivering the optimal level of care. Increasing administrative tasks and a lack of resources compromised their nursing role, and they considered this to have a direct negative impact on patient care. The changes taking place were gradual, with fewer practical tasks being carried out.

> *When I first started this job, which was four years ago, I probably did about 80% nursing, actually doing day to day care for patients. It's gradually dwindled now, down to about 40% nursing and 60% divided half and half between teaching and management.*
> (Nurse K. S.)

Many participants echoed this feeling,

> *...I think the (sister's) job has altered beyond recognition,...become very management orientated, the close involvement with budgets*

> *and that sort of aspect, drifting further and further away from the patients.* (Nurse L., S/N.)

Borthwick and Galbally (2001) questioned the pertinence of continuing to use the traditional nursing framework for health care within a changing political and economic climate. They saw the challenge for nurses as being able to assess how far the profession could stretch to accommodate patients' and professionals' needs before it ruptured. They further suggest that within the culture of the modern N.H.S., emotion is 'out of place' and unsustainable in a contemporary workforce, and is incompatible with skills nurses now require. Extending and expanding the nurse's role to accommodate the changes taking place was seen to affect all grades of staff, with each level expected to increase their workload. Nurses recognised that their roles would need to incorporate others' functions to accommodate the changes.

> *...E grades will be doing F grade jobs, and F grades will be doing G grades, and they will all move out of what they are doing now. They will have less and less contact with the prime reason, I assume, for them coming into nursing was - nursing patients.* (Nurse S., S)

Many ward sisters found that their own role was evolving increasingly into a management role, which is similar to the findings of Wilmott (1998) who examined changes to the ward sister/charge nurse role. Indeed, in order to fulfil the potential of their role, most sisters in Wilmott's study recognised the need to be supernumerary. This would enable them to teach and develop their staff. They acknowledged the possible danger that development would be blocked by the pressures experienced within the current working environment, and the difficulty in fitting everything in to an ever-increasing workload. Furthermore, according to Warren and Harris (1998), nurses' retreat from the bedside is to a large extent the result of the ever-expanding

need for bureaucracy and computer technology. Thus, the time taken to perform these non-nursing tasks had an impact on the time available for bedside nursing.

Fitting it all in

The participants were concerned with the concept of time, and time or lack of it, was an issue which permeated throughout the working day. Time was almost always seen as lacking, or insufficient for the amount of work to be carried out. Many of the difficulties perceived were attributed to its absence, and more 'time' was viewed as a solution to a significant number of the problems. For some, there were never enough hours to complete their work.

> *No, there aren't, (enough hours) and I do just feel that the more we do the more they expect of us anyway, and it almost feels there is going to come a time when you are going to have to take one big step back and say "hang on, I can't!* (Nurse O., S.)

The perception of insufficient time caused the nurses to feel they were drifting away from the patients, and that other issues which required their attention were overwhelming their role. They recognised that to work longer hours in order to achieve both these demands could have a potentially damaging effect on their personal and professional lives.

Nurses' accounts show how the participants viewed the loss of parts of their role in order to accommodate these changes. Changes in the nurses' roles had the effect of reducing the time spent with patients and increasing the time spent in administration. Senior nurses were expected to teach and manage, co-ordinating the needs of the organisation, staff and patients. The nurses confirm the lack of available time to complete all the designated parts

of their role. The consequences of an increasingly extending role were, in their view, that by trying to fit the needs of patients in with other duties the opportunity to get to know the patients and their families was reduced. The time spent on this level of communication with the patients and their relatives brings its own emotional rewards, and the nurses' data feature many instances of this as the reason for entering nursing. However, they perceived that the nurse's role now included many aspects of the medical role, which further encroached on the available time to care for patients, particularly with more use of complicated equipment. Technology was judged as less valuable than caring and nurses did not feel challenged by the skills needed. They did, however, identify that a move towards technological roles detached them from the direct care of the patients and the human connection judged as essential to their role. Changes enforced by remodelling the roles of others were seen to encroach on nurses' time, and although the ability of nurses to carry out different tasks was not questioned, the effect it might have was,

> *...but what I think is important is, that while nurses may well be able to take on all those roles, you have to be certain that you have enough time available to do it, and that you're not doing those 'high tech' things at the cost of the care you need to provide to the patients...* (Nurse J., S)

Specialist nurses employed by and based in acute hospitals worked to a different regime than ward nurses, in that their time was not as constrained by indirect patient care. However, this older experienced specialist nurse, on her visits to the wards, highlighted how the changes affected the contact nurses had with patients through lack of time,

> *...you don't have time to get to know them (patients). I mean, nurses must actually, I would think, miss that sort of contact, time to know a patient and their relatives.* (Nurse Q.,Sp. Nurse)

One of the more satisfying aspects of a nurse's role is having time to assess and learn the emotional needs of a patient, and the curriculum for nurse training includes many aspects of psychosocial needs and behaviour. This is supported by the nurses in Henderson's (2001) study, who described their satisfaction with the emotional rewards of their work, but expressed dissatisfaction with the low value placed on this aspect of nurses' roles by others. However, emotional work or labour as described by Smith (1992) and Lawler (1991), has long been recognised as a fundamental part of the nurse's role. Being unable to spend time with patients was a source of frustration, and this was partly the result of patients being moved through the hospital system as quickly as possible, driven by government targets.

> *...most nurses come into nursing because they want to spend time with patients. Well, when you (the patients) are just on like a conveyor belt system, that's very hard. You don't get to know them, the dust doesn't get to settle on the bed without the next one's coming in, the paperwork just seems to flow like a river, whether you're putting people in or putting people out.* (Nurse N., S/N).

Every patient's admission and discharge is accompanied by numerous papers and documentation, most of which need to be completed by the nurse within a specific timescale of a few hours, and certainly within the same day. Nursing is based on a culture of caring, which involves spending time with patients as well as tending to their physical needs. However, the observational study by Jinks and Hope's (2002) on the activities of trained nurses on surgical and rehabilitation wards, demonstrates the increasing amount of nursing time spent in coordinating and managing aspects of

patient care rather than giving direct care. Street and Robinson (1995), using participatory action research, investigated the effects on the roles of nurses who wished to advance managerially and retain clinical responsibilities. Their findings question whether appropriate experience is obtained in the clinical field to enable nurses to prepare for a managerial role, citing the frustrations experienced by these nurses when attempting to conform to others expectations. Nurses continue to occupy a middle ground between medicine and other professions, performing as the 'glue' which holds an overview of patient care (McCloskey et al. 1996). However, Calpin-Davies and Akehurst's (1999) analysis of the workforce for the prospective substitution of doctors by nurses, suggests that there are insufficient nurses available for this, and with inadequate resources there will be adverse effects on the function of nursing in the future. Indeed, resources are limited, and nurses, although cheaper than doctors, are not an endless commodity. The changing social, political and economic climate constantly strives towards cost containment, and nurses, as the largest workforce in health care (Government Statistical Service 1998), are usually the first area in which reductions are made in times of economic cutbacks.

Needing resources

Resources to provide quality care were presented as a need for staffing and providing suitable treatments. Nurses are required to have a rudimentary knowledge of the demand for beds and their hospital's capacity to cope with it, particularly in their area of responsibility. The corporate view is that hospitals are organised to provide the optimum throughput of patients,

ensuring that treatment is timely and expedient. The nurses stressed the expense of some treatments, but felt that patients had a right to have the most appropriate product such as wound care dressings, regardless of cost. The data consequently highlight the need for knowledge of financial budgeting, a responsibility which rests with senior nurses, and which can directly impact on patient care if badly managed. Budgeting is necessary in all aspects of nursing, from the correct number of staff in post, to ordering the appropriate manual handling or other equipment. Financial issues were an area in which the nurses judged themselves to be deficient, with inadequate training provided and a lack of control over. Ensuring that resources were adequately provided, whether this was staffing, equipment or consumables was seen as an important part of the changes taking place. The cost of keeping a patient in a hospital bed continues to rise, and although new and innovative treatments are constantly available, these usually do not come at a cheaper cost. The nurses were aware that the correct treatment could be costly but was justifiable in most instances,

> *...wound care products are expensive, and I think the patients have the right to expect a product that is going to do the job for them,..* (Nurse S., S.)

Human resources, such as sufficient staffing, were needed to enable care to take place, and competency was seen as equally important as having adequate numbers of staff. The nurses saw part of their role as,

> *...providing the background to enable that (care) to happen at that interface, so it's ensuring that there are adequate staff and that co-ordinating resources that you've got staffing-wise, so that you've actually got enough qualified staff at any one time to care, and for them to have that knowledge.* (Nurse I., S)

Meadows et al. examined the N.H.S. nursing shortage for the King's Fund report in 2000. They found that recruitment and retention was influenced by many factors, including the lack of resources such as staffing and equipment. Resources were also needed in the form of protected study time, to allow for nurses to develop educationally and understand the evidence on which to provide their care. This is confirmed by Carver's (1998) study of registered nurses' role expansions in cardiology, who found that time to receive training in order to learn was vital, although they expressed a need to retain their nursing skills.

Managing the budget was part of the responsibility of the ward sister's role. However, this resource was not always within their control, as the ward budget covers areas for which they do not have management authority. As well as nurse staffing, areas such as drugs, equipment, clerical staff, stationery and consumables are usually included, as costs to the department as a unit. Therefore, although the cost of doctor staffing falls outside the ward budget, the costs of the doctors' use of other resources remain within it. In today's cost conscious health care environment, control of the use of resources is a necessary component of the responsibilities of ward management. Budgets are usually set by the organisational accountant, frequently with little direct consultation with the staff. The nurses identified a need for training in the management of their budgets, as this is an area in which nurses are often expected to be competent with little or no educational input.

> *... our names appear as managers responsible for various budgets on the ward and some of them are out our control...*(Nurse S., S)

She went on to say:

> *... largely to date, still there has been no real formal training in holding a budget, - and in a budget that has always been set on medium incremental points when the majority of staff are on top incremental points, so that at the beginning of each financial year I will always be overspent.* (Nurse S., S.)

Incremental points refer to the level the nurse has attained within their grade structure, and can vary by several thousands of pounds in wages. Thus, the general setting of a budget for staff without regard to the specific points they may occupy within that grading level, has the potential for an adverse effect on the budget. The need to manage the resources of staffing and budgeting had a significant negative effect on the direct care the participants felt able to give their patients.

These accounts highlight the frustrations experienced by those nurses who felt they were not practising the 'ideal' of nursing. They were dissatisfied with the increasing amount of paperwork, perceiving a lack of time for the important elements of nursing, such as the assessment of patients' emotional needs, and spending time caring for patients. Time was perceived as an important issue regarding taking on doctors' roles, as lack of time could have an adverse effect on the function of nurses' roles. Lack of human and material resources were viewed as conspiring to remove the nurse from close proximity of patient care and the increasing workload posed problems for those struggling to cope. Indeed, the more senior the nurse, the more distant they felt from the patient. Pressure of work on the wards prevented many from attending teaching sessions, seen as an integral part of nurses' development and training, particularly in gaining knowledge to carry out care

competently. However, those nurses that were enthusiastic and motivated to develop were keen to embrace the changes and use them to progress within the nursing career structure. The influences on these ambitions are discussed in the next construct.

3. Being ambitious and getting on

The third construct portrays how the participants use the changes in the nurse's role as an incentive, taking opportunities to develop both personally and professionally. Philosophically, change can be described as a fundamental element in the perceived world, and as such remains a constant (Reed and Ground. 1997). Some of the participants could envisage that by embracing the changes, the changes could be a time of exciting development. This did, however, involve taking responsibility for empowering themselves and others, and was perceived by several as returning to previous ways of working.

Embracing the changes

Embracing the changes describes the positive perceptions of change, with nurses encouraging developments and utilising the change processes as a medium to approach alternative methods of practice. Change itself may be implemented through various different models, depending on the relevance to the change taking place. However, for nurses, complex changes appear to be taking place continuously and therefore several different models may be incorporated simultaneously within the change process. Lewin's model of change (1951) identifies three phases of the change process, unfreezing,

moving and refreezing. This appears to be appropriate for many of the change processes in nursing, as numerous changes necessitate movement along this continuum to ensure the change endures. Managing change is an important aspect of the nurse's role, and most national and local job descriptions for qualified nurses include a section requiring the applicant to be cognisant with all aspects of change, viewing it as a challenge and a method of achieving operational and organisational restructuring. Change is progressing faster and becoming more complex, with Muller (1992) attributing it to advancing technology. However, for nurses the effects are multi-dimensional, and one effect was that nurses now felt able to question traditional practices. Nurses who viewed the composition of their roles as based on traditional and historical components, welcomed changing practices as a positive move for patients. This nurse discussed the effects of this on the care of patients with infections, seeing them as a positive improvement,

> *...a lot of what we did was historical, we'd always done it, and actually we did it to be safe than sorry, and so we tended to go over the top with a lot of things, and it's good that nurses are questioning it because patients did suffer for it really...you know they were sort of banged up in a room and (if infectious) - almost treated as if they had the plague!..* (Nurse Q., Sp.nurse)

However, she cautioned that in the bid to embrace change wholeheartedly, many tried and tested practices were being discarded as ritualistic without their value being recognised.

> *...my speciality is moving really quickly, but...there are a lot of younger nurses in (speciality) now and I also feel that in a lot of instances they are throwing the baby out with the bath water.*

Those that were motivated to develop were seen to embrace change, to use the opportunity to improve their education and careers. Much of the literature

at that time extolled the virtues of multi skilling - where nurses were encouraged to take on as many roles as possible in order to benefit their patients' care. Developments in nurses' education promoted patient centred care and change was,

> *...very positive, nurses taking on more things that in the past you would have to wait an age to get done because the doctor is very busy. It is much more patient-centred now where you actually focus on requirements of the patient and you can get on and do things. It is becoming much easier with the changing education...* (Nurse F., C/N.)

Some of the nurses were influenced by their own perceptions of their knowledge, providing them with confidence. If they believed that their knowledge was consistent with that of a doctor, particularly in a given situation, they felt able to challenge a decision in the interests of the patients. This was influenced by several associated conditions within a particular episode on the ward or department, such as the seniority of the doctor, the level of challenge, such as disputing a diagnosis or just taking the initiative in a patient's care, or whether the dynamics of the 'doctor-nurse' game were used to facilitate a non confrontational discussion of the relevant issues, a cardinal rule according to Stein (1967). Observational and anecdotal evidence suggests that this method of communication still persists even in today's modern healthcare arena, with nurses offering hidden recommendations in statements about the patient's condition, and indeed, is supported by Wicks' (1998) study of doctors and nurses working together. Thompson (2003) warns that experiential knowledge, although a necessity in the decision making process, is not sufficient justification for action. Initiating change however, involves taking responsibility for developing and advancing nursing practice. According to Bellman (2003), there is increasing corporate

recognition of nurse-led change, although she suggests that managers of healthcare need to adopt different working practices in order to promote this. Many of the participants linked their responsibilities with their accountability to staff, patients and the organisation.

> *... the essence (of my role) is really to make sure that there is good nursing care on the ward - that the patients on my ward are cared for at the very optimum..* (Nurse I., S.)

The nurses highlighted the need for relevant research, not only as a support for their practice, but as a means of raising awareness amongst themselves and their peers, enabling them to base their arguments on evidence. Although they recognised the need for research-based practice, they found it difficult to implement. This was linked to the negative view of research from both nurses and other professionals.

> *... I think as nurses we've got to get better at putting our views across. I think it's incredibly difficult if you try and put your views across and it's ignored, and at the moment that is what I am trying to do, to get a very coherent argument together backed by research.* (Nurse I., S.)

A similar view was given by this charge nurse, who was very enthusiastic about promoting research in his field, but found it problematic.

> *... actually stimulating staff to do research spontaneously is very difficult, I think.* (Nurse G., C/N.)

He felt that nurses only used research for academic advancement, and that nurses saw professional development and professional practice as two separate components.

> *...research seems to be locked into nurses wanting to show professional development, which is why, I think, most of it is done through courses... they don't see it as having a contribution to the daily improving patient care, at a ward level.* (Nurse G., C/N)

Many authors highlight the importance of research for nursing. Roe (1998) cites the necessity for ongoing nursing research in relation to N.H.S. policy, and the infrastructure for developing improved patient care. With the current focus on effectiveness, Evans and Pearson (2001) suggest systematic reviews are the way forward rather than primary research for nurses. However, according to Royle and Blythe, (1998), the evidence base for nursing should combine clinical expertise, the preferences of the patient, resources and the best evidence available from research. Pearcey (1995), who examined nurses' perceptions of their research skills, identified a marked deficit in elementary skills such as research evaluation and application to practice. Research skills are high on the education agenda, and according to Seymour et al. (2003) nurses need to develop research as part of their ideology and learn to transfer their critical thinking from the classroom to their practice. As a result, this would promote the empowerment of the nurses themselves in their professional role.

Power and empowerment

Being ambitious and getting on was strongly linked to the participants' interpretations of power and empowerment. The nurses' perceptions of their own level of power and the empowerment promoted by others were influenced by many factors within their professional role which challenged their mode of practice. Many doubts were expressed, as it is common to experience some uneasiness during the change process. Individuals become accustomed to a particular way of working with which they are comfortable and do not want upset. During a time of change, the values of

the old culture continue to operate and the new values have yet to be consolidated. Nicholson (1992) suggests that no change is painless, and is normally slow to take place. Resistance is inevitable as individuals question and challenge new ideas, sometimes causing minor setbacks until people grow accustomed to new ideas and absorb the change into the pattern of their daily working lives. However, the changes were viewed as making the role more patient-centred by focusing on patients' needs, and promoting the nurses' own empowerment. The need to become empowered was a vital issue, raised by this nurse who identified the necessity of the supportive framework from which nurses could learn.

> *If you tell people and give people clear defined lines of what they should do in what order and when, they will never have the confidence in the situation to say - well I should do this, this and this. I think you give them very clear guidelines on the way that the unit needs to run, let them know what the philosophy of the unit is, empower them to make their own decisions about the issues that are important.* (Nurse J., S.)

Empowering staff to make decisions has, according to Williams (2002), a direct relationship to empowering patients. The demands for improved knowledge among today's empowered health care consumers, requires that staff themselves must become empowered. Most descriptive definitions attribute information and knowledge as key concepts, involving the patient in the decision-making process. However, the application of empowerment is sometimes alien in the traditionally paternalistic health care arena, where the strategies include direct facilitation and consultation (Williams 2002). Gherhardi (1995) suggests this may be viewed differently by men and women in organisations, with men seeing power as authorisation, staff as subordinates, and themselves as decision makers Many of the participants

highlighted the effects of change in providing opportunities for a traditional female workforce where previously expectations were that a nurse married, had children and then had little choice in the nature of their employment when returning to work,

> *you just go back and fill in, because you have the children. ..these days it's much more okay, you know you can do it - you can get married and still have a career out of it and you can still be ambitious and get on. I think the opportunities are there now for nurses to achieve more, certainly academically, than they were when we were training.* (Nurse Q., Sp.nurse)

Opportunities for women, and specifically nurses, continue to improve. The changing demand for parental employment in recent years has led to a major expansion in the provision of child care services. The number of women with young children under five years of age who seek to work outside the home has risen sharply since the late 1980s, with their employment rate more than doubling between 1984 and 2000 (Cameron et al. 2002). This provides a marked change from the expectation that married women with families and paid employment were incompatible, or at best secondary to their domestic duties (Dally 1982). Since 1997 there has been a shift in public policy support for maternal employment, with the government's current plans to provide over one million new childcare places by 2004 (Department for Education and Employment (D.f.E.E) 2001). However, women continue to be constrained by their biological function as mothers, and by society's expectations of their nurturing role. Muff (1988), who examined sexism and socialisation in nursing, noted that female nurses undergo a dual socialisation, both as women and as nurses, and identify with the traditional female stereotypes. Thus, those that enter into nursing respond to the expectations of the "natural" female attributes of caring and nurturing.

Socialisation into a specific sex role, either male or female begins at birth and continues throughout a person's life. Certain occupations such as nursing, teaching and parts of the leisure industry are identified with a female workforce and in turn, these occupations are identified with the traditional social values and attitudes of female service. May and Fleming (1997) hold that professional knowledge and organisational construction in health care are sustained by gendered identity, perpetuating institutional boundaries between professions. Indeed, as long as nursing remains a predominantly female occupation, these boundaries will be difficult to disrupt. As the data continue to display the influence of gender on multiple aspects of the nurse's role, it is pertinent at this point to explain briefly the basis for gendered differences within our society and their influence on the role of the nurse.

Gender influences and nurses

The division between males and females is based on the different physical attributes accorded to each group. However, although males and females have emotional and behavioural differences, Helman (2000) notes that society is influenced by the cultural meanings assigned to the different psychological and physiological actions. Gender is based on four complex factors: genetic gender relating to the combination of sex chromosomes, somatic gender, based on physical appearance and secondary sex characteristics, psychological gender founded on self-perception and behaviour, and social gender, defining the expectations and rules of the cultural representation of males and females in a particular society. Thus, the gender division of males and females in society leads to a set of cultural

guidelines, both implicit and explicit, which regulate the norms of behaviour, beliefs and attitudes.

The structure of nursing and the role of the nurse are heavily influenced by gender. Sociologically, nursing continues to focus on its subordination to medicine (Joseph 1994). This is due in part to institutional inertia - the traditional acceptance by the female nurse of the male doctor's supremacy. Both professions have powerfully embedded and intrinsic social differences. These are characterized by such issues as gender, class, status, economic and cultural expectations and resources, and there is a wide division in the degree of autonomy held by each profession. Hospitals still tend to recreate the basic cultural gender divisions of the wider society, with family imagery retained in the terms of nurse, sister or matron. Davies (1995) claims that in nursing the dilemma of gender continues to exist with the doctor/father, nurse/mother and patient/child structure remaining prevalent. Indeed, the challenge for many nurse participants is how to embrace change and also to retain their ideal of the nursing role as a separate entity, rather than submerging it beneath the roles of others, such as doctors. The image of masculine identity in Western society continues to align itself with a position of power, and although more men are now entering nursing, their career progression is sometimes disproportional to their numbers. Evans (1997) explores how men relate to the quintessentially female role of nursing, and demonstrates that men disassociate themselves from the lesser value feminine role, sometimes distancing themselves from the image of nursing. Furthermore, she suggests that men in nursing are aided in this by female nurses, and the patriarchal culture in health care establishments.

Paternalism in institutionalised settings such as hospitals, both within nursing and without, promotes inequities of power. The feminist perspective of power is consensus and sharing, whereas the male view is often, according to Ford and Walsh (1994), ritualistic and authoritarian. Thus, the female nurse participants influenced the sharing of power, which was perceived as enabling and empowering staff, and consequently had a positive effect on their nursing practice. This nurse described how her role enabled staff to be caring in their dealings with patients.

> *...they will notice if somebody (patient) is lonely or not participating in conversation, they will find little ways of drawing them in, and nurses will boost their self-esteem... if you notice nurses changing a nightdress they'll say "that's a pretty nightie", and it may sound like nothing, but the whole thing is a gradual nurturing to that person, so I feel that is one of the most satisfying parts to enable me to do that, and also to enable my nurses to do that.* (Nurse I., S.)

However, the nurturing elements remained constant throughout the changes, with nurses offering implicit support to patients during their hospital stay. Williams' (2001) exploration of the nature of intimacy between nurses and patients claims that it is intrinsically linked to the therapeutic relationship through affinity, touch and sharing. Contributing to the notion of empowerment was the level of education, and some of the participants found the changing education of students a challenge in the working environment. The traditional training was giving way to a more academic standard, which for some, was seen as an opportunity to challenge ritualistic practice.

> *... I don't feel particularly threatened by a degree nurse. I would be quite prepared to listen to any student, because students give us knowledge. They are the ones at the front, I suppose, of education, and bring that knowledge to us .* (Nurse S., S.)

Nurse S. had many years' experience in her specialty and was confident and competent in her area of practice, and welcomed the opportunity to develop further. Indeed, changes to the nurse's role within the profession was viewed as empowering for individuals and nursing itself, and this nurse for example was keen to be part of the future developments.

> *...it is becoming much easier with the changing education and the nurse practitioner roles. I think that is a very positive aspect of nursing* (Nurse F., C/N.)

Power and empowerment were linked to the autonomy of staff and nurses' perceptions of the power and control of other professions, thus the issue of medical power is discussed in the next chapter. Many nurses felt able to develop clinical practice for the benefit of the patients which was not medically driven, and which did not require medical permission.

> *... I think we need to take control of the things we want to do, and to give us the scope to develop in other ways, other than just the junior doctors' tasks, so at least some of my people are working on things like swallowing assessments and that type of thing. That is actually quite skilled, and is usually done by a Speech Therapist, and it's of clear benefit to the patients and has nothing to do with junior doctors.* (Nurse K., S.)

Thus, empowerment was linked to taking control of the direction of change. Fulton (1997) examined nurses' views on empowerment from the perspective of critical social theory. This philosophy asserts that in order to understand a social phenomenon, it must relate to the history and structure on which it is founded. The influence of the traditional basis of nursing was reflected in Fulton's (1997) study, in that nurses stated empowerment of others was not possible unless nurses themselves were empowered. Knowledge and experience aided their belief in their own empowerment, but empowerment was limited in relation to more powerful groups such as doctors. Du Plat-

Jones (1999) in her literature review of power in nursing, concluded that nurses need to raise their profile in order to represent and empower their clients. Nursing, therefore, must be seen as the means of sharing knowledge in order to promote empowerment. The relationships which develop in healthcare also impact on the level of empowerment. Thus, developing a relationship with their immediate manager influenced how the participants fulfilled their role.

> *...I have my manager directly upstairs, if I need anything and I don't know how to do it, I usually go and plead ignorance and he does it for me. He does quite a bit for us..* (Nurse E., Sp.Nurse)

Developing a good relationship with their manager also depended on mutual recognition of each other's skills.

> *... the Service Manager is very good at the bigger issues surrounding contracts and things like that... doesn't particularly bother with the nursing side of things now... like training... he puts a concessionary signature on it (the application form) and then that's it.* (Nurse F.,C/N.)

The structure within healthcare continues to change and evolve, however several participants felt that the changes were being repeated from an earlier era, echoing many long-standing challenges and opportunities.

Turning full circle

One of the continuing changes was the academic level required for entry into nurse training. This was viewed both as a reason for encouraging nurses to enter nursing as a career, and blamed for the lack of completion of the course for those who could not maintain a high academic standard.

> *I think it will go full circle, give us another 20 years and we'll be back to taking 5 'O' levels or equivalent...The pressures on the students are higher so there's fewer that are completing...those that do come out (finish training) don't want to stay at the basic*

nursing level for too long because they've got their degrees and diplomas, they want to climb the ladder as fast as possible. (Nurse M., S.)

She went on,

"...but you do actually need people there at the bedside, giving out the tablets and doing the dressings..." (Nurse M.,S)

This feeling was echoed others,

Well, to me, I just feel as if we're going back twenty years, because we did all this twenty years ago when I started my training. I mean, we were doing I.V.s (giving intravenous drugs) when I qualified. I used to do cannulation, we catheterised male patients during our training, and now we've gone the whole circle again. (Nurse R., S.)

Many participants acknowledged that they had acquired skills in the past which were now regarded as extended roles, although these had been included at that time as part of their normal role. Despite the participants having different specialisms and age groups, they shared their views that a significant basic standard of education was required to train as a nurse. Indeed, Collings' (1997) findings from two surveys conducted sixteen years apart, found little change in the reasons why people entered nursing. People-oriented motives continue to attract those whose aim is to care for others although Cook and Webb (2002) suggest that both medicine and nursing are moving away from the patient's bedside.

Langston (1999) claims that nursing parallels the evolution of society, from an industrial age to an informational age, and that society will view nurses as having an increasingly valued level of knowledge. Although the participants recognised the need for theory-based practice and increased nursing knowledge to improve their skills, they felt that generally the population

should take some responsibility for their own health. Hospitals, however, would continue to be necessary for patients needing nursing care.

> *... I think that patients will still want to come into hospital, there will still need to be some environment for them to come into, I am convinced of that.* (Nurse H., S.)

This statement echoes the thoughts of many nurse participants, who claimed that there would always be a need within the foreseeable future for an environment in which to nurse those who required acute nursing care.

This section has centred on the participants' views of the opportunities they perceive as available for development, and the factors which are seen as necessary to promote these. To effect change suggests taking responsibility for any actions, and ensuring that evidence is used to support these. Research use and implementation is an area that needs positive encouragement, and remains a challenge to nurses. The issues of power and empowerment in health care are complex and multi-faceted, and reliant on the control of those in the hierarchically structured professions of management and medicine. Many nurses felt nursing was on a cycle of change that was being repeated, and therefore nothing new was being developed. However, although paternalistic traditions in health care continue to thrive, nurses are developing practices into areas which benefited patients rather than junior doctors. Thus, these nurses viewed developments within the scope of their practice as enabling them to move forward, even though some of the older nurses who had been trained for some years felt that nursing was turning in a circle. Development could however be problematic, with the loss of some areas of practice in order to gain others, echoing the

changing social structure in health care. Some perceived this as a potential threat, forcing them to choose which direction to take. The issues relating to these areas are discussed in the next section.

4. Making choices

This construct contains the categories which developed through the participants' feelings of threat to their role. They felt that pressures in the workplace were affecting their role, they were forced to make choices, and although some of the changes taking place were improvements, some nursing aspects of their roles were being lost to untrained staff.

Feeling the pressure

Nursing has always been associated with hard work, but traditionally this was considered mainly physical. However, physical practical work is now combined with other developments to the role, and subject to pressures within the organisation such as the rising numbers of patients. For some nurses this led to increasing tensions and difficulties in coping, with them occasionally feeling unable to manage their workload.

> *I just feel as though I'm constantly swimming against the tide, and sometimes I go under, and I go under twice, and I just worry that one day I'll go under for the third time. The pressure is vast.*
> (Nurse O.,S.)

Pressure on nurses to deliver the care expected and cope with an ever increasing workload continues to grow as the health system strives to treat an increasingly elderly and sick population. Graham's (1994) phenomenological investigation into how nurses experience nursing, identified the pressure nurses felt to do the routine work yet also to be

involved with their patients, and attributed the pressure to the organisational structure which controls nursing practice. Nurses tried to achieve both their own goals and those of the system by working faster. This was observed by a specialist nurse who had been trained many years.

> *...I can see when I go to the wards - nurses - they are absolutely - you know,- the steam's coming out of their ears and off their ankles where they're sort of racing around!* (Nurse Q., Sp.nurse)

With the constant elevation of government targets, nurses' workloads appear to be increasing exponentially. Through the current hospital system of deploying staff, nurses could be moved to areas of severe shortage, often leaving their own ward area depleted. The aim was to prevent unsafe levels of staffing where possible, by spreading existing staff to cover all shortfalls. However, nurses found this frustrating and demoralising, and this nurse, like many of the participants was aware that juggling the workload resources was only a short term solution.

> *...at the same time you can't keep pushing and squeezing the system, and take it from one area and put it into another and expect that system to cope...* (Nurse S., S.)

The participants employed several different strategies in order to cope with the increasing amount of work. Many worked over their contracted hours in order to complete the required paperwork. I asked this nurse about the administrative part of her role, and whether she needed to do it in her own time.

> *Yes, I do, I do it before (clinical) work, every day, normally I do an hour before work. You know, I get here early to do it because it's peaceful, get here half past six, quarter to seven, and work for an hour and that clears it all away, and leaves me free to do whatever I want, you know, patient-wise, for the rest of the day normally.* (Nurse K., S.)

Many of the participants found that increasing administrative tasks required longer working hours. Those that chose to come into work prior to their shift starting time, revealed the increasing amount of bureaucracy in the quantity of administrative tasks. According to Bolton's (2003) investigation into the role of senior nurses as managers, with their concomitant functions of clinical practice and administration, nurses have mixed feelings over the multiple work roles now required. The volume of administrative duties for senior nurses was similar regardless of their roles, with both specialist nurses and ward sisters experiencing comparable demands. Some nurses took the administrative part of their work home to complete, but in choosing to do so, risked an adverse effect on their family commitments. In particular, those with young children found this more difficult as family expectations were higher, and the demands of family life constrained the use of participants' own time regardless of their willingness to try to work at home.

> *I think my patience with the children is a lot more stretched than it was... some of my staff have got horrendous home problems. I'm lucky, I've got three healthy kids and a reasonably supportive husband. If I didn't have that I couldn't cope at all, no way.* (Nurse M., S.)

Those nurses that had a specialist role also found their work encroaching on their time at home, as it was sometimes easier to telephone a patient out of hours.

> *I do ring patients at weekends. If I've started somebody on (drug) on Thursday and I try to get their dosage adjusted - say they are very new to it (treatment), and so they've been doing it Thursday and Friday, and they have suddenly been let loose on their own on Saturday to do their injections, I usually give them a ring, sort of about 9 o'clock Saturday morning to make sure they managed O.K...but that's my choice.* (Nurse E., Sp. Nurse)

However, she invariably experienced an increase in her patient caseload, and found that extra services were expected to be added to existing time frames.

> *Mondays were Admin days, all except for one (per month) which was a (special) clinic. Now we have two clinics, that's with all the extra clinics...so I'm lucky if I get that Monday afternoon. But then we have lots of patients ring me up or want to come and see us...we tend to just slot them in when we are not in the clinic, so that's a lot of that time gone...* (Nurse E., Sp. Nurse)

Keeping records and documentation up to date, writing letters, answering complaints, dealing with staff sickness and personnel issues, were but a few of the non-nursing tasks undertaken. To execute these tasks competently requires a knowledge of legal and human resource issues, together with secretarial skills and computer literacy. Lawrence et al. (1996) examined the forces which encouraged nurses to remain in nursing. They found the positive effects of social recognition and technological progression contributed to personal commitments. Most of the participants, although feeling that their job trespassed on their own time, felt committed to completing their work as they enjoyed their role. However, they recognised that working long and extra hours is becoming accepted practice, and that trying to do two people's work could lead to burnout.

> *...we know now most professionals, classes of lawyers, nurses, all sorts of people do other than their 37½ hours week... but I ask myself - is it acceptable?* (Nurse D., Sp.Nurse)

She went on,

> *...people work twice as hard as they did 20 years ago... it's something that's becoming accepted practice, dangerous accepted practice throughout the whole of the country...*(Nurse D., Sp.Nurse)

With the increase in information and communication technology, it has become easier for administrative tasks to be completed away from the workplace. Thus, these can frequently be delayed to be carried out at home, or later in the day when direct patient care has been completed. Cherniss (1995) studied groups of human service professionals, consisting of lawyers, nurses, teachers, social workers and others. He found that over a ten year period many experienced professional burnout, and that in order to overcome this, there needs to be a balance between "giving and getting". Personal control, autonomy, and satisfaction with life and work were all found to influence levels of stress and the potential for feeling under pressure. Recent government legislation with the publication of the Improving Working Lives document (D.o.H. 1999) aims to achieve a more acceptable balance between working and home life, and improve the lives of those who work in the N.H.S.

This policy enables staff to work more flexibly, and to choose such systems as working annualised hours. Through this, staff are permitted to work a set number of hours per year but are not constrained to a particular shift pattern, allowing more control over their work-life balance. However, many participants raised concerns that their posts would be jeopardised by future national or local cost-cutting exercises, and felt pressured into continuing their attempts to fulfil all roles in their expanding workload. Nonetheless, as they were frequently unable to complete all their tasks, many participants felt compelled to choose which functions were more important and should be given priority. Making these choices required professional insight into all the available options. The participants were familiar with the expectations of others - the organisation, the general public, peers and superiors. These

added to the feelings of pressure, as the general assumption was that these expectations would be met. There was some disparity in their perceptions of public expectations, although others felt that these expectations were not unrealistic,

> *..peoples' expectations are quite basic and I think are therefore achievable, nursing can achieve an awful lot based on those expectations and look to providing more.* (Nurse H., S.)

Others feared complaints and litigation from those whose high expectations were not met.

> *... I don't think a lot of nurses are very confident. I think because of the Patients Charter, because of complaints, nurses are very worried about being attacked, or being made accountable for what they've done - and they are taken to court for it.* (Nurse R., S.)

Expectations from superiors that a nurse could be available at a particular time for any meeting without consulting them first, added to the feeling of pressure.

> *...again its expectations, some people haven't a clue about why you haven't opened the post in three days. They send you something telling you you've got be somewhere two days later.* (Nurse B., S/C.N.S.)

These statements highlight the lack of control the nurses experienced in attempting to perform all parts of their role to their own and others' satisfaction. The feelings of pressure appear to emerge through nurses' lack of control over the parts of their role influenced by external agencies. Locus of control refers to the beliefs held by individuals over who or what controls events or actions in their everyday lives (Gross 1987). This influences how they react to others and to situations in which they find themselves. The issues related to retaining control in their working environment such as political policy reforms, frequently posed constraints within the current

organisational system of health care, setting boundaries on nursing practice. Government policies such as reducing the time which patients had to wait for investigations or surgery, impacted on the rapidity with which existing patients needed to move through the system (D.o.H. 1997). This, coupled with the external influences of others' expectations, frequently served to increase the sense of frustration experienced in the workplace. An analysis of nursing in relation to the context of health policy reforms by Antrobus (1997), examined their ideological and philosophical basis. Comparing these to the original function of the N.H.S., she emphasises the need for contemporary nursing to focus on patient advocacy by reaffirming the original principles. However, changes to the role of the nurse in the workplace, with added pressure to deal with increasing information technology and clerical workload, could appear to marginalise nursing. These raised considerable anxieties and led to participants considering alternative career paths.

The influences of change drive the choices, in as much as providing a justification for preferences for ways of working in the future. Thus, the influence of advances in the field of medicine impact on the care of the patient, and consequently on the role of the nurse. This raised several dilemmas for the nurses that their way of working was continually changing, but not always in the way they would wish. Several participants raised concerns over the job situation, and whether they needed to make career choices regarding which direction to follow. The differences were more evident between the male and female participants, with this male nurse, for instance, choosing the business aspect rather than clinical nursing.

> *You see, my interest isn't the 'nursey nursey philosophy' and soft stuff as I would call it, my interest is more in the business side, which probably differs from most nurses' ideas of what they enjoy... I prefer the directorate (business) meetings, because we are looking at how to sort things out money wise.* (Nurse F., C/N.)

This participant's sentiments are similar to those in the study of Evans (1997), who found that male nurses segregated themselves from the feminine attributes of nursing. He expressed a lack of enthusiasm for the gentleness of nursing so valued by many of the female participants. He was much more interested in the business side and differed from some of the female nurses who valued the humanistic part of their role. Differences between the genders here apparently sustain these opposing views, with the gender of the nurse also contributing to decisions of career choice.

According to Whittock and Leonard (2003), it appears that other countries are able to attract males to nursing in greater numbers than Britain. Their pilot study examining the reasons for motivation for men to enter and remain in nursing raised several issues, not least the need to address gender specific areas such as feminine connotations of nursing. Further, Cross and Bagilhole (2002) who examined masculinity in men in non-traditional occupations, found that men who experienced challenges to their masculine identity reconstructed a different identity by relating to more traditional male roles such as taking control, thus maintaining themselves as the dominant gender. This concurs with Mac Dougall (1997), who found men in nursing follow a traditionally masculine path, which is one of the reasons for their increasing numbers in positions of power. For the female participants, choices needed to be made in relation to other commitments, and the most beneficial time to take a career break. Indeed, after one interview the

participant told me that she desperately wanted another baby but was concerned that her post would disappear if she was absent on maternity leave. Those nurses that were free to move geographically were seen as more able to progress in their career plans.

> *...the promotion is not there now (locally),...whether it's because of the fact that they're married, or partners, or mortgage here, and so therefore they (nurses) are not as mobile as when they were young, free and single. In order to change that promotion (structure) people want to go into positions paid to stay where they are.* (Nurse S., S.)

Lack of local job opportunities and constraints on their mobility compelled nurses to remain in their current employment regardless of any extra skills they acquired. Although all participants worked full time they felt there was little opportunity to retain their posts if they chose to become part-time. Blackwell's (2001) longitudinal study of part time work and sex segregation, confirms that although full time work for women is becoming less gender segregated, part time work is becoming more so, with a consequent impact on career progression. Indeed, the female nurses' accounts convey the difficulties in adapting their family obligations to the rigid working patterns of twelve hour shifts, which meant that they had less career choice unless child care provision was available and affordable. Although this is improving slowly, particularly with the government's policies in ensuring equal opportunities for women (Cameron et al. 2002), it remains a current issue for those with family responsibilities. A selection of different shift patterns were being piloted, but these were not perceived as conducive to family life.

> *What do they expect when it's a mainly female profession, to work twelve hour shifts? And with a family ?... alright when you're young and you've got no ties and you're dedicated, - and it's your job!, your job!, your job!* (Nurse N., S/N)

Lane (2000) who examined the careers of over 600 N.H.S. nurses, described nurses in part-time employment in the N.H.S as reaching a "bed-pan ceiling", where they are given low status. This was perpetuated by managers who fail to recognise the need for part-time clinical nurses to progress to higher levels, thus impacting on their retention and contributing to the shortage of qualified nurses. Lack of promotion opportunities have also been highlighted by Mackay in 1989. As nursing is a female dominated profession, however, men are seen as having the advantage of not normally being constrained by family ties and responsibilities for childcare, even if they have a family. The financial implications of unemployment posed a worrying concern for future job security, adding to a feeling of implicit job demands.

> *I think in view of the job situation there is pressure but it's subtle, - there is no direct pressure from anyone. Mostly it comes from within, (yourself) but there is a subtle feeling that if you don't do something you won't have a job, because you've got to justify your grade all the time.* (Nurse K., S)

Losing parts of the caring role to others

Threats to the nurse's role illustrated the paradox of promoting developments, but also restraining them. In order to develop future skills, it was necessary for the participants to delegate some parts of their role. This transition was aided by the doctors directing tasks for the nurses to carry out, leaving them little choice over which skills to retain, and which to relinquish. There was a feeling of need to take control, to use this as a means to choose the direction of development.

> *...we need to take the reins, but I have this awful feeling we won't, and I think we will have missed, yet again, another opportunity.* (Nurse N., S/N)

The nurses were apprehensive about losing parts of their role which they deemed worthwhile, but which could appear less valuable to managers or other professions.

> *There is a concern I think within the profession that as people - as nurses - take on more high-tech roles, all those non high-tech roles such as psychological care, such as physical comfort, are deferred down to the health care support worker, and some nurses feel that in doing that it's denigrating the value of those roles of psychological support and physical care.* (Nurse J., S)

These intangible parts of the nursing role were very important to the nurses, and they needed to be able to convey those qualities when carrying out direct care. Watson (1985) describes this as an interdependent and intersubjective process, and part of the conditions necessary for human caring. As such, it is sometimes difficult for trained nurses to explain to untrained nurses who may not have been given the necessary knowledge and understanding. These are skills that many consider basic, however, they are the important issues which ensure the patients are well cared for and comfortable. They enable the nurses to nurture the patient, part of the role which they are reluctant to lose to others. These basic practical skills can, when applied to the nature of nursing, encompass a wide range of expertise not visible to others, and therefore not measurable or considered valuable. They are the skills, however, which lend presence to the interaction between nurse and patient, promoting a feeling of well-being in the patient, and satisfaction in the nurse. It may be that this interaction takes place on such a fundamental level that the connection is not acknowledged or indeed recognised by those whom it does not concern. Many authors seek to identify this communication, and indeed explain in detail the concept of caring. However, it frequently remains elusive except to those who experience its shared

meaning, and the description of basic skills provides a vehicle for its application in practice. The effect of diluting the number of trained staff with untrained members was therefore an area which the nurses felt should be monitored. Indeed, the results of a study by Chang et al. in 1998 identified that both direct and indirect care given by trained nurses was reduced when untrained health care assistants were introduced. This supports the concerns raised by the nurse participants that health care support workers do not receive sufficient training thus reducing the quality of personal care being given to patients.

> *...support workers are a very large impact upon nursing and you have to be very careful that it doesn't affect care that's provided.* (Nurse J., S.)

Several of the senior nurses felt that the number of support workers had grown over the past decade, and that consequently this increase had affected the mix of skills within the nursing team. In many areas the name by which the untrained role was known was also changing, from nursing auxiliary or assistant to health care support worker.

> *...ten years ago patients would have had a team of nurses looking after them with perhaps a couple of auxiliaries, but the auxiliaries were very much perceived to be just the people who made the cups of tea and got your things or put the flowers in the vases and things like that, but that has changed very dramatically in the last five years...and now those health care support workers are having much more impact upon direct nursing care* . (Nurse J., S.)

With changes in increasing technology and management needs removing nurses from direct bedside care, the role of the untrained health care support worker continues to change. Initially recruited to supplement the removal of traditional, apprentice-style student nurse trainees into higher education, (U.K.C.C. 1988), health care support workers are required to undertake a

competency based vocational qualification in their work area. They are classified separately from pre-existing unqualified nursing auxiliaries, although it is common practice for these two types of support workers to work together in a clinical area with no visible means of differentiation. However, according to the R.C.N.(2003), their numbers are increasing dramatically, with a 46% increase in three years. This increase in numbers highlights both a need for those with basic skills to be present at the bedside, and the relocation of the trained nurse to indirect nursing roles. Indeed, the participants associated certain risks with delegating this part of the nurse's role to the untrained nurse. This participant emphasised the feelings of many,

> *The risk is that if those people aren't trained adequately, then either the quality of the care drops to the patients, or the patients feel they have not got skilled enough care looking after them, or extra work falls to the registered nurses.* (Nurse J., S)

Delegation of any part of the trained nurse's role is subject to the knowledge required to carry it out. Thus, according to the professional code (N.M.C. 2002) the trained nurse must be satisfied that the person delegated to execute any duty must be competent to perform it. Nurses are therefore deemed to have the higher level of knowledge to be able to assess their own workload, the needs of the patients, and the competence of their staff. According to Thornley (1997) and Pearcy (2000), many untrained health care support staff work without the supervision of, and carry out procedures normally completed by, a trained nurse. In order to accommodate all aspects of care, the participants recognised the need to consider what they were now being required to do. This led to the impression that their nursing role was being directed by the doctors, rather than themselves or the needs of the patients.

Doctors directing nursing

Historically, nursing has remained under the aegis of medicine. The medical profession, as a more privileged occupation with its inherent autonomy, monopoly and specialised knowledge, acquired its power after a long campaign dating from the nineteenth century (Blane 1997). In contrast, nurses achieved relatively little power or control over their work, which was delegated to them by the doctors. One of the participants had worked in another hospital with a doctor, and supported him there in his more junior role, but that did not prevent him from behaving formally in his current role as a consultant, with no recognition of their previous working relationship.

> *...I'd known him as a junior doctor...but he very quickly took on this persona of " I'm a Consultant, I wear a suit, I say what goes," and it was really strange.* (Nurse A., S/C.N.S.)

She noted that even though he was comparatively young, his behaviour differed little from his more senior colleagues.

> *...you would have thought that he (Consultant), coming at the age of 40 would be dynamic and innovative and accepted all the changes, but in fact he's more entrenched in traditional roles of consultants than any of the others, really.* (Nurse A., S/C.N.S.)

The consultants were not seen as part of the ward team in some areas, and not expected to comprehend the role of a nurse.

> *"Consultants, well that's a different breed! - and really they don't understand (the nurse's role) but you have to work with that.*
> (Nurse H., S.)

Not all participants experienced this division, however, and nurses caring for elderly patients felt that their doctors saw all their patients as individuals. It

was felt that this related both to the speciality and to the doctors' personalities, that the multi-disciplinary team respected each discipline's skills and worked closely with the nurses. Each understood and relied on the function of the others, and worked in conjunction with other team members to provide the means by which patients could be discharged from hospital. However, this method of working appeared to be moving away from the traditional doctor-led decision making and was not common to all areas. In 2000, Bradshaw posed the question of the purpose of a modern nurse. She examined the historical view of nursing competency, and found that this was based on biomedical subjects. Issues which arose from this were the need for defined competencies, and also discussion regarding the ongoing mutation of the role. However, external demands and traditional working practices continue to influence how nurses function. Thus, acknowledgement of these issues allows nurses to raise awareness with others, and retain those which they value.

These statements from the nurses underline those issues which are perceived as threatening to their role. The majority can be viewed as outside the control of the participants. The increasing workload was a dominant factor, deriving from the expectations of health care professionals, the public and the government. The implications for these nurses regarding their choice of career progression depended upon whether they were able to move to another area, and the constraints of their family commitments. Their ability to retain those nursing skills perceived as valuable to their role was governed by the demand to take on medical tasks, those roles relinquished

by doctors but still needing to be carried out. In turn, in order to do this, the nurses would be required to abandon some of their own workload, particularly in those areas which could be carried out by an untrained nurse. These areas however, appeared to many as the essence of nursing, an important part of their professional relationship with the patient and their personal commitment to their role. However, there was a marked difference between the male and female perspective, highlighted by the male charge nurse's comment on the "soft stuff" of nursing, in which he had no interest. The soft stuff of nursing was, nevertheless, highly significant to the female nurses who valued it and did not wish to delegate it to the untrained staff.

It is pertinent here to acknowledge that the perceptions of nurses may be affected by their age, previous experience, level of seniority, their current job role and their gender. Naturally, these issues have the potential to influence the results, and I have attempted to show, within the bounds of confidentiality, how their perceptions have been influenced by these issues. However, as shown in the table at the beginning of this chapter, the age range of the nurse participants varies from thirty years to fifty years, with the majority of nurses between thirty and forty five. Although it is not possible to restrict the sample to exact specifications of job role and experience, this age span offers a natural boundary which allows for the comparison of their perceptions and subsequent theoretical sampling within a similar age group.

Nurses' accounts : overall findings

The overall findings of the nurses' accounts demonstrated through these four constructs illustrate the issues that are significant to the nurses in the process of change. They portray the different perspectives and expectations of the participants. From my analysis of their perceptions and experiences, they exhibited an underlying collective feeling of nurses' different roles developing cautiously, albeit subject to constraints and influences from outside agencies such as the government and the medical profession. Their role appeared to be greatly influenced by the need to provide a service which would enable them to care for patients to their own and others' satisfaction. An integral part appears to be formalised educational development, sometimes determined by the need for nurses to fill the workforce gap left by the medical profession, or the need for specialist nursing knowledge. There appeared to be an increasing overlap in the roles of the trained and untrained nurses, and between trained nurses and doctors. The changes to nurses' roles instituted as a result are perceived to have developed from the influence of the government and the direction of the medical profession. The need to develop nursing knowledge underpinned the role as an abstract concept permeating the structure of the organisation, influencing the nursing role and the improvement of nursing practice. However, the drivers appear to be external, both from medicine and the patients, and although patient care could be assumed to be nurse led, the nurses conveyed reactive responses to the changes rather than proactive ones. These elements are displayed in Figure 3.

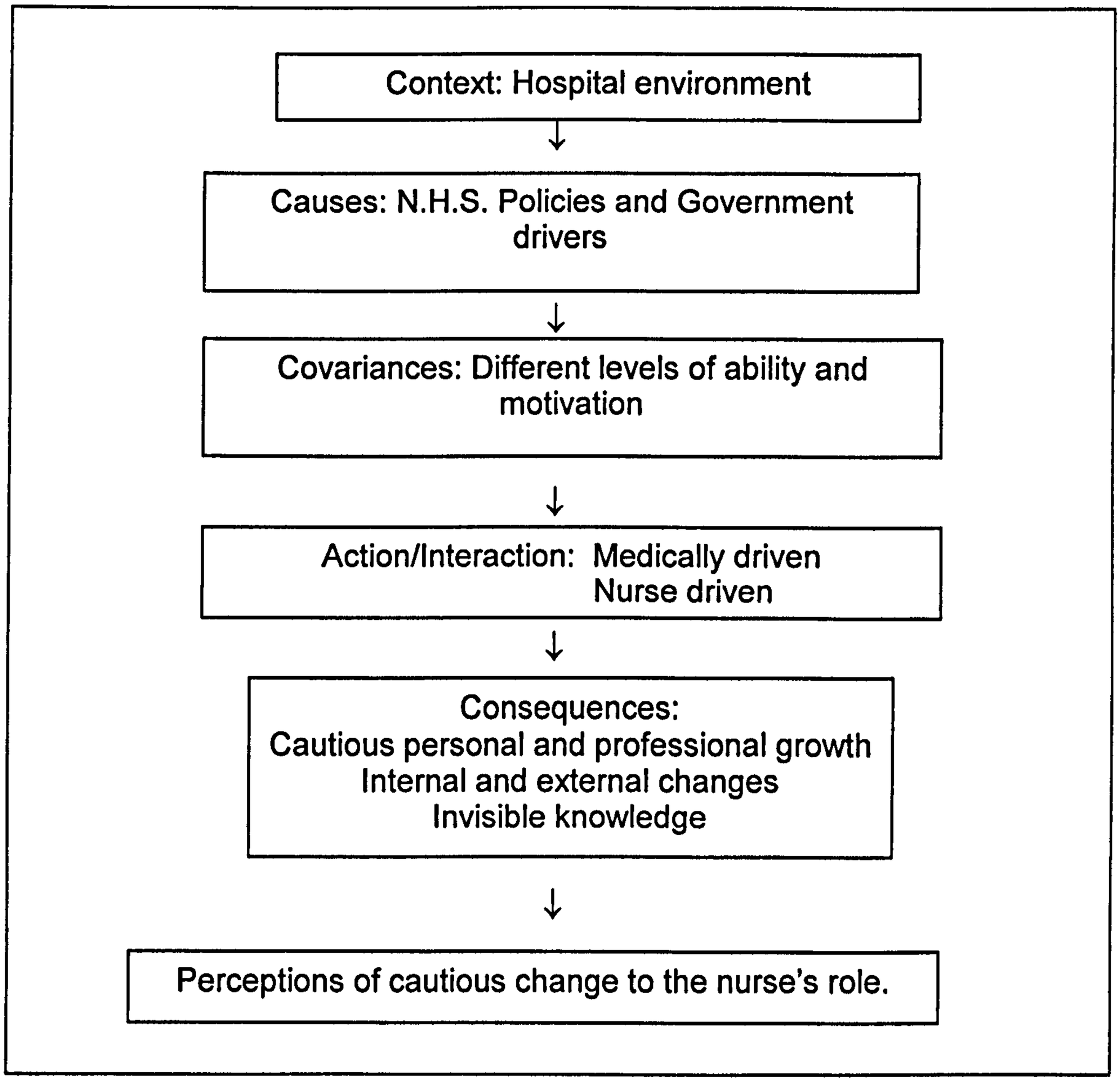

Figure 3. Elements from nurses' data promoting cautious change to the nurse's role.

This led me to the question that if nurses perceived their role was constrained and directed as a result of influences from outside the profession, that is, medically directed, how did the doctors with whom they worked perceive it? In order to discover this, it was necessary to interview several members of the medical profession, and this is discussed in the next section.

CHAPTER 4

DOCTORS' PERCEPTIONS OF THE NURSE'S ROLE

Introduction

Initially, arranging to interview doctors proved quite complicated. Having achieved this, the difficulties of finding a mutually convenient time and place then became apparent. This was not so difficult with the less experienced junior doctors as they were based on the wards and constraints on their time were less rigid. However, to interview the senior registrars and consultants required long negotiations in order to find some time when they would be undisturbed, which they would be prepared to share with me. Table 2 is repeated here to show the relevant information regarding their personal and occupational details.

		DOCTORS		
Code letter	**Age/ m/f**	**Current Specialty**	**Career level**	**Years in current post**
T	50 M	General and breast surgery	Consultant	10
U	42 M	Trauma and surgery	Registrar specialist	13
V	36 M	Surgery and urology	Registrar on rotation	5
W	25 M	Colo-rectal surgery	Junior House officer	1
X	40 M	Breast and vascular surgery	Registrar on rotation	5
Y	24 F	Surgery/urology	Junior House officer	1
Z	25 F	Vascular surgery	Junior House officer	1

Table 2. Population and Sample: Doctors; n = 7

Although the interviews were from doctors working in the same group of hospitals, by nature of their training all doctors below the level of consultant are a transient population and therefore had experiences in other hospitals. Also a significant proportion was foreign, with some doctors coming from the Indian sub-continent, Middle Eastern and the Mediterranean areas, but most had lived and worked in the United Kingdom for many years. The quotes are reproduced here verbatim and may in some instances be grammatically incorrect, due to English being the second language of some of the participants. I began by interviewing the very junior doctors who were known as housemen, regardless of sex. When no new data emerged, I interviewed the senior registrars, and then the consultants. There was a marked difference in their perceptions of the nurses' role, and this related to the doctor's level of responsibility and authority. In order to clarify these, the career level of each doctor will be added after the letters used in order to identify his or her status, (H.O. for a junior houseman, Reg., for registrar, and C. for Consultant).

The major constructs

Four major constructs evolved from the data which were:

1) *working together*, 2) *retaining nursing*, 3*) challenging medical power* and 4) *defining boundaries.* The caring, nurturing role of the nurse was a significant element in the data. The following diagram, figure 4, represents the categories and constructs.

1.Working together

⇧

Having a good working relationship	**Supporting junior doctors**	**Respecting nursing knowledge**
Working together	Taking on medical tasks	Educating nurses
Still learning	Blurring our roles	Patients come first

2. Retaining nursing

⇧

Understanding the role	**Maintaining clinical skills**	**Caring for patients**
Changing nursing role	Taking a task-orientated approach	Caring for patients
Understanding the named nurse		Having the time
		Losing nursing values

3. Challenging medical power

⇧

Knowing your place	**Developing in the right direction**	**Specialist nurses are different**
Following the rules	Progressing technology	Trusting specialist expertise
Conflicting interests	Increasing demands	Feeling safe
Consulting the doctors	Expanding role	

4. Defining the boundaries

⇧

Drawing the line between doctors and nurses	**Needing alternatives**	**Holding ultimate responsibility**
Accepting the problems	Moving forward	Clinical accountability
Making decisions	Evolving world trends	Worrying about the patient
Retaining authority		Serving the medical agenda

Figure 4. The categories and four major constructs emerging from the doctors' data.

The constructs which developed from the doctors' data indicate the importance of working relationships between nurses and doctors, and the issues which influence their working together. The framework developed as

supported by these relationships, but identified the areas where there was an observable division in the roles. These differences, particularly with the caring aspect of nursing, evolved as a significant issue for the doctors. This is displayed in figure 5.

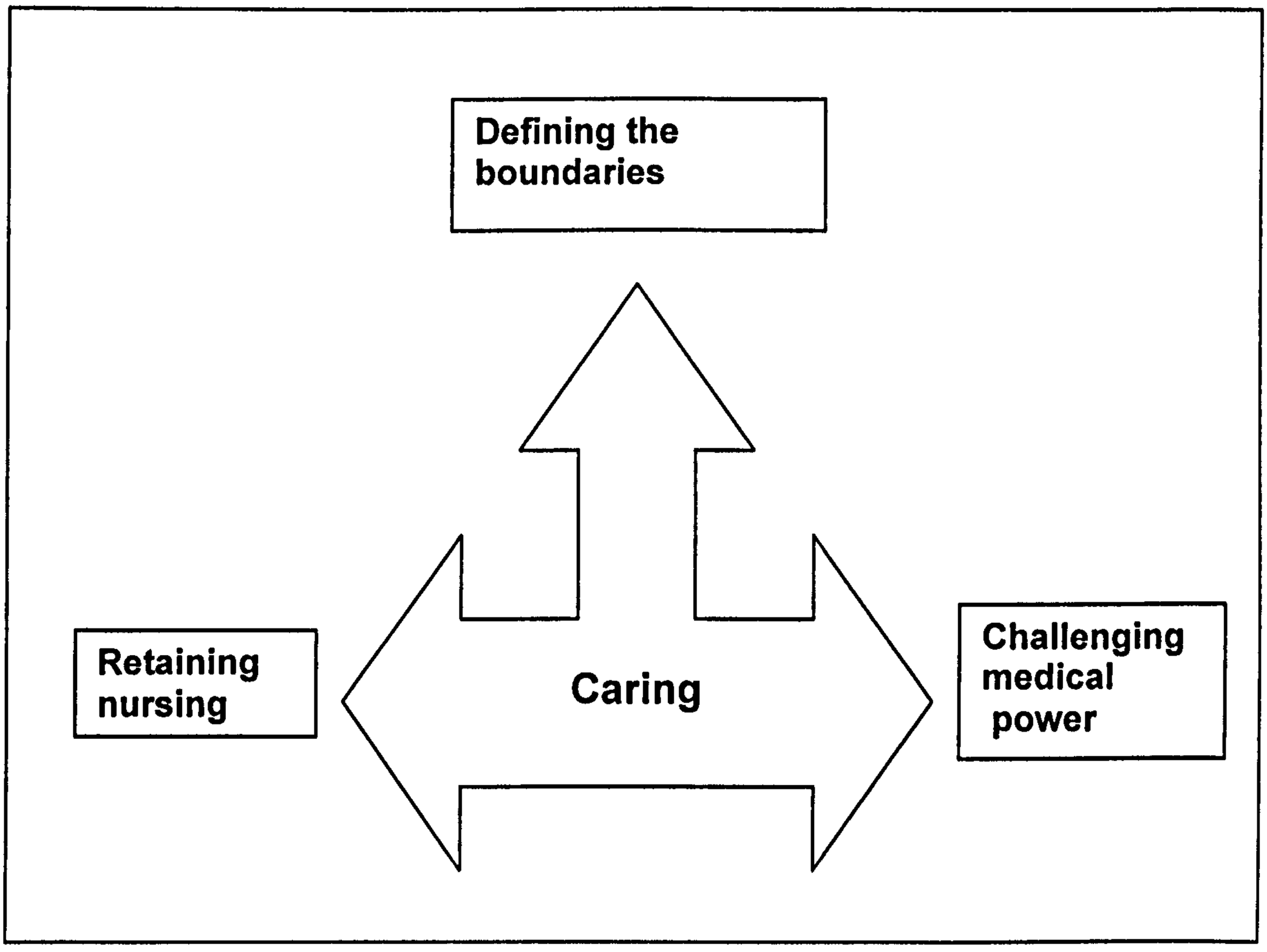

Figure 5. Diagrammatic representation of the framework of the doctors' perceptions.

Overview of the theoretical framework: the four major constructs.

1. Working together

Working together describes how doctors and nurses interact on the wards. This construct developed mainly through the concepts which emerged from the data collected from the pre-registration house officers. *Working together* was important as a basis for mutual cooperation. Although the value of

working together was mentioned by the more senior doctors, for the house officers it was a major factor in their socialisation into the working environment of health care.

2. Retaining nursing

Some doctors thought that nurses should 'nurse' and not involve themselves in such issues as education or further academic study. Clinical skills and the value of the caring part of nursing were felt to be an important component of the nurse's role. However *retaining nursing* was important to the doctors, even if it meant nurses focusing on task-orientated skills.

3. Challenging medical power

This construct gives examples from doctors who felt nurses were stepping into the doctor's role without the knowledge or responsibility to do so. However, it also highlighted their respect for the knowledge of the specialist nurses who worked closely with particular consultants. *Challenging medical power* arose from their perception of conflicting patient interests, with nurses challenging decisions.

4. Defining the boundaries

Traditional boundaries between doctors and nurses were perceived as becoming increasingly obscured. The doctors were conversant with many of the changes taking place in health care but were keenly aware that they held ultimate responsibility for the patient's care. There was the suggestion that a

third 'hybrid' profession should be developed as an alternative to nursing or medicine.

Each construct contains ideas which doctors considered important in the role of the nurse. However, they recognised that the role is continuing to develop and that future changes would affect the way in which nurses' nurse. These ideas are discussed in the following sections.

1. Working together

This construct was developed mainly through the concepts which evolved from the interviews with the pre-registration house officers (H.O.s), very junior doctors usually starting their first job after qualifying. Although the importance of working together was also mentioned by the more senior doctors, to them it was not such a priority. For the H.O.s however, this was a crucial factor of their socialisation into the working environment of health care.

Working relationships

The junior doctors considered having a good working relationship with the nurses on the wards as vital to learning how particular wards function. They changed jobs every six months, so needed to quickly gain a working knowledge of how the organisation worked and the geography of the hospital. Nurses could readily provide this information, thus easing the doctors gently into their new post. They could also be less than forthcoming if the junior doctor did not recognise their experience within the organisation.

Therefore having a good working relationship enabled the junior doctors to understand some of the nursing activities which took place in context, and to learn to work as part of the ward team. It helped doctors with their workload, when nurses carried out some of the practical tasks such as taking bloods, or putting a needle in a vein (cannulation). One of the juniors was particularly appreciative of help from the nurses, but felt nurses needed to stand up to pressure to carry out doctor's tasks.

> *I am really surprised actually when a nurse comes up to me and says 'would you like me to take the bloods, I need the practice', or 'don't worry, we'll do the cannulation for you'. I - like fall over backwards, - thinking wow that's amazing, that's really good, thank you, I don't expect it.* (Dr Y., H.O.)

The medical and nursing roles operate both independently and collaboratively. Good working relationships enable both doctors and nurses to function effectively and reciprocate support. Teamwork in healthcare remains a significant factor in the smooth running of the service. Dissatisfied members can easily disrupt smaller teams or groups which operate at ward level. Nurses and doctors working together need to portray a united relationship in order to retain the patient's confidence in their care, and the data describe the doctors' perceptions of working with nurses on the wards. The knowledge focus within this is based on the junior doctors' need to build a rapport with the nurses with whom they worked. This became a reciprocal relationship where there was an exchange of education and understanding. The data highlight some surprises for the doctors who did not expect nurses to be able to take blood, and also of the junior doctor who recognised that nursing might have its own agenda which should not necessarily include

medical skills. She was conscious that these tasks were still classed as medical skills and that nurses who did not want to do them should refuse.

> *I think if you don't want to do it you should stand your ground and say well, thank you for offering but no thank you very much we've got our own agenda that we need to look into and improve upon, and that doesn't leave us much time for taking over medical skills. (Dr Y., H.O.)*

The issues surrounding nurses taking on medical skills have been a subject of ongoing debate for many years. Junior doctors' hours continue to be reduced in order to improve their working lives and conditions. The implicit acceptance within the heath care environment that nurses will acquire those parts of the doctors' roles the doctors are unable to do due to lack of time, has led to many nurses themselves working increasingly longer hours in order to manage their own workload. The study of Walby et al. (1994) concerning the relationship between medicine and nursing draws attention to the cultural differences between the two disciplines, posing 'tidying up' as an example of both a trivial and important issue. Indeed, nurses tidying up after doctors promotes the subservient handmaiden image, and they suggest that this gives a clear indication of medical hierarchy in an organisation where this takes place with the potential to sabotage nurse-doctor relationships.

Socialisation of doctors

Part of the concept of collaboration between nurses and doctors involved the socialisation of the newly qualified doctors into the hospital culture. Working relationships are a key aspect of health care where most of the systems are interrelated rather than isolated, and many of the less visible aspects of nurses' roles such as facilitating the formation of beneficial relationships, are

indicated in the doctors' data. Being agents of socialisation for junior doctors required patience and support on the part of the nurses, and a broad knowledge of decisions relating to some of the problems the junior doctors were likely to encounter. The junior doctors were keen to ask nurses' opinions if they had doubts, and recognised that in some situations, the nurses knew more than they did. Checking that these doctors prescribed the accurate doses of drugs became expedient for all, with junior doctors relying on experienced nurses for help when they were unsure of the correct action or dose of a drug. Although nurses cannot legally prescribe drugs except within strict protocols, the doctors assumed they had the knowledge to recognise an incorrect prescription. The prescription of medicines is an area in the doctor's domain, although nurse prescribing is now beginning to be assigned to nurses working within specific fields, such as tissue viability and wound care. The basis for prescribing is the level of knowledge required in order to do so competently and safely. Knowledge of the physiological action of a drug is necessary to understand and prescribe its use. In the areas where the study took place, the pharmacist examined all prescription charts on a daily basis ensuring that the amount and type of drug used was prescribed correctly for that specific patient. It was important to the junior doctors that their prescriptions were accurate and not in need of adjustment before being dispensed, and they relied on their relationship with the nurses, and the nurses' knowledge to support this. However, prescribing rights continue to be extended for nurses and although not commonplace on acute wards, nearly 30,000 nurses in the United Kingdom are now able to prescribe (Harrison 2003).

McCallen's (2001) literature review of interdisciplinary practice indicates that teamwork is influenced by political factors and the culture and context of working methods within healthcare. Socialisation of doctors into the medical role commences in medical school, as they become part of the chosen elite selected for medical training (Blane 1997). It also involves attaining the appropriate professional behaviour towards clients and colleagues, usually known as the informal curriculum. Although this is learnt in theory during their training, applying it to practice in their first jobs, without the protection of student status, involves learning to employ social skills in the ward environment. Whitehouse et al. (2002) examined the experiences of medical students in their final year, assessing whether these promoted confidence in their ability to be a doctor. They noted that self-directed learning and educational supervision aided clinical skills, ability and being able to work as part of a team. Although doctors are supervised in their first junior year, initially they rely equally on nursing and medical support. The survey by Paice et al. (2002) on the relationship between pre-registration house officers and their consultants showed that the trainees were appreciative of clinical support and positive feedback. Indeed, Lambert and Goldacre (2000) who investigated the views of two cohorts of junior doctors over two separate one-year periods, found that the junior doctors regarded both senior nurses and doctors as supportive.

Supporting junior doctors

The junior doctors were very conscious that some nurses would be able to take on several of the doctors' more routine tasks but pointed out that nurses

should not be forced to do so. However, at this time, the impetus for nurses to develop these skills was promoted both locally and nationally. Much of the literature encourages multi-skilling with nurses feeling compelled to take on as many extra skills as possible for the good of the patient (Edwards 1995, Hopkins 1996). Authors such as Hunt and Wainwright (1993) and Bowman (1995) focus on the expanding role of the nurse into the medical domain, highlighting the attendant responsibilities and viewing these in a very positive fashion. However, according to Calpin-Davies and Akehurst (1999), little research has been carried out regarding the question of whether there are sufficient numbers of nurses available to take over doctors' tasks. They conclude that the assumption the nursing resource is, or will be adequate, is false. The reasons for this are two-fold; an on-going reduction in the number of nurses entering nursing in the future, and more specifically, whether nurses with the required skills would be available. They suggested this could have a negative effect on both the nursing skill mix and the proposed doctor-nurse substitution. Indeed, the exploratory study by Dowling et al. in 1995 mapped the work nurses took over from doctors and pointed to a significant need for strategic planning. In addition, the need for appropriate educational support for new roles in nursing was shown to be a crucial factor.

Edwards (1996) argued that by entering nursing, nurses implicitly take on the moral obligations which accompany that role. He identified an ethical obligation, including obligations to other health care professionals. Some nurses found that refusing to take on junior doctors' skills presented them with the dilemma of not acting in the patients best interests, as set out by the

N.M.C. Code of Professional Conduct (N.M.C. 2002). Indeed Graham's (1994) phenomenological study of how nurses experience nursing, suggested that educational reform was needed to overcome the demands of a medically orientated care system, in order to allow nurses to develop expert professional nursing.

The nurses used their professional knowledge to support junior doctors, and this was acknowledged by the junior housemen who were interviewed, who felt that support from the nurses was a vital part of learning how to be a doctor. They came onto the ward straight from medical school or having only worked six months in another hospital or area, were relatively inexperienced and not always supported by their senior medical colleagues. It was important to them to be seen by their more senior medical staff as being able to cope with the workload from the first day, and many relied heavily on the nurses to promote this image of efficiency and competency.

> *This is my first job and when I started here... I didn't know what I was doing and I very much relied on the nurses. I find the nurses here are very clued up on how they want to treat their patients and that sort of thing. They tend to help us out on drug doses and that sort of thing. Obviously when you are a houseman, you really don't know what you are doing or how things work... I don't think I could have got on very well if it wasn't for the nurses.* (Dr W., H.O.)

Both doctors and nurses recognised that it was crucial to work as a team, both as a benefit to themselves and to patients. In the context of modern health care, there is an increasing reliance on collaboration and teamwork between disciplines. The ability of doctors and nurses to work together is one of the many issues shaping current health care practice. During the time that this research was taking place, the junior doctors became part of a pilot

nurse/doctor mentorship programme. This involved several experienced registered nurses who each acted as mentors to newly qualified doctors. The doctors were supported through their induction to the wards, the socialisation process and the medical culture. It enabled them to view their nursing colleagues as supportive, and it cultivated mutual understanding, promoting a respect for nursing knowledge.

> *I think the nurses do a really good job to be honest with you. I think that they know sometimes more what they are doing than we do and I don't think I could do my job without them. I'll always ask their opinion if I'm stuck and I don't have any qualms at all, and they usually come up with some pretty good ideas because I've only been in the job four months and I respect the fact that they've been here a lot longer.* (Dr Y., H.O.)

Respect for nursing knowledge appears to change as the doctors become more senior. One of the older more experienced doctors at consultant level, identified a disparity between academic and practical requirements of the nurse's role.

> *...nursing has become or is going down the road of becoming an intellectual academic profession where basically it's a practical job, and I think this has been an error.* (Dr T., C.)

The changes in the doctors' estimation of nursing knowledge arose as the doctors themselves became more experienced and hence more knowledgeable. The perceived gap between the nurses' and doctors' knowledge widened in relation to the increased responsibility held by the more senior doctors. This doctor assumed that nurses did not require a theoretical understanding for their role as carers, and considered the academic route of nurse education a mistake as nursing is a practical skill.

> *...it's in your nature to be a carer, to be kind, to be gentle, to be understanding, the number of O levels or As you've got is unrelated to that. (Dr T., C)*

Although not explicitly mentioned by him, these behavioural attributes are posited in the feminine qualities associated with nurses. Indeed, academia is deemed to have a masculine construction (Knights and Davies 2003, Deem 2003), with high level educational qualifications frequently viewed as unnecessary for practical, mainly female disciplines such as nursing. However, there is an increasing body of evidence to support the view that patients cared for by knowledgeable and educated nurses have more positive outcomes (Aitken et al. 2003, Bonner 2003).

According to Kubsch (1996) medically controlled tasks can produce intra role conflict incompatible with the expectations of nurses' professional roles. However, this doctor's views that the number of ordinary (O) or advanced (A) level subject qualifications were unrelated to the qualities required for a career in nursing, contradicts the principle that an appropriate level of knowledge is central to nursing care in order to perform the role satisfactorily. Champion et al. (1995) in their cross cultural comparisons of nurses and doctors, point out that nurses will continue to experience difficulties in changing practice if they are undervalued through traditional and ritualistic perceptions of their role.

Nurses as carers

This doctor's comments accentuate the invisibility of much of the nursing knowledge required for nursing care, although he recognised caring and understanding as crucial. He was adamant that the nurse's role was that of carer and that academic excellence had little influence on someone's ability

to nurse, and those senior doctors who were registrars confirmed his views. Caring is considered a privileged aspect of nursing, and individual and organisational beliefs regarding the practice of nursing determine perceptions of personal care, both by the nurse and by others. However, to separate the action of caring from the knowledge required to carry out that care disregards compassion and concern for another, and fragments the interaction between nurse and patient. Watson (1985) describes caring as simple but complex, which indeed could describe the majority of the fundamental elements of the nurse's role. Caring involves finding time to care, having appropriate knowledge and the ability to communicate information. Boykin and Schoenhofer (2000) highlight the benefits to nurses and to patients of this special time by using reflective accounts.

Finding the time to do the small extra tasks for patients, observing and acting upon an unexpressed need, has a positive effect on the patient's outcome. This was demonstrated by McLeod's (1994) study of the role of ward sisters, where she identified the practice of nursing as a process of "noticing, understanding and acting" (p.365). These qualities were found to be crucial in contributing to the patient's recovery. The actions taken by these sisters, and their interpretation of patients' needs, resulted in doing the "little things that count" (Macleod 1994). Although viewed as simple, these actions often included highly complex practices designed to facilitate expert nursing care. Benner's (1984) study supports this stance for expert practice, endorsing the considerable theoretical knowledge required to underpin it. The doctors' comments underline the invisibility of many aspects of nursing care, and

stress the problems of making visible the many components which contribute to the role of the nurse. Conway (1995) in her investigation into the knowledge of expert nurses suggests that nursing expertise protects patients from potential harm by inexperienced junior doctors, a view which is supported by the accounts of junior doctors in my study. However, some of the nurses in Conway's study (1995) felt powerless and alienated, and also lacked managerial support when advocating for patients against proposed medical care. Indeed, there is a continuing lack of formal recognition of nursing expertise; possibly due to the unacknowledged assistance nurses give to junior doctors in order to support them.

At the time of the study, an ongoing programme of multi-disciplinary education for nurses and doctors was implemented and this was recognised as promoting awareness of each other's roles. Consequently nurses and junior doctors shared many of these sessions which were led by either a nurse or a more senior doctor such as a registrar, depending on the subject. Thus, mutual understanding of each other's roles was cultivated through this medium and that of nurse-doctor mentorship. The nurse-led subjects had less emphasis on technical data and included such issues as 'breaking bad news' and the impact of changing body image through surgery or chronic illness. The junior doctors also received teaching from their own tutors, and from which nurses were excluded. The junior doctors respected the knowledge which they perceived the nurses possessed, but the more senior doctors did not deem this as important. However, the junior doctors needed nurses' knowledge to support them in their own work, and enabled them to

save face in front of their seniors. Cupach and Metts (1994) state that we present a particular face when interacting with others, projecting an image of what we wish to present, and want others to accept. The junior doctors tried to avoid loss of face through lack of knowledge, uncertainty or mistakes and perceived that nurses were able to help them to prevent this by supplying appropriate and timely information when required. The significance of 'saving face' for junior doctors relates to the impact loss of face could have on the interaction and communication with their senior colleagues. Thus, the doctors' data underline the impact that nurses' knowledge has on their working together. For the junior doctors, a beneficial working relationship was an important factor in providing a safe environment in which they could ask questions and were offered support. This highlights the changes that take place in the nurse's role possibly due to increased levels of knowledge, as nurses gained confidence in their ability to provide answers to the questions raised by the junior doctors. From the comments it was clear that the doctors felt that direct patient care should take priority over nurses' educational requirements, in an attempt to ensure that patients' needs came first. Working together for the patients' benefits therefore demonstrate a positive effect on the working relationships between nursing and medical staff.

> *... at the end of the day everyone's wanting the best for their patient. A lot of times I need to be reminded about things and it's helpful.* (Dr. Z., H.O.).

A more senior doctor, who although he agreed with the principle, perceived that the roles of doctors and nurses were different, echoed these sentiments.

> *I think the bottom line (is) that medical and nursing staff, they should work together as a team to help each other and to help the*

patient, but each one has his own role because each one has his own responsibility. (Dr. X., Reg.)

The data confirm that the doctors perceive the roles of nurses and doctors as separate and different; however, both have the common focus of patient care. The findings demonstrate that the doctors' perceptions of working together with nurses varied according to their seniority and experience. For the junior doctors, support from the nurses played a vital part in their own role performance, and enabled them to feel confident and competent in their dealings with patients and their superiors. Their reliance on nurses' knowledge, particularly over such significant issues as the dosage of drugs, suggests a level of trust which decreases with the corresponding increase in doctors' experience and knowledge. The perception that caring requires few skills and less knowledge, highlights the invisibility of many aspects of nurses' roles. Although the doctors viewed nursing as an important part of the patient's care, they viewed the nursing role as separate from the medical.

2. Retaining nursing

Part of the doctors' views of retaining nursing related to their perception and understanding of what nurses did. It is frequently difficult to understand the role of another unless one steps into the 'other's' shoes, and this may remain influenced by the values of the individual. Indeed, Parsons (1967) states that personality values are articulated with the social structure through the concept of role. Role concept is important in interaction, and is a basic element rooted in the cultural and social environment in which individuals live and work. Indeed, Parsons (1991) further asserts that values within a social system have a common or shared pattern, and a uniform ideology. However,

symbolic interactionists maintain that roles develop through interaction with others and are created rather than prescribed.

Understanding the nurse's role

Those junior doctors who had been required to spend a few days working on the wards of their training hospital as auxiliary nurses during their training as medical students, appeared to recognise the different value systems influencing the roles of nurses and doctors. The older, more experienced and particularly the foreign doctors, would not have undergone this exposure to the nursing role as this would not have been included in their training. These comments highlight the emphasis on practical nursing skills, usually carried out by an untrained or inexperienced nurse.

> *I've always had a great respect for nurses, I think it really hit home to me when I had to do a few nursing shifts as a medical student, but I could never do what they do full time, no way.* (Dr. Y., H.O.)

and

> *...as a medical student I didn't really get much experience with the nurses at all, I just felt in the way really - 'oh my God not another medical student' - I didn't really know what a nurse's role was until I got there and did my shift.* (Dr Y., H.O.).

The doctors recognised that nurses' roles changed over time as nurses acquired experience and knowledge to perform at a higher level. However, doctors' understanding of the outside influences causing changes, such as specific government legislation in the form of the Patients Charter standards, was limited in part to the impact they had on the working role of the doctors. Thus, the directive that every patient would have a 'named nurse' where a named registered nurse would hold twenty four hour responsibility for planning a patient's care, was in the early stages of implementation, and

doctors' knowledge of this was subject to various interpretations. It was perceived by some as the nurse working on the ward for the full twenty-four hours, and when I asked this doctor about the 'named nurse', in common with his peers, he showed little understanding of the idea.

> *Well no, it wouldn't work because you can't work 24 hours a day at work...It probably works to a certain extent where you have a certain number of named nurses in one bay and then the different named nurse works from that day to another day...it's all to do with continuity of care. I think the more hours you are prepared to work then the more continuity of care you are going to have. (Dr W., H.O.)*

Misunderstanding of the nurse's role by those outside the profession led to many experiences of frustration with the implementation of the named nurse concept. This particular standard of the Patients Charter had a huge impact on the way nursing care was organised, and these comments emphasise the lack of comprehension from the medical perspective. There appeared to be little understanding by the doctors of the effects of the government directives which caused such major changes to the roles of nurses both locally and nationally. The underpinning concept of a specific named nurse taking responsibility for each patient's care was that one person would be accountable for planning the care rather than physically being present throughout the twenty-four hours. Consequently, this mandate had a significant effect and influenced many changes to nursing practice. The advent of primary nursing meant that nurses cared for all the needs of a small group of patients (Manthey 1980), rather than the traditional method of task orientated care where the same one task was performed for all patients. However, the doctors thought all nurses should work to the same standard, regardless of whether they were the named nurse for a particular patient.

> *The named nurse - I think it's irrelevant actually - because your named nurse isn't there twenty-four hours a day all through your stay. I don't really see the role of the named nurse, because, at the end of the day, whose ever name is over the end of the bed with the patient's, makes no difference which nurse is looking after you, you should get the same quality of care throughout the shifts, so why have a named nurse?* (Dr. Y., H.O.)

In many hospitals the names of the patient, consultant and nurse were usually displayed above the head of the patient's bed in order that each team would know the names of those patients for whom they were responsible. The doctors expected that the quality of care would remain constant regardless of different nurses working on different shifts. However, although this expectation is justified, the aim of the named nurse is that the more knowledgeable experienced nurse plans patients' nursing care, and is therefore named as the lead. Other nurses carry out the planned care when the named nurse is absent. Consequently this shift in emphasis to centre on the patients' needs rather than carrying out a series of tasks was reflected by changes in the organisation of nurses and their occupational role. Nurses were expected to have a wider knowledge of the patients' problems and to use their knowledge and skills to resolve them when appropriate, as the named nurse directive reinforced individual responsibility and accountability. The literature at that time applauded the satisfaction that many nurses experienced due to their new ways of working (Melville 1995), and through government promotion of the Patients Charter, patients came to expect their own clinically skilled nurse.

A further impact of implementing the 'named nurse' and primary nursing was that the ward sister's role of being 'in charge', with one person having an

overall view of the ward and knowing details of all the patients, had changed. However, these changes were perceived by doctors as removing the system of leadership and leaving little guidance for the organisation of patient care on the wards. Some senior doctors found this change difficult to cope with after many years of working with ward sisters who understood what was expected of them.

> *... I hate the fact there is nobody in charge any more, absolutely hate it!! I think it's been a total disaster. They've done away with matrons, they've done away with sisters, and it's left the whole thing totally rudderless without a decent captain who knows what's going on on the ship, and this has been an enormously retrograde step and I think it's appalling!* (Dr. T., C.)

Some of these sentiments have been echoed more recently by the government with their plan to bring back the 'modern matron' (D.o.H. 2000).

The leadership role of the matron as the person in charge of the nurses, representing organisation and command within the hospital structure, is a role that many wish to see reinstated. *Retaining nursing* included doctors' perceptions of practical nursing skills, and described their rationale of the nurse's role. The findings show that nursing as such was perceived as the tasks nurses carried out for patients, the traditional expectations of hygiene, nutrition, and attending to bodily functions. Although they emphasize the importance of clinical skills in nurses, the doctors did not view the changes as allowing nurses to perform increasingly complex procedures, but rather as encompassing a greater volume of the simpler tasks. Nurses were taking over the skills of cannulation and taking blood, providing results from computers, and recording heart traces. Some doctors did not perceive any changes to the nurse's role at ward level, with the day to day clinical care of making observations and fluid management remaining the same.

I don't think the nurses' role has changed in terms of what its role is reflected to the patient, it just begins to encompass more things, so nurses have, if you like, started to do more things on the ward...I think in terms of ward work though, a lot of the basic nurses' role, which is the day to day care of the patient, observation, management of the patient in terms of making sure fluids are in, problems that arise are pointed out, that remains much the same, I don't think that has altered. (Dr. V., Reg.)

Several more complex skills being carried out by nurses as expanded roles in other areas are regarded by doctors simply as tasks. Nurses are working in operating theatres as surgeons' assistants, with their own roles in the surgical team. However, these roles are constrained by medical and legal boundaries and the knowledge and skills required are frequently undervalued and dismissed as repetitive. Many doctors consider these roles as remaining within the confines of nursing but with a technical perspective, and seen by doctors as different to their role.

...I still think they are actually working within their role in the nursing profession and they should stay that way, because if they would like actually to change their role (to mirror the medical role), they'd better get (a) medical qualification and work as doctors. (Dr. U., Reg)

The doctors valued 'nursing' itself although some found this difficult to define. They described it as part of nurses' physical work, particularly the caring involved in human contact. Examples of caring abound in the literature, from the theoretical to the practical (Boykin et al. 2003, Watson and Foster 2003, Hoover 2002). Benner (2000), however, contends that the very intangibility of nursing care should not lead to its dismissal. Indeed, McDonald and McIntyre (2001) writing from the philosophical viewpoint, propose that the nature of nursing care is conducted on a personal basis, and recognises the need for care of one human being by another (Eriksson 1992).

Maintaining clinical skills

Historically, nurses have been taught by doctors through developing the skills those doctors perceived as necessary, and gaining expertise based on the traditional technical medical model. Within healthcare the medical model continues to take priority for doctors and is therefore used by them as a measure of nursing knowledge and education. Thus, their emphasis tends towards assessing the technological aspects of nursing as a dimension of knowledge rather than the invisible elements of caring. Technological skills carried out by medical staff were frequently those which the doctors deemed suitable areas for nurses' role expansion. However, Cassidy (1996), reporting from a joint Royal College of Nursing and Royal College of Physicians conference, warned that there were many professional pitfalls for nurses with career aspirations to take on medical rather than nursing roles. Maintaining clinical nursing skills was important to the doctors, although as nurses progressed up the career ladder, and contrary to their medical colleagues' ideas, they tended to forfeit some of their clinical skills for management functions. More recently, government changes have encouraged senior nurses to continue to develop both their career aspirations and their clinical skills by implementing roles such as consultant nurses (D.o.H.2000). These nurses combine their expertise with senior positions in order to benefit both staff and patients. Although this role has only recently been officially acknowledged, these nurses have been resident in the health service for many years, usually in the role of ward sister or nurse specialist. This was recognised by the more junior doctors.

> *I think possibly right up until a senior level that nurses can maintain a certain degree of clinical skills.* (Dr. W., H.O.)

Maintaining clinical skills involved being able to perform particular roles and to display the technical ability valued by the doctors. Nurses are developing some basic medical skills and also specific parts of more complex medical tasks, driven by the need for these to be carried out by the appropriate person. Some of these are invasive procedures requiring a higher level of knowledge and accountability.

> *Nurses are putting in central venous lines, (accessing large veins in the neck) and we know nurses are harvesting veins for some cardiac surgery...the chemotherapy nurses are task orientated, putting in the lines, they're doing it all the time.* (Dr. T., C.)

He went on to say that this was a return to older previous ways of working and not always acknowledged by nurses.

> *It (task orientated nursing) is coming back, but it's in another guise and you don't recognise it yet. I recognise it but I don't think the nursing profession recognises that actually some of them are going back to task-orientated nursing - on a different plane, a different degree of complexity, but that's what it is.* (Dr.T., C.)

A major component of nursing consists of carrying out tasks, however, these tasks are conducted in relation to other needs. Hunt and Wainwright (1993) proposed that task orientated care did not allow nurses to nurse patients in the true sense, but only to perform elements of care consisting of a series of tasks. However, nursing is based on caring while carrying out tasks within the role, and major nurse theorists such as Leininger (1981), Watson (1985) and Rogers (1980) have attempted to define the caring role. According to McCance et al. (1999) the relevance of these theoretical perspectives of caring to nursing is indicative of the centrality of the concept to the nurse's role. Indeed, the concept of caring permeated much of the doctors' data, and was an issue which doctors at all levels appeared to recognise as integral to nursing.

> *...at the moment I see the nurse's role, they are ever so much more caring than we are. I think doctors are just not caring enough as we breeze in and breeze out and I think...I am always surprised when the patients say thank you on their cards to the doctors as well because I don't really think we deserve it to be honest, they (nurses) are just so much more caring.* (Dr. Y., H.O.)

Caring for patients' needs often appears simplistic, however, many nurses use this time as an assessment of patients' psychological and physical states. Through conversation and interaction with patients during these procedures, the signs of psychological need can be noted, reported and acted upon. Simple procedures such as washing a patient provide a signpost for monitoring the condition of the skin, whether it is dry or friable, leading to assessment of nutritional needs, mobility needs or aids, deficiency in blood chemistry, and further issues which patients may be reluctant to verbalise. To perform this assessment requires knowledge of anatomy and physiology and of the interdependent elements which can affect patients' states of health. Indeed, this was discussed at a recent nursing conference when the controversial debate on whether nurses - through chasing technical roles bearing a higher status than nursing care - were becoming "too posh to wash" (Bore 2004, p.28). However, the secretary of the Royal College of Nursing, Beverley Malone, defended nurses' positions and quoted the importance of retaining all parts of the nursing role in order to be able to appropriately assess a patient's condition. Nursing skills encompass direct body care, and physical and psychological caring was associated with the amount of available time. Caring for patients is linked to having enough time to do so, and time, its effective use, who has it and who does not, influenced how the doctors understood the broad question of the nurse's role.

Perceptions of Time

The dimensions of time are quantifiable, however, the time nurses spent with patients, that is, the visible part of nursing, was seen as valuable and perhaps more flexible than it really was in practice.

> *The nurses, they tend to look after fewer patients and so they have more time to spend with their patients. Doctors tend to look at the disease and are tied up in theatre or organising investigations...I think possibly the nurses have more time to know the patient better as a whole...* (Dr. W., H.O.)

Jones (2001) sought to clarify the issue of nursing time through a comprehensive literature search and subsequent theory derivation. He explained that time in nursing is mostly defined by clock time, the measurement of seconds, minutes and hours during which nursing tasks are carried out. Clock time itself is observed as a linear monochromic model, moving from one event to the next, and orientated towards tasks, schedules and procedures (Hall 1984), as portrayed by Dr.W's comments. Indeed Jones (2001) suggests that the medical profession represents and promotes the culture of linear time by focussing on outcomes, and partly for this reason is the dominant profession in health care. Nursing time, however, although constrained within the culture of linear time, is also temporal, dealing with the process of caring, knowing the patient and interacting with them, but is still measured according to the dictates of clock time by the medical profession.

Perception of time varies according to the individual's current activity and the context in which that activity is carried out. However, it is inevitable that the nursing workload will be unstable. Unplanned activities such as emergency admissions, deterioration in a patient's condition, or staff sickness, all impact on the amount of work to be completed during a shift. Although published in

1979, Grant's system for calculating nursing workload echoes many of the important elements required for patient care today (Grant 1979). The debate over task-orientated care versus individualised patient care continues, and reveals the dissonance between the real and the ideal world of nursing. Doctors' perceptions of nursing appear to centre on task orientated care, while most nurses welcome individualised care for patients. However, the constraints of time and variations in the dependency of patients, measured by the amount of nursing time required, frequently conspire to prevent this happening. Many tasks can only be performed by a trained nurse, who may be the only one on a ward, and therefore the workload becomes task orientated by default. Indeed, in Belgium, a system has been devised to audit nursing tasks in every hospital unit, with basic indicators for completed tasks (Harrison 2003). These are measured daily and the evidence this supplies is used if more staff or resources are required. However, mabny time consuming elements of nursing are intangible and therefore difficult to measure. According to Hughes (1999), basing workload measurement on direct physical activity or straightforward patient care is inadequate and provides unreliable information. Furthermore, she suggests that patients control the time factors of nursing care, which are dependent on their nursing needs. Both doctors and nurses felt the constraints of time, with the perception from both that each had more available time than the other, and time to nurse, to be with the patient, was seen as important part of the nurses role in retaining the concept of nursing.

> *...it's holding hands, all that sort of thing, but I think every now and then you do rub a bum.* (Dr.T.,C).

Giving pressure area care or 'rubbing a bum' as described here is an implicit part of basic nursing care (although skin is no longer rubbed). It is one of the significant nursing skills that require assessment of the patient's physical and mental condition, including their level of disease and nutritional state. Describing it in the simplistic manner of rubbing a bum misrepresents the knowledge required to maintain effective skin integrity and patient comfort. Patients developing pressure sores in hospital incur ever-increasing costs to the N.H.S. However, an alternative interpretation of this comment may be a description of nursing presence, a philosophical concept based on existensialism (Doona et al. 1997). These authors described presence as the context in which nursing care takes place, deemed necessary for making judgements to decide the required nursing actions, and based on philosophical rather than technical foundations. Thus, actions taken by nurses for patients in this context become more meaningful for both, with human needs revealed and answered in an intersubjective encounter. Nursing presence appeared difficult for the doctors to describe. It was interpreted as caring and the manner in which nurses interacted with patients. Recognition of and responding to the need for this interaction requires an alternative knowledge base to practical knowledge, and education regarding patients' psychological needs is given an early focus during nurse training, as one of the core values of nursing. However, other significant nursing values were perceived by the doctors as resting on the previous hierarchical structures which had been present on the wards.

> *... you have to go back to the ward sister and her senior staff nurse, who in many ways used to be tyrants, but they were tyrants who ran beautiful ships. There were some rogues, but on the*

whole they ran beautiful ships, everybody was comfortable and knew where they were, and they were well respected. (Dr T., C.)

Although rigid hierarchical structures in nursing have been replaced by a more democratic style of management, shifting values in society dictate the public voice. 'Back to basics', a recent political party slogan by the Labour Party, identified public demand for a return to higher standards in health care, education and policing. Indeed, there appears to be a continuing demand in the Press (Hall 2004) for a return to traditional 'Florence Nightingale's standards' where patients are protected from interruptions during such fundamental times as mealtimes, when wards are closed to visitors, doctors and therapists while patients eat. This mirrors the doctors' perceptions of a traditional hierarchy representing traditional standards, perceived as preferable to the changing ward structure. However, if health care reflects society and public demand, the role of the nurse will continue to change, with either a return to the traditional or a reinvention of the contemporary role.

This section describes the doctors' perceptions of the nurse's role in practice, particularly in relation to the issues the doctors see as necessary components. However, it also reinforces the perception of separateness of nursing from medicine, as technical abilities are designated as tasks and nursing itself, although valued, is seen as remaining within its own clinical framework. Time is seen as a valuable commodity, of which nurses are perceived to have more than doctors. This perception, however, belies the importance of the interaction which takes place between nurses and patients at an intuitive level, requiring expert knowledge and experience, and giving nurses insight into patients' expressed and unexpressed needs. The doctors

perceived further progression and consequent change in the nurse's role as a potential challenge to medical power, and this is discussed in the next section.

3. Challenging medical power

Some of the issues detailed by the doctors in this construct relate to their perception of how nurses appear to challenge doctor's authority. Included in these ideas are the doctors' perceptions of the designated specialist nurses, whose role they viewed differently to that of general nurses. The specialisms which employ a specialist nurse tend to be those where patients require a high information input, monitoring and support. These include conditions such as respiratory medicine, breast cancer, or stomatherapy, where patients have a portion of their bowel removed, and ones which had a large number of patients having long term treatment for conditions such as diabetes or lung cancer. The doctors' perceptions of general nurses on the wards, however, were that they had a specific position within the healthcare system, and this evolved as *knowing your place*.

Knowing your place

Knowing your place in any situation, work or socially, involves following the rules and not overstepping boundaries. Each organisation has its own culture and set of rules, which employees learn as they become more familiar with, and part of, the organisational structure. Although nurses were viewed as significant health professionals, for the doctors their place within the health care hierarchy was secondary to the medical role.

> *I believe nurses have a very important role regarding caring for the patient, but it's only an additive role to the medical care. It shouldn't interfere, or shouldn't compete with the medical staff caring for the patient because I think caring for the patient is a responsibility and it should be clear which one is responsible.* (Dr. X., Reg.).

Many nurses would challenge this view, stressing that their role is not additive but autonomous. Furthermore, the continuing culture of deference to doctors leads to the expectation that to challenge medical judgement is unacceptable. However, it has long been recognised that challenging can be carried out in different ways. Stein's (1967) seminal paper on the interplay between doctors' and nurses' communication, has been widely used as an example of maintaining medical dignity while enabling the nurse to advise and inform the doctor. *Knowing your place* is also related to personal and professional identity in both nursing and medicine. Ohlen and Segesten (1998) who analysed the concept of professional identity discussed the implications of nurses acquiring greater confidence in themselves. They suggested a deepening self-awareness and empowerment improved confidence in a role, and aligned with the nurse's responsibility to provide skilled nursing care to the best of their ability. Thus, power can be manifest in any interaction and professional relationships can be challenged in a range of settings. The findings establish that there are many causes and consequences influencing nurses' ability to challenge medical power. Although confidence in their own knowledge appears to serve as the fundamental justification for debating issues which arise between the two disciplines, many sociological aspects such as power, status, gender, and social rules have the potential to inhibit this process.

Power and doctors

It is necessary at this point to explain the underlying assumptions of the perceived challenge to medical power. Therefore, I will discuss here the theoretical and actual basis of power, how it operates in society, why doctors are perceived as a powerful group, and what effect this has on the nurses' role.

According to Stevens (1983) knowledge of power itself, its sources, methods and response to it offers its own type of power. Dimensions of power are frequently associated with the concepts of authority, leadership, influence and politics. Power is a complex concept, and Stevens (1983) uses the categorization of French and Raven who identified the different types of power in 1960. These are briefly described here to provide an explanation of the relationship of power and its potential impact on the nurse's role. Reward power is based on the premise that resources such as income, recognition, praise or status promotion, is possessed by an influencing agent, and can be attained through conforming to the agent's demands. This type of power is most common in the employer/employee relationship where the employer has the resources to provide the rewards. Thus, the position of doctors and nurses within the organisation would be to comply with the rules and regulations in the hierarchical structure. Coercive power is based on punishment of non-compliance through negative sanctions. In contrast to reward power, use of coercive power can detract from the future power of the agent as compliance may only be at a superficial level, with little internalisation. Nurses are in a position of compliance with medical direction

in health care, and thus may acquiesce but not agree. In areas such as wound care for instance, where nurses may have a greater level of knowledge than the doctors due to experience and evidence, they nonetheless are forced to comply with medical 'orders' even if they consider there is a more appropriate choice of dressing.

Sharing a common bond with the influential person promotes referent power, which can be used to establish and maintain good relationships. However, within health care relationships the balance is variable depending on the knowledge of the individuals. Junior doctors for instance, have less power over nurses than senior doctors, but still retain power by nature of their profession. Legitimate power is based on obligation and the acknowledgement of a social hierarchy. Nurse - patient relationships are an example of legitimate power where patients usually agree with the suggestions for treatment plans. However, expert power is derived from the perception that an agent has an expert knowledge base, is trustworthy and reliable. The influence of expert power is limited to the agent's field of expertise, such as medical advice, and particularly within this area expert power is extremely potent. Thus, for nurses to challenge the expert power of senior doctors requires confidence and a high level of knowledge of the relevant issues. Informational power is based on the agent's ability to persuade the recipient to comply with a specific mode of behaviour. This type of power is useful in areas such as health promotion, where information about the effects of adverse behaviours such as smoking may bring about a change in lifestyle. It may also apply when doctors give information to

patients or nurses, regarding treatment choices. Moreover Stevens (1983), describes additional categories of power. These include positional power which combines authority and reward power, legitimising the power to recruit, promote and discharge staff in an organisation. Nurses have this power, but only at a senior level. Functional or personal power may be used as a persuasive tool to encourage others to grant further power to the agent. There are other power relationships which may exist between an agent and recipient and learning to use the appropriate type of power in any given situation is a critical step towards initiating change. Power may also develop from an occupation's own professional ideology and medical power has a traditional and historical basis for its power over nursing. This is highlighted through the doctors' emphasis on task-orientated care, which to them appears as a preferential way of working, and by senior doctors' perceptions that nurses are subordinate and should not interfere with or dispute their instructions. Although this issue is extensive it is important to briefly discuss it here in order to understand the foundations of the perceived secondary role of the nurse and the doctors' perceptions of challenge to their power.

Historical basis of medical power over nursing

Many ideological foundations contributing to a current role are embedded in the past, and this view applies to both nurses and doctors. Traditionally and historically, the care of the sick had been part of the religious role of monks and nuns, and mediaeval religious orders are viewed as the true antecedents of the nursing profession. However, during the 19th century, changes took place which impact on the role of those in nursing today. In the early 1800's,

nursing the sick was frequently the work of disreputable women who were ignorant and unfit for any other employment. Indeed, Dickens portrayal of the nurse Sarah Gamp as gin sodden and dangerous, although viewed as typical of the opinion and character of many nurses during those times (Dickens 1844, 1984 ed.), perhaps unfairly condemns all nurses of that period. The nurse of those times however, was without doubt, autonomous, often providing a service where none other was affordable or existed (Abel-Smith 1960). This, in itself, was seen as a challenge to medical power. Early campaigns to define nursing work, and to reform the role of the nurse, were influenced by the need for nurses to have high moral characteristics rather than technical skills. These characteristics were believed to be inherent in educated, middle class women, and sadly lacking in the domiciliary nurses of the early to mid 1800s, who bypassed the medical referral system to provide a cheap and convenient service of their own. The esteem in which these nurses were held posed a threat to both the power and finances of the medical men of the day.

Movement of nursing training into the hospitals under the jurisdiction of doctors therefore, sought not only to improve the skills of nurses, but also to displace the independent and unsupervised practice of domiciliary nurses and their threat to medical authority (Rafferty 1995). Thus, public prejudice and private interests combined to deny the literary stereotype of the nurse depicted by Dickens 'Sarah Gamp', the independent practice and respectability necessary for her continuation (Summers 1989). The inspiration and influence of Florence Nightingale, who began her career in

1850s, has long been recognised as fundamentally important to the foundation of nursing as a profession (Lloyd 1968). The medical profession at that time also discerned a need for skilled attendants, both on the battlefield and in the sickroom, to work with them and for them. Typically not totally altruistic, they nonetheless recognised the humanitarian and scientific advantages of having a knowledgeable pair of hands with them at the bedside (Williams 1980). Medical training for doctors was also moving from apprenticeship in their master's house to the hospital environment, thus increasing medical contact with nurses working in hospitals, and consequently extending doctors influence over nurses' roles (Peterson 1978). Obedience was emphasised in nurses' hospital training, primarily to the doctor, and in his absence, to the senior nurse or matron.

However, medical Practitioners in the 19th Century were not given their power by a grateful public, rather this was through pressure on the social institutions which regulated their work. Local subscribers financed the voluntary hospitals, and had control over which patients were admitted. The doctors gained a degree of professional autonomy by persuading those holding financial control that accidents and emergencies should be admitted by doctors on humanitarian grounds. Agreement was also obtained to exclude specific categories of patients, such as those with infections or terminally ill. This led to a higher level of control by the medical men regarding who would be admitted to hospital for treatment. In 1856, (due to the Medical Act), three types of medical staff, surgeons, physicians and the apothecary surgeon who was the fore-runner of the General Practitioner, were united as a professional

group and called doctors. This also had the effect of distinguishing between qualified and unqualified staff, thus strengthening the doctors' position. By achieving control over admissions and uniting as a qualified occupational group, doctors were able to acquire professional power, autonomy and monopoly of the health care system. As a result of this, financial reward increased, and a combined shortage of doctors served to promote their status (Blane 1997). Accepted unity amongst the members of the medical profession against outside influence and those who aspired to limit medical power, provided a protective mechanism for doctors and maintained a selective inclusion in the profession. Traditionally, nursing has been women's work seen as a continuation of their nurturing subservient role, and the paternalism of medicine perpetuated the image of the obedient nurse as the doctor's handmaiden (Maggs 1983). Thus nurses as women and as helpers, were expected to recognise their position in the hierarchical structure, and to 'know their place'. Consequently, with such an influential foundation of tradition and history between the two professions, with nursing skills rather than a specific knowledge base taking priority for doctors, any disagreement with their authority or proposed plan of action could be viewed as a challenge to medical power. Therefore 'knowing your place' as a nurse evolved from the doctors' data as an example of nurses' additive role to the medical management of the patient.

However, power relationships in health care are interwoven with organisational and occupational systems and the context in which health care functions. Power may be exhibited in various guises which frequently serve

to reinforce the governing position of medical power within the caring professions. For example the popular impression of the medical profession as knowledgeable, with an almost deified public image due to their involvement in life or death decisions, supports their dominant role in the caring professions through the use of ideological power. In the clinical setting, there are many reasons for the power differential between nurses and doctors. The nature of the tasks performed, social standing and gender are central to nurses' lack of status. Lawler (1991) identifies many nursing tasks as 'dirty work', such as washing patients and dealing with body fluids, as traditionally performed by women, and beneath the intervention of doctors. Hugman (1991) suggests that occupations are power structures within themselves, namely that with the professionalisation of an occupation, such as medicine or law, it becomes instilled with its own dimension of power. He further suggests that nurses lack power because they have never learnt the rules of corporate politics, and that organisational politics are played by a set of rules regardless of the size of the organisation. Orientation to rules is acquired differently by women and men through early socialisation. Indeed, there appears to be a strong division between the roles of doctors and nurses, although I noted that the female doctors were not as confident in breaking the rules as the males.

Power is frequently displayed through forceful behaviour and an assertive manner is part of the personal dimension of professional identity. However, this is an aspect which can lead to conflict in the workplace, with conflicting

decisions regarding the best interests of the patient sometimes leading to animosity between doctors and nurses.

> *I think sometimes there is a lot of friction between doctors and nurses.* (Dr. W., H.O.).

When I asked him why he thought that was he replied,

> *I think possibly conflict of interests in patient care and I think that the problem comes with lack of communication between doctors and nurses.* (Dr. W., H.O.)

Difficulties in communication appeared to promote conflict in certain situations. Some nurses feel they are acting in the best interests of their patients, and undertake to provide services for patients without deeming it necessary to wait for medical permission. This more experienced doctor explained how he felt that the higher grade senior nurses were keen to take on these areas without understanding the responsibilities that accompanied their actions, that they wanted to have part of the doctors' role without the responsibility. He went on to give this example of what had happened when he had referred a patient to the Macmillan Cancer Nurse and the ward nurse felt that she should be able to make the referral herself.

> *In my view, they can't do that because they need to discuss and to explain to the patients what we found in the operation. And the patient we expect, after that, will ask a few questions, mainly about the prognosis or any further treatment, and I don't think the staff nurses have the teaching in their basic training or qualification to go through the whole items of pathology, treatment, prognosis and further management. ...some of the nurses are influenced by the higher grade sisters, they also take this role sometimes because they think that they should compete with the medical staff which I don't think is a very good issue or an idea...* (Dr. X., Reg.)

Another Registrar who believed that the nurses were acting from an inferior level of knowledge, and that putting this into practice could have a detrimental effect on a patient's care, echoed his views.

I have noticed the difference is, there is a lot more questioning, which is fine, except that a lot of the time the answers aren't necessarily what they want to hear, or if it is, if they are what they want to hear, it's then applied inappropriately to other people, because not everybody (patients treatment) is the same...and there are occasions when I feel this extra knowledge - because of the lack of extra backup or experience, - sometimes comes off badly as opposed to better. (Dr. V., Reg.)

According to Porter (1999), the expectations of others places doctors under immense psychological pressure, and they are taught in medical school to think of themselves as knowledgeable in order to be able to cope. Thus, the nurse's role is viewed as subservient to medical power, with actual and perceived lesser and different knowledge and the balance of power between the doctor and patient usually weighs heavily in favour of the doctor. The findings suggest that the doctors' perceptions of challenge originate from their image of nurses as less educated, and dependent on the doctors' greater knowledge. This conflicts with the actions of a confident, competent professional nurse, and nurses acting as the patient's advocate and in their best interests are almost guaranteed to clash with doctors' opinions at times. However, there is an ongoing propensity for misinterpretation of ethical and moral stances in health care, with opposing positions taken by both. Hyland (2002) who explored the issue of autonomy and patient advocacy from an ethical stance, questions whether nurses have the right to assume this position, or whether another health professional would be preferable in different situations. Indeed, she suggests that, in a similar instance to the doctor's interview data, the nurse was construed as interfering with the doctor-patient relationship. Nurses have a duty of care, as laid down in their Professional Code of Conduct (N.M.C. 2002), and duty is defined through a code of ethical principles. However, in health care actions are rarely

unequivocal, and therefore the consequences of an action must be considered in relation to the effect it may have on others. Nonetheless, both medical and nursing roles are based on ethical principles, primarily working together for the good of the patient.

Davies (1995) who explored the issues of gender in nursing proposed that medicine is able to present itself as rational and masculine, through the feminine activity of nursing, thus gaining power and privilege. Cultural images of expertise appear, according to Stivers (1993), to bear masculine properties. Thus, combined with the culturally determined organisational behaviour established by Gherhardi (1995) in relation to gender, nurses are expected to comply with medical instructions. Indeed, the compliance of nurses in the medical encounter has been well documented, and the medical model has been applied unconsciously even in such typical nurse - led settings as the inter shift handover. Here, the language of medicine and the abbreviations for certain diseases are used, thereby emulating medicine as a professional group.

Conflicting interests

There may be a potential for conflict in almost any ward situation. According to Wicks (1998) there is a latent conflict just below the surface of communication between doctors and nurses. The 'objective' viewpoint of most doctors, focussing on physical malfunction is frequently in contrast with the more 'subjective' feminine view of nurses who focus on psychological as well as physical needs. However, some doctors perceived the conventional

role of the nurse as limiting, and there was acknowledgement that nurses had been prevented from developing in areas where their skills would have been more beneficial to them and their patients.

> *..the traditional role of nurses, in my opinion was used very much to restrict what nurses can do.* (Dr. U., Reg.)

Moreover, the doctors expected to be consulted over any decisions made regarding the patient's care, although they saw it as the nurse's role to provide them with the information.

> *I have never worked in a situation where the nurses were complete handmaidens, so they didn't have any individual thought or decision - well had an individual thought but didn't proceed to make any decision on their own back, and I hope I never will.* (Dr. V., Reg.)

He was however aware that his career progression influenced his view of nurses' decision making, and that he now felt differently from the time when he had been a junior doctor.

> *But having said that, more of the (nursing) decisions are being made now, so maybe I am noticing it now because the higher up the ladder you go - I don't get, if you like, if you want a better word - bullied or pressured into agreeing with their (the nurses) decisions.* (Dr. V.,Reg.).

He felt nurses should be able to justify their decisions with reasons for any plan of action and that,

> *If they can give you a good argument for their side then I find that non-threatening and am quite happy to carry on. The nurses who don't give me an argument or reasons behind their decision, are less likely to be looked at favourably.* (Dr. V., Reg.).

However, to present a rational argument for a course of action requires a level of knowledge not always attained by nurses, although evidence-based practice has become the driver for effective clinical practice and supports many of the treatment decisions made (D.o.H. 1996). Nonetheless, the wide variety of information available needs to be

critically appraised before being accepted as valid and useful. This more junior doctor considered that nurses should adhere to the principles of nursing rather than make medical decisions.

> *I think the main thing is to stick to the principles, when the nursing career started, as to look after the patient, and they (nurses) have a very important role to look after the patient and their role I think is very clear.* (Dr. Y.,H.O).

She felt that some nurses wanted to make decisions for the wrong reasons, for their own self-importance rather than for the patient's benefit.

> *When they want to take over the few things from the medical career, from the medical (doctors) care, I think it is a very good idea if they learn that perfectly and we think that they are safe to do that, but I feel now they just want to feel very important in taking part of the medical career without being involved in the real medical care of the patient.* (Dr. Y., H.O.)

Decisions about patients' treatment and consultations with doctors frequently take place during the medical ward round. Each consultant together with attending doctors and nurses, will slowly progress through the ward visiting his or her patients. Discussions take place and plans are made according to the available information. Busby and Gilchrist (1992) studied the interactions which occurred during a ward round, and observed that information was passed to doctors from nurses ten times more frequently than to patients. Although providing and receiving information, the nurses in the study by Busby and Gilchrist (1992) functioned in a subordinate capacity, finding it difficult to challenge medical opinion due to their lack of assertiveness. Thus, existing patterns of medical dominance continue to prevail, as doctors retain the authority to control and act on the knowledge they possess and that which they gain through others, or by technical means. However, to meet the

increasing demands of health care and expand their role, nurses' skills need to develop in all areas including technological in addition to practical skills.

Developing in the right direction

The increasing use of electronic equipment and technology in hospitals has allowed for ever more complex interventions to take place in the care of patients. Those who would almost certainly have died following a heart attack or major surgery are now supported and kept alive by a profusion of apparatus designed to read changes in their condition at a fundamental level. Complex instruments now read the percentage of oxygen and carbon dioxide in the patient's blood with detailed accuracy, allowing for instant reaction by nursing and medical staff. Any slight change in the heart's output, or mode of beating is monitored by machine, reported by nurses and acted upon by doctors. Thus, the current view in health care appears to concede that the traditional observation skills revered by nurses in the past are becoming obsolete when compared with the accuracy of progressing technology. In 2000, Bradshaw reviewed the issue of competence for nurses from a historical perspective. This analysis showed that although the traditional system expected to produce bedside nurses, as nurses' roles became more complex, so too did the knowledge they required. Thus, the medical viewpoint was that the increasing demands of modern health care pressurised nurses to change, according to patients' needs. However, this also raised questions for doctors regarding the role of nurse practitioners, who were being trained to take over more complex medical roles.

> *...But I can't actually see the point of the nurse doing a role identical to that of the doctors...I can't see actually two professions doing the same function.* (Dr. U., Reg.)

He further suggested that patients should be served in two ways; by doctors and by nurses and that their roles should complement rather than oppose each other. Expansion of the nurse's role over time was acknowledged by most of the senior doctors, particularly those with long experience in their speciality.

> *The roles nurses have are different now from what it was fifteen years ago. It is expanding, they are taking more responsibility and they are getting actually more experienced and more qualified that they were before, and they are even getting more ambitious and I can see this is a good thing.* (Dr. U., Reg.).

Support for nursing development was indicated by these doctors, particularly if the expansion was seen to be in the right direction. However, there were varying opinions on expanding roles and as an alternative, this doctor thought that developing a third profession - part doctor and part nurse would be the way forward for health care.

> *The word nurse we need to get away from - it's almost a clinical assistant.* (Dr. T., C.).

I asked him if he thought this would be more of a doctor's role than a nurse's,

> *A bit of both...it's a question of recognising that's what's happening, and let us say - right let's welcome this new profession, someone who doesn't want to spend five years going through medical school, someone who doesn't want to spend all their time rubbing people's bums and talking to them, but whose goals, ambitions, desires, are somewhere in the middle.* (Dr. T., C.)

He went on to say that the nurse's role was evolving into that type of career pathway, but nurses themselves were slow to recognise it. Nonetheless the doctors displayed a tendency to regard expansion as taking on medical roles,

rather than advancing the practice of nursing itself. Megennis et al. (1999) who explored nurses' own attitudes to expansion, found that their sample of nurses who worked in cardiology investigating heart problems, were positive towards their own development, but raised concerns that doctors would offload the more mundane tasks, exploiting the nurses' goodwill. Fragmentation of nurses' clinical roles and the potential for litigation, were other areas causing disquiet.

Specialist nurses are different

The paper presented by Warr et al. (1998) at the International Council of Nurses, highlighted the ongoing creation of a sub-professional National Vocational Qualifications (N.V.Q). group in nursing. These unqualified workers, particularly in the larger teaching hospitals, were found to provide high quality care without the distractions experienced by qualified nurses. However, Warr et al. suggested that vocational education in the health context relies on attaining skills for task-orientated care rather than conceptual thinking. Expanding the nursing role therefore, may propel registered nurses into specialist areas with a more supervisory role, instead of retaining their direct caring role. Most of the doctors viewed specialist nurses as having a superior level of expertise in their field of practice. This doctor regarded their role as different to ward nurses, with a unique relationship existing between them.

> *My own relationship with particularly the (specialist) nurse, and what I hope will be the (other specialist) nurses...we trust each other because we both know what we will be saying and it is the same, and unless you have that very close working relationship then the system won't work, and they (patients) get conflicting advice.* (Dr. T., C.).

Although specialist nurses were deemed to have a superior level of expertise, those who carried out practical procedures were still regarded as principally as nurses, and assisting the medical role.

> *she is trained to do one particular job, to an additional number of doctors, but she is still working as a nurse and she is not treating the patients. She is doing a procedure which will help, sort of, patient management, but she is not treating the patient. (Dr. U., Reg.).*

This statement reflected a view contrary to that of the consultant, although most of the doctors at this intermediate level of Registrar agreed with this point. Many specialist nurses can recommend treatment, however, they can usually only prescribe drugs within a set protocol, and this is generally carried out on the consultant's advice. For example, it is an accepted procedure that a patient suffering from a condition such as lymphoedema, where the skin is stretched and taut due to swelling, would be advised by the specialist nurse to visit their own general practitioner to obtain some antibiotics, should the skin become infected. Specialist nurses working in other areas, such as diabetes, are able to provide insulin for their patients directly, rather than referring them back to doctors for consultation. This same doctor was not prepared to be accountable for specialist nurses' practice, feeling that they were responsible for their own actions,

> *.... if you are talking about specialist nurses who can actually work independently, she will be responsible for what she does and then the doctors will not be held responsible for anything that goes wrong with her work.* (Dr U., Reg.)

This could be construed as a negative view of specialist nurses' expertise, as the perception here is that these nurses will have poor outcomes of treatment. This doctor was also reinforcing the perceptions that medical

treatment always has a positive outcome because it has been instigated by a doctor. Nonetheless, an advanced level of nursing expertise may pose a challenge for medical power, as views are questioned and knowledge and information can demystify the process for both nurses and patients, Fulton's (1997) investigation of nurses' views on empowerment, found that medical power and authority limited any decisions made by nurses, reflecting acquiescence to medical control. Specialist nurses, however, are self-directed and make complex decisions, although they operate in conjunction with medical management. Thus, the relationship between doctors and specialist nurses is considered as a partnership, and less hierarchical than in normal ward areas. Conway (1995), however, studying nursing expertise, argued that specialist nurses operated from the medical model which supports medical knowledge, and thus undervalues the holistic caring role of the nurse. The doctors wanted to ensure that nurses had enough knowledge to confirm they were safe to carry out procedures previously under the aegis of medicine.

> *A qualified staff nurse should have enough knowledge to be aware about the dangers of intravenous drugs and this sort of thing...* (Dr. U.Reg.).

The more senior nurses were viewed as managerial rather than clinical, and this doctor did not like to do ward rounds,

> *.... with the sisters, particularly, because they don't know much about their patients at all.* (Dr. X., Reg.).

He felt this led to potential risk of mistakes being made through a lack of knowledge of patients, but that nurses believed it was part of their role to carry out instructions whether or not they understood them. The expectation that a senior nurse on the ward should be a clinical expert is a reasonable

assumption. However, managerial and clinical demands on this role frequently conflict, causing difficulties in organising the workload. The continuing trend in the N.H.S. to devolve managerial functions to ward level, and consequently to the ward sister, has implications for the structure of that role. Yassin (1996) interviewed fifteen ward sisters, who although satisfied with most aspects of their job, raised several areas of concern. Although much of the literature focuses on clinical change or expansion to the nurse's role, changes in the health care organisation requires that nurses have a knowledge of personnel and disciplinary issues, recruitment and retention of staff, audit, contracting and government targets. This requires a working knowledge of the organisation at strategic level. Through attempting to establish a systematic method of admission and discharge of hospital patients, previously largely controlled by doctors, nurses pose a further challenge to medical power.

According to Cash (1997) the issues of power within, or over other groups, rests on that group's epistemological base. Cash (1997) asserts that this is a central concern for nursing underlying the drive for professionalisation. Formal nursing knowledge promotes authority and competence, and nursing as an emerging discipline and independent profession required this is an ideological foundation. However, formal knowledge is strongly aligned with science and status, excluding those who are unfamiliar with its elitist language. Cash (1997) further claims that nursing knowledge operates within a matrix of other disciplines, and is limited by the control held by each profession. Thus, an autonomous profession, such as medicine has the

power to constrain the development of 'semi'-professions, through defining their disciplinary boundaries.

This section demonstrates that from the doctors' perspectives nurses are expected to understand their role and position within the hierarchy of health care, which is generally assumed to be subordinate to the medical role. Doctors were cautious of nurses taking on roles without the underpinning knowledge required for safe practice, and felt that some nurses wanted only the status of performing medical roles. The need for a different career pathway from medicine or nursing was highlighted as a potential solution to some of the problems or needs of a developing health care programme. Contrasts between the professions are intensified by their differing ideological stance, with attempts by the medical profession to monopolise the health domain in order to retain autonomy. Their control of specific knowledge allows for an exchange of competence and integrity, with respect from the community, and promoting trust and higher social status. Therefore, the need to protect their professional boundaries is founded not only on their medical practice, but their elite position in society. Thus, defining these boundaries is discussed in the next construct.

4. Defining the Boundaries

This section describes the contrasts perceived though the blurring or overlaps in the doctors' and nurses' roles, and demonstrates some of the problems which the doctors perceived that this caused. Nearly all the doctors felt there were specific boundaries between the roles, and although

nurses were considered capable of performing some tasks, the diagnostic and treatment skills were an accepted component of the medical profession.

Drawing the line between doctors and nurses

The doctors were conscious of the need to 'draw the line' between medicine and nursing, placing their own boundaries on the responsibilities for the patients and accepting any of the problems. Although they understood that there was some overlap, they felt specific areas belonged to either nurses or doctors.

> *The doctors can't cope with everything, the social side, the caring side, the bathing and the clothing and the lifting and the drug round and the being there to talk to, the dressings, you know...and the nurses just wouldn't be able to cope without the doctors because they wouldn't be able to shift (discharge) the patients after managing them well. (*Dr. Y., H.O.).

She felt that nurses had a distinct goal, separate from that of medicine.

> *.. you are quite regimented about what your role is and what you do and what you want to do. I wouldn't go up to a nurse and say 'do this' and 'take that', because I know I would get my hand slapped. You've got a purpose there, and for the time I've been working on the ward it's been clearly defined for me.* (Dr. Y., H.O.)

Junior doctors, however, at the start of their careers on the wards, tend to rely on support from nurses, allowing themselves to be guided when being socialised into their role (Radcliffe and Lester, 2003). Thus, blurring of the medical and nursing roles occurred more frequently at this level. However, although interprofessional working was accepted as crucial for junior doctors, they nonetheless recognised even at their junior level that only doctors could make certain decisions.

> *I know that as a junior doctor I depend on nurses, especially coming into a surgical job which I have never done before. I mean, I need the guidance of the nurses even though because I'm*

> *a doctor I have the power, whatever, to do certain things, but I rely on the guidance of the nurse, especially senior nurses to help me along the way.* (Dr. W., H.O.).

Although at the beginning of the doctors' careers nurses' knowledge was seen as decisive and a comfortable support, as the doctors became more senior the nurses' knowledge was viewed either as threatening or inappropriate for their caring role. According to the doctors, the nurse's role was considered as expanding to accommodate medical needs rather than those of nurses or patients. Although the doctors were keen to answer any questions regarding their management of a specific patient's treatment, they sometimes were concerned that nurses would apply this knowledge inappropriately to other patients with a similar condition without consulting them first. This was perceived as detrimental to both patients and medical staff. In 1997, Allen, who continued the debate on the negotiated order of the nursing and medical boundary put forward by Svensson (1996), found there were divergent perspectives between the occupations. However, in 2002, Reeves et al. presented an evaluation of an interprofessional training ward, a unique concept to date in the United Kingdom. Students of various disciplines, medicine, nursing, occupational therapy and physiotherapy, planned and delivered interprofessional care to a group of rheumatology and orthopaedic patients. All students were generally positive about the experience, perceiving it as valuable for future working practices on the wards. However, some blurring of the boundaries is unavoidable, and reflects the impractabilities of maintaining a formal division of labour on the wards.

Alternative solutions

Increasing demands on doctors were seen as forcing changes in nurses' roles. However, some doctors felt that nurses in Britain were only following the examples of other countries, where nurses already had well established expanded roles,

> *...I think the other factor is, other parts of the world have already (gone) went through this and things went alright with them and we just followed. So we are not actually leaders in this but we followed this after it was sort of well established in other countries, where we realised that actually there is more for the nurses to do.* (Dr. U., Reg.)

One of the other doctors who came from abroad, felt that nurses in his home country had been trained to carry out many years ago what we consider as doctors' roles:

> *They were taking bloods, and putting cannulae and putting catheters in for the patients, and they were trained in this so many years before the nurses in this country, just to relieve the working pressure on the doctors...*(Dr. X., Reg.).

Another senior doctor with many years experience saw the nurse's role as progressing with unlimited potential.

> *I think there should be no limits. If one has potential ability to do more than her role, she should proceed and progress, furthering her career and do more. (Dr. U., Reg.)* .

I asked him if he felt that the nurse's role would then overlap the doctor's,

> *...the tricky part of it (is) when the nurses do more and more and their work comes near to the doctor's work. It will be difficult to draw the line between nurses' work and doctors' work. There is a line, it can be drawn, although this line is not easy all the time. (Dr. U., Reg.).*

The doctors were aware that changes in their own profession's working practice affected the nursing role. The changes in the junior doctors shift

system reflected the need for senior doctors to gain specific information from nurses when junior doctors were not available.

> *...I will look to the nurses for a direction, and especially in our present system where we have the shifting system with the houseman, the nurse becomes far more important, they take on some of the houseman's role.* (Dr. V., Reg.)

Thus, when a junior doctor was not on hand to assist, the nurse was used as a substitute in order to gain any relevant knowledge regarding the patient's condition. Nevertheless, when I asked him whether he thought the reduction in junior doctors' hours influenced how nurses' roles were changing he was adamant that it did not.

> *No, no, no, it is not a change within the medical juniors, it is definitely a change within the nursing attitudes.* (Dr. V., Reg).

He went on to describe his feelings when confronted by a student nurse who had studied the anatomy of the veins of the hand and forearm in detail. He had enjoyed discussing the subject with her, but

> *...found it was scary in terms of like having a student nurse asking you with such great detail and naming individual veins within the sorts of groups of veins within the hand and the arm and the ones we go for (use for an infusion) and what they are connected to.* (Dr. V., Reg.)

However, even in this instance he had recognised limitations in the nurse's knowledge, which became apparent as they discussed the intricacies of anatomy,

> *but then as we expanded, it was lost, the detail was lost because she hadn't known any further....* (Dr. V., Reg.)

The doctors' perceptions of nursing knowledge related to the values attached to particular skills. Thus displaying a greater depth of knowledge and understanding was viewed as more significant than the skill to carry out simple medical tasks such as inserting catheters or collecting a blood

sample. Expectations of a specific role and its function play a significant part in the recognition of knowledge, with each group having its own needs for its use. The role of junior doctors is supported through accessing nurses' knowledge, and by using it as a means of helping them to perform their own roles.

Scholes and Vaughan (2002) discussed the implications of cross-boundary working for the multiprofessional team. They drew on data collected for a series of case studies, exploring the organisational barriers to the implementation of new roles in practice. With the government's emphasis on improving patient services through enhanced nursing practice, and the clinical governance agenda of improved communications and teamwork (D.o.H.1999) interprofessional and multiprofessional working practices are deemed suitable mechanisms for blurring working boundaries. According to Scholes and Vaughan (2002) new nursing roles formalise those areas which had previously been carried out informally by nurses. However, they found that nurses needed definition regarding the limits of their role, both from doctors and nurses. Masterson (2002) who reviewed the policy developments of cross-boundary working explored the professional and political implications for nurses, including multi-professional learning. However, Masterson (2002) emphasised the lack of support for this concept from professions other than nursing, thus hindering shared education. He further noted that any change affecting the nursing workforce as an occupational group influences the service boundaries of other health care workers. Thus, practice similarities between professions can have major

benefits for patients, although professional bodies such as the N.M.C. and R.C.N. are anxious to maintain control of the educational standards. However, not only education but also clinical accountability was a deciding factor in the boundaries of responsibility between doctors and nurses.

Doctors' clinical responsibilities

Clinical accountability for patients was an area acknowledged by doctors at all levels. Holding ultimate responsibility for patients' care was a defining limitation between the roles of doctors and nurses. One doctor saw this as convenient for nurses who were not comfortable making decisions.

> *The doctors are informed because they (nurses) don't like to have responsibility, and if they want to have responsibility then they should share in the care- the whole care of the patient. But their training and their knowledge doesn't help much towards that.* (Dr. X., Reg.)

Accountability is an area which has developed an increasingly raised profile in recent years, both for doctors and nurses. Some doctors feel there has been an escalation in "defensive medicine" where investigations are carried out on a patient in order to protect the physician from legal action,

> *...you can do a CT Scan (computer tomography) at any time you want to cover yourself, you can do whatever blood tests you want at any time to cover yourself.* (Dr. X., Reg.)

Carrying out investigations on patients to obtain a definitive diagnosis or exclude a particular condition was a safeguard employed when there was a lack of clinical evidence or when the doctor was inexperienced. Indeed, with each new intake of junior doctors, the number of investigations ordered rises sharply in their first few months, until they gain the knowledge and

confidence to make clinical decisions. In contrast, however, it was sometimes felt that nurses' limited knowledge could have an adverse effect on the decision the nurse might make regarding a patient's care. Dr V. gave this example which he felt could be inappropriate for patients who needed a tube down their nose and into their stomach.

> *If somebody spits out their N.G. (Naso-gastric) tube and they are not sick, it is not a problem, but if it comes up in somebody with, for example, a hole in their stomach or a repair at the other end of the gut where you want to maintain a decrease in pressure because you (surgeon) are worried about what you have done in theatre, then that situation is inappropriate. Yet the limitation in (nurse's) knowledge is the fact that there is nothing going out of this tube and the patient's not vomiting.* (Dr V., Reg)

The clinical responsibility for the management of the patient remains with the doctor, and he thought that nurses' decisions sometimes influenced that management when the medical team were not informed of the actions taken.

> *"Other examples is the stopping of I.V. (intravenous) fluids in certain patients. Most of the time people can wait (be without fluids) six to eight hours. Occasionally people can't, because they've got deteriorating renal functions, or they are dehydrated and you (doctor) need to be informed, and those are the (nursing) decisions that are made.* (Dr. V., Reg.)

Boundaries between the medical and nursing role in such instances were seen to overlap, but could on occasion be detrimental to the patient. Nurses who crossed these boundaries and made decisions regarding an intervention in treatment were expected to have the necessary knowledge to assess all the contributing factors. However, realism in medical drama has demystified the healing professions, and with this demystification comes a reduction in the charisma surrounding the medical profession. This is compounded by doctors less informal mode of dress, their consulting style and their introduction of themselves to patients by including their first names. It is now

much less common to see doctors wearing a white coat, although this retains its symbolism of medical authority. Thus, this lack of formality and a less visible hierarchy influences whether nurses feel able to take decisions without consulting the doctor. Similarly, changes in the use of hospitals, where the patient's stay is now much shorter than in the past, and the move to the primary care sector, all influence the number of para professional occupations making decisions which affect patients' treatments (Morgan 1997). Nevertheless, currently doctors continue to be held responsible for the patient's clinical care, of which this junior doctor was very aware.

> *I think nurses' work can encroach on doctors' as far as taking blood and that sort of thing go, but I think one of the major differences between the nurse's role and the doctor's role is responsibility. I think at the end of the day the responsibility lies with the doctor. That is probably part of the reason why nurses cannot prescribe drugs and doctors can. I suppose it causes hassle when the nurse has to come to the doctor and say can I have this or the other... (but) if there was a problem it would be the doctor that would be held responsible and not the nurse.* (Dr.W., H.O.)

This doctor highlighted the problems he thought lay ahead, with the medical profession attempting to resolve their own predicaments though nurses.

> *I think we've got a lot of difficulties in front of us. There are nurses who want to play doctors, there are doctors who want nurses to play doctors, and there are demands by doctor educationalists who are another 'pain in the neck' group, that nurses should play doctors, because doctors, they say, are working too hard.*
> (Dr. T., C.)

According to the doctors, expanding the role of nurses was acceptable only within limits, with little valid rationale for nurses and doctors carrying out the same role. A study by Snelgrove and Hughes (2000) of interprofessional relationships between doctors and nurses, identified a shift in role boundaries according to the context of the work. However, the doctors in their study

placed more value on experience, whereas for the nurses formal qualifications were the preferred route to role expansion. Indeed, in contrast to Dr. T., this junior doctor saw nurses progressing into non-clinical areas such as management, rather than developing skills to use in practice on the wards, still seen as part of the doctors' domain.

> *I think probably the higher you go the more you go into administration and that sort of thing. I don't think that the higher you go the more you encroach into doctors' territory.* (Dr. W., H.O.)

In this instance, doctors' territory appeared to relate to higher levels of clinical expertise, where ability to practise at an advanced level was viewed as a medical prerogative. This appears to have its basis in the level of acceptable knowledge required to make clinical decisions, and career developments for senior nurses were expected to be outside the clinical field. Indeed, McPhail (1997), notes that nurses are now required to have competent managerial skills in order to administrate people, budgets, information and operational issues. This does not however, exclude their clinical role, as the change process incorporates the multiple aspects of nursing. The doctors identified specific boundaries between their own and nurses' practices. They viewed nurses as more able to cope with the caring part of the patients' needs, rather than their medical management and need for cure. However, the doctors recognised the demand in other countries for nurses to take over many medical tasks, particularly where there was no one else to perform them. Nurses already slotted into the junior doctors' role of providing medical information when the juniors were not available. Nonetheless, clinical responsibility was seen as firmly attached to the medical role, with accountability for patient care belonging with the doctors. Nurses' career

development was viewed as progressing into a further managerial role rather than a clinical one, with expert practice more a medical privilege rather than a nursing pursuit. Changes in nurses' role functions did promote a nursing overlap into the medical boundaries, which was acceptable to doctors provided nurses had gained the required level of knowledge.

Klein (2001) studied the politics of the N.H.S. and the changes taking place for those who work within it. The N.H.S. has traditionally been in conflict with the medical profession, either from pay, private practice or the reorganisation of its structure. Nurses were not included in policy making which was deemed the concerns of doctors and the N.H.S. Government decisions regarding the service were made in relation to how acceptable they would be to the medical profession and whether antagonising the profession was an affordable political and financial cost. However, political reforms and changing governments in the 1970s and 1980s coincided with the shift in the composition of medical graduates where more than half were women (Klein 2001). Doctors remain the most trusted profession and government reliance on doctors to implement policy at the point of service has not changed. However, according to Glazer (1995) the medical profession can no longer rely on being able to influence policy, as one effect of the reforms is the power of the strategic organisation to stop or limit certain specialities. Targets are set on an annual basis with failure to meet specific figures threatening a withdrawal of services. Cunningham (2002) advises that clinicians may experience tension between achieving these standards and maintaining safe practice if there are insufficient staff to carry out procedures.

However, Armstrong (2002) claims that challenges to medical autonomy can be resisted by providing evidence based-medicine, as external constraints would be less justified.

Nursing is inherently a practical discipline, the application of knowledge to practice is gained through empiricism and interpretive approaches to patient care (Giuliano 2003). In 1998, Jordan and Hughes explored the utilisation of physiological bioscience knowledge taught to forty-four post registration students, and its application in the workplace. They established that nurses attempting to implement their advanced knowledge in clinical practice posed a significant challenge to medical autonomy, and their increased knowledge did little to advance their status amongst their peers, managers or the medical profession. They found that enhancing their knowledge level offered protection for their professional status, as untrained nurses continue to play an increasingly significant role in health care. It also required an informal renegotiation of interprofessional working patterns; with a higher level of knowledge, these nurses were in an improved position to evaluate medical practice. Any tension was reduced by playing the doctor-nurse game (Stein 1967) so that initiatives from nurses appeared to come from the doctors. Further, Jordan and Hughes (1998) found that doctors were more likely to relinquish control of borderline territory, with less status. This is similar to the findings of this study: doctors accept that nurses could carry out tasks such as taking blood and passing catheters. Rikers et al. (2002) examined the inherent decision-making processes of medical experts, and sub experts, experienced and less experienced doctors, using the theory of 'encapsulated

knowledge'. Findings imply that expert doctors employ qualitative knowledge gained through experience and add to their clinical reasoning of biomedical knowledge. As a result of this experience in their previous treatment of patients, they are able to access specific clusters of concepts existing in long term memory, with which to arrive at a diagnosis. To achieve this level of encapsulated knowledge, experts need at least ten years in their field. These appear to have similarities with Benner's (1984) expert nurses and their use of intuition to assess a patient's condition. It may also serve to explain the disparity which sometimes occurs between the doctor and the nurse, over what is considered an appropriate medical decision. Moreover, it supports the findings that doctors were more likely to negotiate suggestions from an experienced nurse, whose knowledge, although not recognised formally, is nonetheless acknowledged in specific situations.

Doctors' accounts: overall findings

Thus, conclusions drawn from this chapter appear to be that doctors' concerns rose in relation to their clinical responsibility for the patients. They felt this was part of the dividing line between medical and nursing practice. Similarly to the nurses, the doctors' perceptions may be affected by their age, previous experience, level of seniority, their current job role and their gender. However, to the doctors, nurses' roles were different from medical roles at a fundamental level, with many of the significant elements relating to the level of knowledge required by each profession in order to competently assess the patients' needs. Although initially during the early parts of their career, the junior doctors needed the knowledge and support of the nurses in order to

function effectively, as they progressed, they needed the nurses less. The more senior doctors at registrar level and above, with their own increase in experience and learning, were able to identify that gaps in a nurse's knowledge could pose a problem in the clinical decision -making process. The changing political agenda for nursing, influencing the structure of ward organisation, posed the question for doctors of whether senior nurses knew what was taking place on their own wards. Although these nurses would know more details about a smaller group of patients, the overview of the whole ward may be lost, leaving some doctors with the impression that no-one was in charge of the ward. Nurses were viewed as having a specific role in caring for patients, although senior doctors used their knowledge of both the patients and their conditions when the juniors were absent. Thus, doctors' perceptions of changes to nurses' roles appear to be viewed as a continuum, depending on the position and experience of the doctor. Junior doctors perceived the changes as promoting an order of equality whereas the seniors were clearly concerned as to where the changes would lead. These elements are displayed in Figure 6.

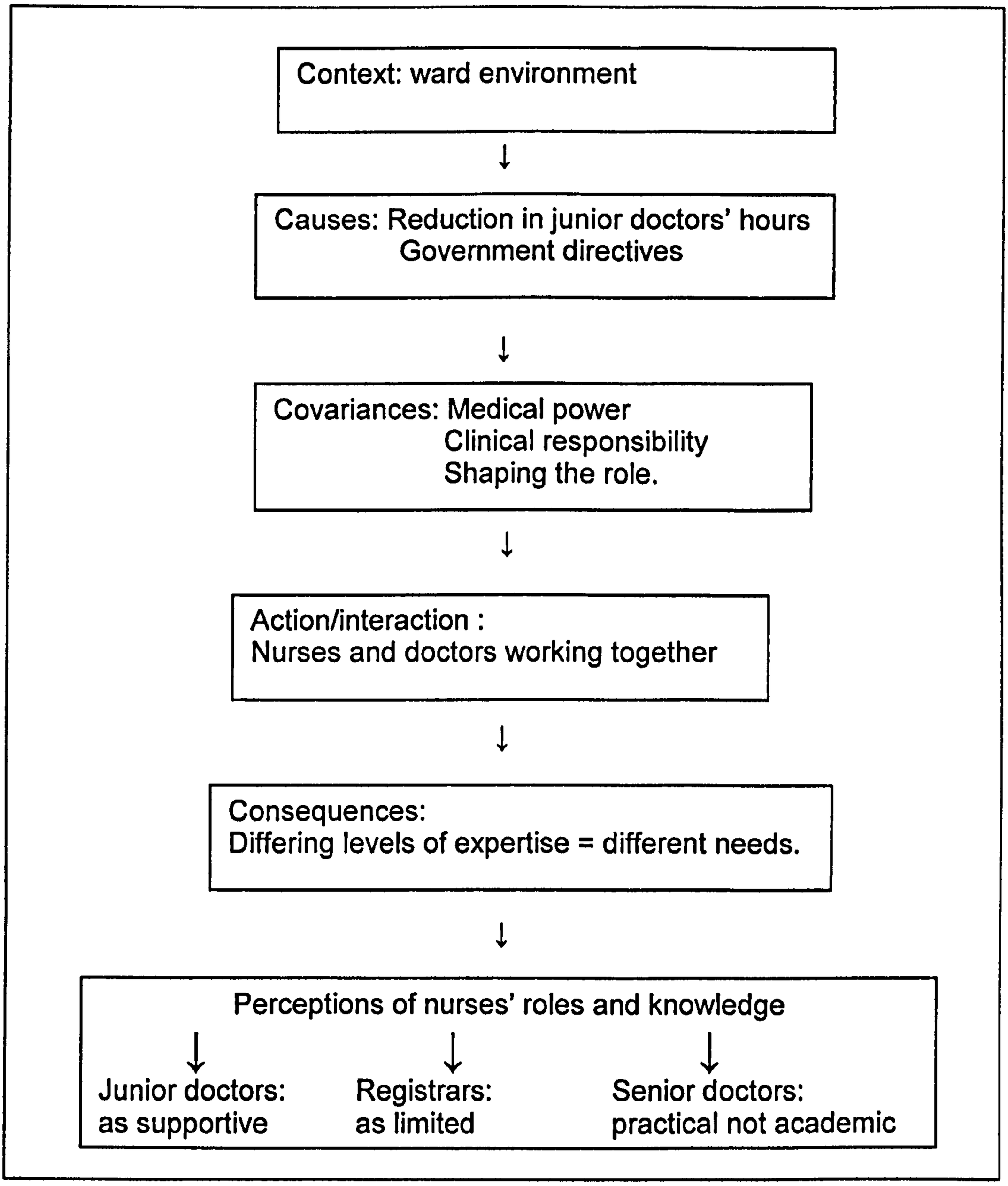

Figure 6. Elements from doctors' data displaying the context and influences of doctors' perceptions of the nurse's role.

The sample of doctors, although diverse in their experiences and length of service, were united in many similar views. Those who were very junior shared some similar perceptions with those who had been in the medical profession for many years. This may have been reflected by a common working culture and medical background, and their own socialisation.

However, many of their differences correlated to the doctors' own increasing skills and knowledge as they progressed. They related the changes to the nurse's role to the level of knowledge nurses needed to attain to progress, and to care effectively and safely for the patients. The social world of the hospital environment appeared to be reflected in the perceptions of both nurses and doctors. Their interactions symbolised the hierarchical structures within the organisation of health care. Perceptions of changes to the nurse's role would, however, be incomplete without the views of those being nursed, and I embarked on the next stage of the study by interviewing the patients. The results of these interviews are described in the next chapter.

CHAPTER 5

PATIENTS' PERCEPTIONS OF THE NURSE'S ROLE

Introduction

Interviewing the patients was very different in many ways from interviewing the other two groups, who although not sharing the same profession, did, nonetheless share the same working environment. The patients however, were on the 'other side of the bedclothes', thus their perceptions of the nurse's role and their views of the nurse's function are reported from a unique perspective. The participants were sought from various specialities, including general surgery, urology, maxillo-facial surgery, orthopaedics, gynaecology, general medicine, and cardiac care. Table 3 is repeated here to show the participants' details.

			PATIENTS		
Code letter	**Age M/F**	**In patient ward specialty**	**Previous in-patient hospital experience**	**Length of current stay**	**Occupation**
A	74 M	General surgery	Yes	21 days	Priest
B	34 F	General surgery	Yes	4 days	Health worker
C	76 M	Vascular surgery	Yes	28 days	Council worker
D	69 F	Acute medicine	Yes	15 days	Housewife
E	59 M	Colo-rectal surgery	Yes	19 days	Government officer
F	39 F	Head and neck surgery	Yes	5 days	Government officer
G	72 M	Cardiac medicine	Yes	10days	Fireman
H	65 M	Urology	Yes	7 days	Teacher

Table 3. Population and Sample: Patients; n = 8

Data saturation was reached after eight interviews with five men and three women were completed.

The major constructs

The three major constructs which emerged were separate and distinct from one another, dealing with the major issues significant to the informants. These were 1) *changing healthcare environment*, 2) *building relationships*, and 3) *responding to patients' needs*. The categories which form these are displayed in figure 7.

1. Changing healthcare environment

⇧

Expanding the nurse's role — **Changing professional culture**

Differing trained and untrained roles — Education and experience

2. Building relationships

⇧

Waiting for the doctor's decision — **Getting to know the patient**

The nurse/doctor relationship — The nurse/patient relationship

3. Responding to patients' needs

⇧

Having a gift for healing — **Loving the job** — **Having time**

Being there for the patient — Caring for patients — Informing the patient
Reading the signals

Figure 7. Categories forming the three major constructs developed from the patients' perceptions.

The findings illustrate how the patients perceived the changes to the role of the nurse, and what it meant to them when receiving care in the hospital environment. To the patients, some of the changes were easily recognisable, but the sources of those changes were not always obvious to

them in the form of explicit external directives, both professional and political, although their expectations appeared to be high. Experienced nurses were valued and their expertise and knowledge was seen as being gained over time and experience through nursing practice. Although described in different ways, they perceived a strong vocational element still remaining as an integral part of the nurse's role. The framework is represented in figure 8.

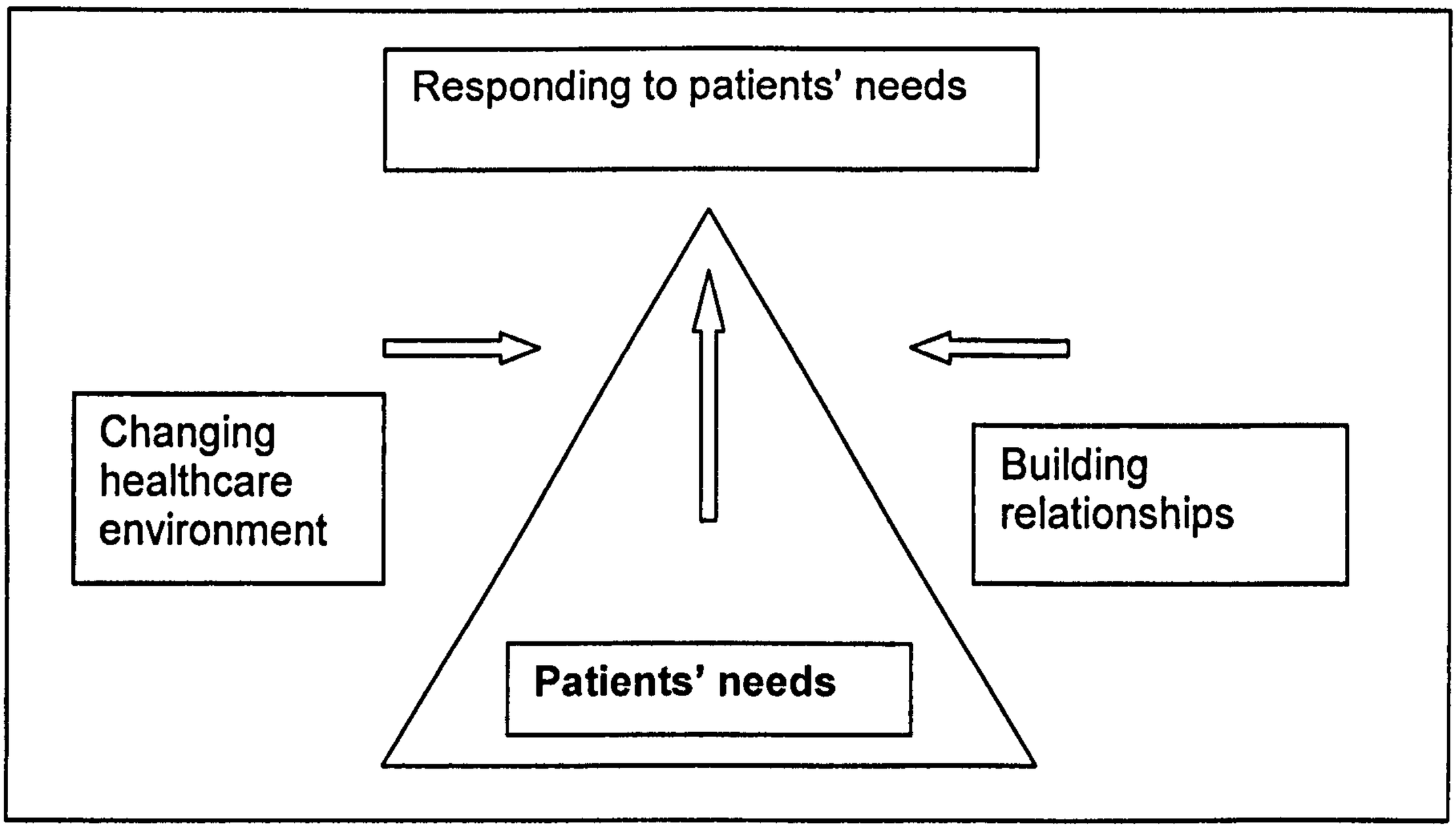

Figure 8. Diagrammatic representation of the framework of the patients' perceptions.

Overview of the theoretical framework: the three major constructs.

1. ***Changing healthcare environment***

This element incorporates the many professional issues which the patients saw as impacting on the nurse's role. Patients recognised the changes that are taking place within the workplace environment, with the consequent influence on professional culture, how the trained nurses are expanding their role, and there was recognition from some but not all that there is a difference between the trained and untrained nurses.

2. Building relationships

The explicit relationships between the nurse and the doctor and the implicit relationships between the patient and the nurse formed the major part of this category. The assumption made by many health care professionals is that patients are unaware of or uninterested in nurse/doctor interaction. The findings demonstrate that these issues play an important part in the patient's perception of the nurse's role.

3. Responding to patients' needs

The needs of the patients and how the nurses responded to them were significant elements in the findings. Patients described how they felt that there was still an unacknowledged vocational aspect of the nurses' role, which was categorised as 'having a gift for healing'. Many patients recognised that as nurses developed their skills through time and experience, they were able to subtly understand and act on unexpressed patient needs.

1. Changing healthcare environment

The culture of the modern N.H.S. is affected by its organisational and social structure. Professional boundaries are constantly changing, and the identity of modern nursing is changing with them. This, in turn, affects how the recipients of health care perceive the role of the nurse.

Expanding the nurse's role

Most of the patients felt there had been substantial expansion in the role of the nurse, particularly over the last two or three decades. Many of those interviewed were over 50 years of age, and had some previous experience of nursing care through either their own or a close relative's hospital stay. One of the participants who was a retired priest, remarked on the changes he had observed over the last 40 years. Similarly to many of the other participants, he remembered that the hierarchy in hospitals in the past had affected both nurses and patients, but felt that nursing care was now more flexible in its approach.

> *Obviously in those early days it was all a little bit more rigid...I'm not terribly good at doing what I'm told".* (Patient A.)

Although the health system was more relaxed for patients however, he felt that now the nurse's role was more complicated, as nurses were expected to carry out functions which would have not previously been part of their role.

> *Obviously nurses are called upon to do lots of fairly complex operations and to do things which presumably 40 years ago they wouldn't have done - you know they would have been done by the doctors.* (Patient A.)

Many patients supported this but felt that the role had expanded technologically, whereas 20 years ago,

> *..everything was related to care of the patient in terms of physical care and sort of more nursing care type of things, whereas now it has definitely moved, particularly for trained staff - doing much more technical things ...* (Patient B.)

She did however, recognise that changes in the healthcare environment meant that patients now spent less time in hospital,

> *...people stayed in hospital a lot longer then - I mean you didn't come in and out in three days, you would be on the ward for a*

*week, maybe two weeks, you know, just for something even routine... (*Patient B)

This patient went on to describe how her observation of the nurse's role was based on her own experience of feeling particularly unwell following her operation and needing intravenous (I.V.) antibiotics to treat an infection.

I do remember the (trained) nurse coming and doing the I.V. drugs, but the trained nurse didn't come to me for anything else, so unless it was something technical, in a sense of medication, which wasn't really required very much except I.V.s, then I didn't see them... (Patient B)

She felt that as nursing changed the role of the nurse became unclear, and that:

..perhaps it has become a bit smudgy between the edges, a bit blurred between what they, you know, like to be able to do, and what they can do and what they are expected to do, and it did seem a lot more orientated towards providing a service that met what the doctors wanted them to do, rather than what or where the patient was, unfortunately. (Patient B.)

Two other patients gave widely different interpretations of how they saw certain parts of the nurse's role. Both felt that the trained nurse should not be doing 'menial' tasks, such as giving out cups of tea, but one had asked the nurse why she did it.

I said to her, why are you bringing the tea around, you are a staff nurse for heaven's sake, ...(her reply) ah but it gives us pleasure to do this for patients. When we are giving medicine or injections it is not a very nice thing to do, she says, but having given you a nice cup of tea or a cup of coffee or whatever, that gives us pleasure, - and I thought well, what a lovely thing to say... (Patient C.)

Although this patient had appreciated the answer, one of the other informants felt that nurses,

...seem to spend a lot of time doing menial tasks, like making beds, running around for (urine) bottles and things like that. (Patient E.)

He further commented that,

> *...I think they should be able to get more people to do the menial tasks instead of the staff nurses. There is a shortage of nurses so it says and so people tell me, yet the nurses are doing something like that.* (Patient E.)

The patients tended to disapprove of the nurses carrying out 'menial tasks' such as giving out cups of tea and urine bottles. This highlights the ambiguity of the nurse's role and the expectations which accompany it. However, these perceived domestic duties will become part of the new housekeeper role currently being implemented in most N.H.S.Trusts as a result of government plans for making the patient's hospital stay as comfortable as possible (May and Smith 2003).

The increase in information technology

Computers and information technology play an increasingly important role in the delivery of health care, by changing professional culture and becoming an integral part of our society. Indeed, the developments of computerised systems of health informatics are a growing phenomenon, with a move away from illness management towards wellness and self care (R.C.N.2004). However, the same patient, Mr E. felt that the technological advances in the nurse's role, with regard to computerised systems for accessing patients' blood results or reporting various patient events, were not particularly helpful.

> *I don't know what they do on them computers...I suppose they put everything on computers...now I don't know what they do, I suppose they put everything into it about the patients* (Patient E.)

The need to record patient information and to have immediate access to it continues to escalate as the health care environment and patients' treatments become more complex. In the current climate, where litigation is

an ever-present possibility, the ability to use a computer is now recognised as an essential basic skill for nurses. The patient who felt that nurses should have recognised his need for information about his condition, did not verbally express his need for reassurance. He perceived this as an integral part of their role, and the lack of interaction left him feeling worried and confused, complaining that nurses spent too much time on computers. He was not aware, as many patients are not, that all results of tests are now filed on computers, and nurses are required to access them, print them out and pass them on to a doctor, who then will discuss them with the patient. In this particular context, all the patient could see was that no-one empathised with his concerns, he knew he had cancer, and felt the nurses should have understood his need without having to ask. The effect of this was that he was angry with the nurses wasting time on computers. In a different context, where he could have seen the results being printed, his perceptions of the nurse's role in relation to computers may have been different. Thus, computer literacy is another part of the nurse's role which requires education and knowledge, but is not visible to patients. A delphi study by Saranto and Leino-Kilpi (1997) identified which aspects of computer skills were needed by nurses, and word processing, emailing and accessing the local hospital information system were identified as crucial. Their study clearly supported the need for a designated training programme on nursing informatics. Indeed, Randle's (2001) longitudinal study of student nurses reported that technology was given high status throughout their course, and was associated with scientific and medical power. With the emphasis on evidence-based practice, all health care professionals need to be able to

search relevant databases for informed research. However, the investigation of midwives in the labour ward by Hillan et al. (1998), established that many do not have basic information technology (I.T.) computer skills and as the comments from the patients demonstrate, from their perspective computer skills are both invisible and not highly valued.

Not all patients considered that nurses should lose touch with the basic skills, and compared this with their own experiences,

> *...I was in the Fire Brigade for 28 years in charge of the Fire Station, and as you work up the ladder you lose touch with the little jobs...you still need to do some of those sorts of things like we did up there...* (Patient G.)

The changing healthcare environment and subsequently the culture of the organisation influenced changes to the nurse's role. According to Handy (1985) there is a strong tendency for people to conform to the behaviour others expect of them, following the organisation's structure, rules and role prescription. However, patients recognised the need for nurses to maintain their competence in order to be able to perform their technical role and to develop their knowledge. Tonuma and Winbolt (2000) describe the journey taken by one conventional nursing unit to overturn its traditions and create an environment which would allow nurses to nurse. They suggest that although most nurses aim for individualised nursing care, in reality this is sometimes difficult to provide. Implementing a participative care model however, facilitates care directed by the needs of the patient. Person-centredness relates to valuing patients as people, and is regarded as an optimum method of health care delivery (Coyle and Williams 2001).

Savage (2000) draws upon the findings of an ethnographic study to explore the relationship between economic requirements, corporate culture and nurses' cultural practices. The definition of culture has multiple interpretations, depending on which discipline it represents. In organisational studies, culture is associated with defined characteristics, and the shared beliefs and values of a homogeneous group. Culture and economy can be seen as mutually constituted. Savage notes that economic restraints can promote cultural change, with the ability to impose corporate and government priorities. Much of the political agenda drives the changes in health care, thus a brief outline of the current plans are touched on here to provide a background which may influence the patients' perceptions.

Political drivers

The N.H.S. plan published in 2000 provides a framework for change within the current health service provision, with plans for "a health service designed around the patient" (D.o.H. 2000, p. 17.). Within the next few years, the government aims to achieve a reduction in waiting times for patients waiting for treatment. In order to realise this, they propose a corresponding expansion in staffing. The plan advocates greater involvement for patients, with more choice, patient representatives and advisers, and with forums available for discussion of patients' issues.

The clinical governance framework puts the user (patient) at the centre of care. At this time, with the continuing growth in health care and the spotlight on the N.H.S. as an organisation, there is a need for care to be effective, of a

high standard, and to be based on evidence. However, the review by Thomas et al. (1999) of clinical guidelines found that it was difficult to evaluate their effectiveness in clinical practice. Resources in health care are continually stretched; nonetheless, time for training and education is crucial if a high quality service is to be delivered in the future. Government driven projects such as the National Institute of Clinical Excellence (N.I.C.E.), and the Commission for Health Improvement (C.H.I.), examine, monitor and publish the results of the standards attained by each N.H.S. Trust. The quality and excellence of the patient's experience is used as a measure of the Trust's performance, with 'stars' awarded for each level of achievement, along with monetary resources for those who are outstanding. The government's introduction of the "modern matron" (D.o.H. 2001a), a figurehead deemed by the public as a cure for many of the basic problems in the N.H.S, appears as a perception of a previous age where high standards were a consequence of rigid hierarchical rules, and where nurses were regimented and did as they were told. The move to reintroduce the matron appears to be an attempt to deal with the problems afflicting the health service by supplying a traditional model to represent past standards. This authoritarian figure would ensure high standards of care by enforcing a system of obedience. Historically, however, not only did the nurses comply with the rules, but so did the patients, thus reinforcing the paternalistic rules and expectations then in place. Pearson and Raeke (2000) suggest this was based on the patients' trust in the doctor, one of the central features of the doctor - patient relationship.

Current government strategy embraces many issues, including the prevention of admission to a hospital of those patients, particularly the elderly, who would be better cared for at home if resources were available. The move towards setting up systems to provide this intermediate care is a key government strategy, particularly in relation to the ageing population in this country (D.o.H. 2000), and the National Service Framework for Older People (D.o.H. 2001b) recommends several areas for development. The framework identifies the need for a further provision of services to be made available to patients not requiring acute hospital admission, such as those with palliative care needs or increasing dementia. Bradshaw (2003), considering the recent policy and ideological changes in the N.H.S., contends that until the last decade, British health care has changed little in the last fifty years. Thus, delivering the N.H.S. plan intends to make health care more responsive to the public's needs. Grimson and Grimson (2002) comment that health care is influenced by an information revolution, and more knowledgeable and informed patients will influence future demands. Indeed, Pearson (2003) suggests that the modern role of the nurse is multi-disciplinary in itself, and that nurses should review their role boundaries, and ensure nurturing remains a central characteristic for a trained nurse.

Trained and untrained roles

Many patients recognised the higher level of responsibility which came with the trained nurse role, not only with developing extra skills, but also with the increasingly in-depth knowledge the modern nurse now requires to carry out normal tasks such as administering particular drugs.

> *...there is a difference, because they (untrained) are not allowed to give drugs, which is a heavy responsibility, it must be so easy to make a mistake when you are tired, or perhaps when one drug has a similar name or it's a replacement for something else."*
> (Patient D.).

She also felt that untrained nurses were aware when the trained nurse was needed, and she had a high opinion of the untrained care she received,

> *...what I did find was, if he wasn't able professionally to deal with something, he would soon find somebody who could..."*
> (Patient D.)

Other patients found it difficult to differentiate between the trained and untrained role, and I had various replies to my enquiries about these. Some felt that both the trained and untrained roles were changing, particularly over the past few years. This was recognised in part by the trained nurse's ability to solve technical difficulties such as problems with the administration of their intravenous fluids. Knowledge of these areas requires a higher level of education, deemed appropriate for the modern health care climate. The patients recognised the need for nurses to maintain their competence in order to be able to perform their technical role and to develop their knowledge, as well as retaining their nursing values in caring for patients. Dieppe et al. (2002) reporting on Bristol University's workshop on the clinical encounter between patients and nurses, illustrated the importance of interaction and identified four key elements. These were values and attitudes, time spent with patients, trust and the context of the encounter. In the ward context, patients felt that the different versions of uniform helped, but unless there was some means by which to identify who wore which uniform, it meant little to them.

> *You have a wide range, (of uniforms) which is beginning to make some sort of sense of the colours ...but I recognise that the red*

ones (trained) do the more important jobs and so on...and that some of the other ones are more like the old style nurse used to be (untrained)...but probably even they do a lot more than probably they did in the olden days. (Patient H.)

The only differentiation in the white uniforms between trained and untrained staff, and indeed between any other discipline such as occupational therapy or physiotherapy, was the different colour piping on the sleeves. In many hospitals this reflects the desired flattened hierarchical structure of the organisation. To many of the patients, however, this difference in the piping was not seen as obvious, and could be confusing.

...although they wear the uniform similar to your bit of red piping around (the sleeves) to say they are a sister or a staff nurse, I don't know the difference. I do know that piping means something, in different hospitals it means different things.. (Patient C.)

This comment is supported by the findings of Sparrow's (1990) study on the issues surrounding the nurse's uniform, one of which was that patients tended not to distinguish the different roles of staff in various types of uniform. Indeed, the idea of all health care staff wearing white can be disconcerting to patients who are not sure which specialty is attending to them. Some patients found that they could identify the differences in trained and untrained staff by the tasks they carried out,

.it was obviously, mainly, in what they were able to do, you see. You could get your drip (intravenous fluids) fixed, or not, if there was a problem, and mine kept having problems, it kept seizing up and some people could see to it and some people couldn't...the differences were there and should be there..." (Patient H.)

However, Patient H. felt that improving the untrained role could release the trained nurse for other roles,

...it is obvious that nurses were, I thought, were doing some things that could be passed to auxiliaries...and I am talking about very basic things like bringing a glass of water..(Patient H.)

Although there are specific boundaries identifying the responsibilities of the trained and untrained roles, it is usual for any nurse to respond to a basic request of this nature, which perhaps explains this patient's comment,

> *...they all seem to do the same, obviously if I want to know something I'll ask a staff nurse...* (Patient E.)

The issues surrounding the trained and untrained nurse's role, and the nature of the work carried out by each group is the subject of continuing debate. Historically, nursing competence was measured by the efficacy of practical bedside care (Bradshaw 2000), and formed the basis of traditional nurse training. The introduction of untrained nurses known as health care assistants, health care support workers or nursing auxiliaries, to perform this direct and visible basic care, has led to trained nurses providing more technical and indirect care (Chang et al. 1998), which is often conducted outside the vicinity of the patient, and for which nurses need training in differing skills. Indeed, Jinks and Hope (2000) who carried out an observational study of nurses' activities on surgical (acute) and rehabilitation (community) wards, identified that 70% of activities undertaken by registered nurses in the acute setting could be classified as indirect care. This included elements of the role which form part of the management of the patient, such as admission and discharge, and coordination of the ward and staff, rather than care in direct patient contact. Many crucial tasks are carried out away from the patient, but on their behalf, including educational and learning activities to ensure understanding of a patient's condition.

In the current healthcare environment, the education and experience of nurses has been the subject of much political rhetoric, and various roles have

been developed to recognise and reward experienced nurses, both financially and professionally. Over the last two decades there have been far reaching changes to nurse education, and although these were acknowledged by some participants, education as part of the nurse's role appeared largely invisible. This patient felt that his recent stay in hospital had changed his perception of the contemporary nurse, and that current academic requirements were necessary but excluded many of those who would have become nurses in the past.

> *Having been in education and so on for most of my life, I'd always wondered a little bit about nurses' education -not that I know a lot about it -but it seems to me this has got terribly academic...there were lots of girls or friends I knew when I was younger who went into nursing, who don't seem to do so nowadays, and I had the impression that academically they weren't quite up to it .*
> (Patient A.)

He went on to say that,

> *...coming here this time has changed my views as to what is necessary in a modern nurse to what was necessary 40 years ago - and it's very different.* (Patient A.)

Education for nurses

The patients' accounts exhibit different views of nurses' academic requirements, however. Although many of the patients held the view that nurses' education now required an academic focus, one patient, who himself had attained a high position in his own career without formal qualifications, felt this to be unnecessary. He compared the need for qualifications in nursing with the change in society's expectations, and with the need for academic rigour in other professions. He did not feel that education was a prerequisite for nurses.

> *...education - five GCSEs and things like that, I think its ruddy ridiculous, I mean there is a lot of good people what would like to go into nursing but haven't got that qualification. I don't see why they need that - never used to, and you used to have good nurses, and I've been going to hospital for years...* (Patient E.)

He felt that nurses could gain promotion without academic qualifications,

> *...you need so much education, but I don't think you need (too much of) it. Where I used to work at the big house (prison) I mean, now you have to have G.C.S.E.s and God knows what, to go in there. I did 28 years in there, I had a school certificate which was going when I went to school, but that's all, and I got promotions..."* (Patient E.)

Nevertheless, recent recognition by governing bodies that trained nurses need to be fit to practice, that is, to be competent to carry out health care according to patient need, has led to Government Ministers calling for a more practically based training (U.K.C.C. 1999, 2001). The patients who felt that education was necessary in order for nursing to grow also acknowledged this.

> *...education is a good thing, because after all if you're going to progress, you've got to, you've got to have developments and improvements, I mean if we hadn't we would still be having the old wad over the nose to put you to sleep, you know, and sometimes that could kill a patient couldn't it?* (Patient D.)

Another patient spoke about the need for nurses to remain competent.

> *There is no good training somebody on something and then not giving them the chance to use it for six months...If you are going to spend a lot of time training somebody and educating somebody to be able to do a certain job, then you have to make sure they get a regular opportunity to do it.* (Patient F.)

With the current emphasis in nursing as in other professions on the role of work-based learning to foster effective functioning within the organisation, investment in staff education is promoted both locally and nationally (Spouse 2001). Work-based learning infers that services will be developed in conjunction with changing patient needs through remaining flexible yet

resilient, and offering continuous development and supportive further education. However, with the focus on activity and facilitation of patients through the hospital system as quickly as possible, the knowledge aspect of the nurse's role is often disregarded. Although knowledge based professional judgement is an integral part of any nursing care necessary for a patient, this frequently remains obscured.

These accounts illustrate how patients view changes to the nurse's role and their effects on professional culture. The nurse's role is recognised as complex and changing, but with less clarity of purpose if nurses need to carry out menial tasks. To the patients, giving out drinks, collecting urine bottles and accessing computer records, were not seen as a significant part of the role, but were however, a necessary part of the care of the patients. Higher academic requirements for nurses were recognised as a prerequisite of the organisation, but some patients felt these excluded those who would have been good practical nurses. However, although nursing knowledge and education are not explicitly identified, they form an implicit part of the nurse's relationship with the patient in the form of clarifying doctors instructions and giving information, and this is discussed in the following section, 'building relationships'.

2. Building relationships

The two areas framing this construct are major categories which incorporate the issues the patients raised regarding the relationship between nurses and doctors, and nurses and patients. "Waiting for the doctor's decision"

identifies those areas where the role of the nurse is perceived as attendant to the medical role, and "getting to know the patient" refers to the building of therapeutic relationships between the nurses and patients. Many intangible and subtle power influences ebb and flow between the relationships of these three groups, illustrating their connection with the nurse's role.

The nurse - doctor relationship

The initial part deals with the patients' perceptions of the interplay, or lack of it, forming the foundation for the interdependent working between doctors and nurses. Stevens (1983) suggests that the public have an image of nurses which accepts and expects changes in their role. However, as spectators in the nurse-doctor relationship, the patient participants were adept as discerning much of the interaction which took place between the two professions. Many patients perceived that nurses and doctors worked well together and that teamwork was essential to the nurse-doctor relationship. They also recognised that some discussions take place behind the scenes. Although the nurse's role was seen by some as medically directed, to others it appeared that nurses were almost as good as the doctors and both were working towards the same goal.

> *There is, first of all, a much more sense of equality - at least a sort of being on a par with one another between a nurse and a doctor.* (Patient A.)

He believed that nurses' roles were now more complex, and nurses were called upon,

> *..to do things which 40 years ago they wouldn't have done, you know, they would be done by the doctors and that would be that..* (Patient A.)

Another patient however, did not regard this equality in such a positive manner, feeling that the nurse's role was now less clearly defined, and still a mix of practical and academic functions,

> *I don't really think nurses should have to spend time on bedmaking, what with all the other things they have to do today...*(Patient D.)

She went on,

> *I think when they (nurses) are looking at x-rays they seem to know what to be looking for , and they seem to understand what they are seeing...*(Patient D.)

Some patients noticed less divergence in the roles of doctors and nurses, feeling that with changes over time nurses were now expected to carry out more complex procedures. Through experience and education, nurses learn many aspects of patients' treatments, which frequently include an overview of other specialist areas such as radiography. Although nurses frequently have to wait for the doctors to make a decision regarding a patient's treatment, the handmaiden image is perceived to have disappeared,

> *...I think the time's gone by when nurses used to follow the doctors around, and the new doctors were learning as well, going round with them, you used to see a lot of that at one time, I don't think that happens so much now, nurses following doctors and surgeons around like puppy dogs.* (Patient C.)

Stein's paper in 1967, emphasising the 'doctor nurse game' where nurses help the doctors to make decisions in a non-confrontational manner, has recently been revisited (Stein et al. 1990). However, Svensson (1996) reporting on interviews gained from nurses in five hospitals found that recent changes in the organisation of nursing work had altered the way in which nurses interact with doctors. The nurse was often called upon to deal with the results of the doctor's behaviour, presenting a buffer zone and acting as

a mediator between doctors and patients. Thus, nurses are frequently viewed as providing cohesion, and acting as coordinators between patients and the multi-disciplinary team.

The patients' data reveal their perceptions of the hierarchical nature of the nurse-doctor relationship. Although initially the relationship was potentially equal, further analysis demonstrates that patients view nurses as accepting doctors' decisions regarding patients' management. Thus, professional autonomy for nurses was seen as limited by their level of medical as opposed to nursing knowledge. In this relationship, nurses were able to work together with doctors, but patients perceived that the medical team made the treatment decisions. The foundations of medical management are rooted in the traditionalist practices implemented at the inception of nursing as a discipline secondary to medicine. This background is interlinked with power and status. I asked the patients how they viewed the nurse's role in relation to the doctor,

> *I think she is piggy in the middle really...she has obviously got to explain to the patient what the doctor has said, but then I would imagine the doctor would say that's what she's there for...* (Patient F.)

Notably, this female patient did not expect the doctor to interpret what he had said, feeling that the nurse would explain more fully after the doctor had left. She also highlighted the gender issues within the nurse doctor relationship, and the perceived limitation of the nurse's knowledge,

> *..I would imagine it's very difficult for a woman being stuck in the middle because they will be asked questions by the patient and there is only certain, I would imagine they have only got certain guidelines that they can go to...* (Patient F.)

Communication between patients, nurses and doctors

The relationship between nurses and doctors tends to be more visible to patients during the process of the ward round. Although the traditional round with its supporting entourage no longer takes place in many hospitals, it is still commonly accepted that a nurse will be present when a doctor assesses or examines a patient. Both nurses and patients expect that nurses will relay medical information given to the patient during this encounter, as the consultant was not expected to explain treatments, but

> *..just breezed in and breezed out..* (Patient F.)

This patient also emphasised the need for the nurse to act as the doctor's spokesperson, in order to relay information back to patients during the ward round. He felt it was part of the nurse's role to initiate discussion between the patient and the doctors,

> *...they (doctors) discuss between themselves, but they don't discuss much with you (the patient), so I think that a nurse could discuss it with you ...I mean I was scared to death when I started going in (hospital).* (Patient E.)

The literature analysis by McQueen (2004) on emotional intelligence in nursing work supports the suggestion that modern nurses have a necessary role in meeting patients' needs for information. By co-operative negotiation with the multi-disciplinary team, nurses are able to act as communicators between the patient and doctor. As this patient commented,

> *..a lot depends on their (doctors') attitudes. I mean some, some consultants are so sort of cold and clinical that you don't feel you could tell them anything, and you feel a fool if you want to tell them something that's bothering you ...you think, Oh, I can't bother with that, it's only a small thing, but then it might be a clue to what you are really suffering...*(Patient D.)

She felt that the nurse's role was to pass the relevant information on to the doctors.

> *... because you see, they (nurses) are the go-betweens aren't they? They are jolly important to the doctors because they see the patients so much, whereas the doctor will ask you questions and make notes, he might not see something the nurse will notice...* (Patient D.)

Patient D. also highlighted the communication difficulties encountered with medical personnel for whom English was not their first language. This issue is becoming more common due to the growing number of doctors from other countries now entering the British health service.

> *It must be difficult to work with people if you are English speaking and you've got someone from another country who doesn't have a real grasp of colloquial speech. They find it difficult sometimes to explain to the patient, or how to understand what the patient is trying to tell them. Now you get a good nurse, and that can smooth things, that can facilitate things.* (Patient D.)

Ward rounds provide a forum for nurses and doctors to share information about and with the patient, and to plan and evaluate care. Manias and Street (2001) explored the power relationships and interactions between medical and nursing staff during the critical care ward round. They found part of the discussion took place in a separate room away from the bedside, where consultants were able to regulate the physical visibility and therefore the contribution of the nurse. Although nurses are still seen as reluctant to challenge medical decisions, this patient felt the doctor - nurse relationship was different now,

> *...on the whole they seem on quite free and easy terms, I mean they seem able to discuss things. There is still that deference between the nurse and the doctor, - the doctor he has the main responsibility and if they perhaps don't agree with his diagnosis they are not going to say so unless invited to. Unless invited to give an opinion they won't voice it, because the consultants are*

another leg in the game, I think they are sometimes a little bit awesome. (Patient D)

Being older may have influenced this patient's traditional view, but several patients continued to view the nurse's role as subordinate to the doctor's,

...it is secondary inasmuch that you wait for the doctors, there is the clear hierarchy, isn't there? The doctor is going to come round, then the specialist, the Consultant or whoever, and the hierarchy comes through. It is very obvious that nothing would happen until the doctor has said so, or very little. (Patient H.)

He felt this affected the working relationship between doctors and nurses,

I also detected a certain amount of animosity between the nurses and the doctors, especially upwards of the nurses...but there was nothing lasting about it, but the difference was there (between doctors and nurses) and it was obvious that the nurses were aware of the difference too. (Patient H.)

Although he felt there was no visible antagonism between the nurses and doctors,

.. there was a certain amount of lack of joy, but nowhere did I detect any unpleasantness, not at all, it just wasn't there. And after all if the doctors are superior in role, in rank, and in expertise, obviously you know, some of the doctors are very highly trained and qualified, it is inevitable that those who aren't quite, are sometimes going to have a dig... (Patient H)

The current training structure for doctors in this country requires that they move around to different hospitals considerably during this time, to gain experience in many different areas of practice. Many nurses spend several years in one speciality, accruing knowledge which is not always recognised or appreciated by doctors spending as little as six months in any one area. Most aspects of patient care are interdependent on several disciplines, and multi disciplinary teamwork is recognised as an effective way of managing patient treatment. However, the consultant retains ultimate responsibility for the patient and the authority over their care. Examining the issues

surrounding multi disciplinary teamwork in a geriatric assessment unit, Gair and Hartery (2001) observed that doctors maintained a disproportionate level of power. However, they confirmed that by reducing the level of medical dominance, patient care was enhanced through the contribution of all team members. Oberle and Hughes (2001) compared doctors' and nurses' perceptions of ethical issues when working on medical and surgical wards. Although all participants experienced ethical problems as patients neared the end of their lives, the main difference was that the doctors made the decisions and the nurses had to abide by them. They concluded that this was part of the function of each role, rather than differences in opinion. It does, however, emphasise that the doctor has the controlling interest in the decision making process. Nonetheless, when no medical staff were available, this patient felt that the nurses were able to continue without the doctor's help,

> *...they have got to know how to work everything (equipment), you see, because when the doctors are not around, whose got to do it? Nobody, only the nurses, and it's wonderful the way they come round and change things (renew pumps etc.)...* (Patient C.)

Doctors do not usually attend to faulty equipment however. This comment highlights the status of technological knowledge from the perception of that patient. Although gradually changing, much of the current healthcare system rests upon the hierarchical order of authority, with doctors occupying the principal position. Medical culture promotes and maintains the expectation that the doctor will dictate and prescribe the patient's treatment. However, McCloskey et al. (1996) suggest that nurses' roles are influenced by the roles of those around them, and that the 'functional' middle ground of the nurse's role was the glue that held patient care together. Indeed, it is well known and

implicitly accepted that if there is a gap in the system, for example no porter to take a patient to theatre or a doctor available to take blood, or anyone to clean up the floor, for the patient's sake, the nurse will fill the gap and carry out the required task. This is rarely acknowledged in the present health care culture, and is one of a number of less visible elements which impact on the nurse's role. The data demonstrate however, that the less visible elements are important components of the nurse - patient relationship, and their significance is explored here.

The nurse-patient relationship

The relationship between nurses and patients has always been highly valued by both, and its positive effect on the patient's well being has implicit recognition (Kitson 2003, Lotzkar and Bottorf 2001, McQueen 2000). It was important to the patients in this study that the nurse 'got to know them', and that there was an easy rapport. High value was placed on qualities such as empathy and interpersonal skills, and the trust and friendship which developed between nurse and patient as a result. Patients being involved in their own care was seen as essential to the relationship, facilitated by having approachable nurses. This patient spoke about one of the nurses who, she felt, encouraged patients to talk to her,

> *...I could hear the number of questions she was asking the patients, and she was doing the drug round and she was in the next bay which must have had I suppose five patients in, something like that, ...and it took her ages, it took her absolutely ages to go through those five or six patients, but the reason why it took her so long was because she was talking to the patients and she was absolutely fantastic.* (Patient B.)

The trust that developed in the relationship between the nurse and this patient influenced the confidence he showed in the decisions made by the doctors. This patient's need for surgery had been caused by many years of smoking, and he had been advised by the surgeon to give it up.

> *...I said if smoking has caused this (diseased) lung, which I don't think it has, I said, smoking is not good for your health, I agree with that so I have cut it down to 4-5 a day. I know I should give it up altogether, but the staff nurse, she gave me a form to fill in, and she said, you know Mr. (patient's name) the surgeon was right, really you shouldn't smoke at all in your condition, so I said OK then, and they said they were going to send me to a clinic for some patches or whatever...* (Patient C)

These comments illustrate the positive consequences of effective relationships, although the contractual manner of the nurse - patient relationship frequently renders it unequal. Lawler (1991, p.158) describes the "environment of permission" within the social context of a hospital ward, where some sense of control is given back to the patients, allowing them to feel less vulnerable. This same patient went on to describe the relationship which he had built up with all the nursing staff over the time he was in hospital, comparing it as similar to the security felt within a family.

> *...well, you pick up a relationship through - I was in the hospital for three weeks, and I saw various staff nurses and sisters and ordinary nurses, - and the rapport between us was like - Oh, one family was going off duty and another family coming on, it was grand, it were really lovely because they had all got the same attitude, in different ways, but still as nice and still as professional. You see, they listen to you, you know, they listen to you.* (Patient C.)

Many patients experience a sense of vulnerability in hospital, and although this may not be explicitly expressed, is part of their psychological care when undergoing treatment. Kelly et al. (2000), reviewing the literature on bone marrow transplant patients, points out the needs of patients to emotionally

engage with the nurses caring for them. Hochschild (1983) suggests that suppressing or inducing feelings in order to care for others is a form of emotional labour, a subject which Smith (1992) investigated with a group of student nurses. In 2001, Smith and Gray re -examined the issues which surround emotional labour in nursing by exploring the views of student and unqualified nurses, and from which they identified several psychological aspects of patient care. All the nurses maintained that emotional labour was a most important part of the nurse's role, and the social psychological aspects such as trust, intimacy and friendship were viewed as an integral part of the nurse-patient relationship. However, displaying qualities such as empathy and compassion can cause further emotional strain on the nurse, and the therapeutic value of emotional and interpersonal work can be obscured by its lack of visibility (Mc Queen 2000).

Attree (2001) studied the criteria used by health professionals and patients to assess the quality of patient care, and found that greater emphasis was given by patients to the psycho - social and emotional rather than the physical, aspects of care. The important issues of communication, information and listening were considered an integral part of quality care. Fosbinder's (1994) study of patients' perceptions of nursing care indicates that interpersonal relationships between patients and nursing staff were of significant importance. Both these studies support my findings, which demonstrate that by displaying confidence and competence in their job, nurses' attitudes to the care they gave enabled patients to feel confident and trusting in return.

However, the relationship between the nurses and patients demonstrated the expression of patients' different needs, including those which required nursing knowledge to influence patients' care. Jones et al. (1997), who examined relationships between staff and patients on a stroke ward, identified several different needs from both. In particular, issues such as lack of time and relevant knowledge of rehabilitation amongst the staff influence their relationships, which ranged from participative to hierarchical depending on the personal qualities of both. From the patients' perspectives, changes to the nurse's role were accentuated in relation to their need for, or loss of, the invisible aspects which are deemed part of the essence of nursing. Qualities such as empathy, trust and interpersonal skills were essential to the patients in developing rapport with nurses and predisposed to developing a therapeutic relationship. Pontin (1997) describes this part of the nurse-patient relationship as 'looking out for you' where the comfort of the patient, both physical and psychological, took priority. My study confirms that trust can influence a patient's decision to undergo surgery, as the patient had confidence in the nurse's explanation of the risks. Although the medical team had described these, his decision to agree to the operation was not established until he had been able to explore all the options with the nurse. This requires knowledge of the surgery, risks and benefits, and also interpersonal skills to allow the patient to express his concerns.

Idvall and Rooke (1998) who explored the meaning of nursing care on surgical wards found several areas such as advocacy, protecting privacy and giving emotional support were nurses' main concerns for their patients.

These concerns were founded on their professional practice, and identified holistic care as meeting the physical, psychosocial, emotional and spiritual needs of the patient, and maintaining high standards of care. Caring in nursing requires many humanistic skills, and this was recognised by all three groups. It had particular significance for the relationships between nurses and patients. The Oxford dictionary (1990, p. 169) describes caring as 'compassionate, especially to the sick or elderly', although most health professionals would have difficulty in defining the concept of caring with such a short definition. Indeed, Watson (1985, 2003) continues to debate this issue from many perspectives, including practical application and abstract conceptualisation. Caring about patients involves the acts and less visible nebulous concepts of empathy, sympathy and reassurance. Reassurance, however, is a significant phenomenon in nursing, and the need to reassure and be reassured is a common experience in health care. Fareed (1996) explored the experience of reassurance from the patients' perspectives, and demonstrated that factual information, explanation of their condition, communication, trust, optimism and the humanistic qualities of the nurse were significant factors in feeling reassured. This supports not only the importance of communication about a patient's condition, but also of empathy and the obligation of the nurse to provide it. Indeed, in a caring context, reassurance can be conveyed through physical contact and touch, and is deemed appropriate to communicate comfort, support and security. Friedrikkson (1999) who examined modes of relating in a caring conversation concluded that nurses and patients are present as people as well as the roles they play, and touch facilitates a connection between them.

Thus, the patients' perceptions of the nurse's role include the value ascribed to their interactions with nurses in promoting confidence and understanding. This section demonstrates the significance of different relationships in the hospital setting. Patients' views of the interaction between doctors and nurses were influenced by their own expectations. They expected the nurses to communicate with the doctors about their (the patients) conditions and complaints, and relay this information back to them. They recognised the relative positions of nurses and doctors in the health system, with doctors having the controlling interest. They also noted the expertise displayed by experienced nurses in areas other than nursing, such as reading x rays. However, the patients' own relationships with nurses were based on a more socio-psychological level. They needed to engage emotionally, to be listened to and to be able discuss their fears. It was important that the nurse got to know them as an individual, and to understand their feelings. This enabled the nurses and patients to build a sensitive rapport, and a trusting relationship through which to explore the patients' needs. This next section, therefore, examines the subtle and complex issues surrounding those needs in relation to the nurse's changing role.

3. Responding to patients' needs

Responding to patients' needs describes the many abstract and less visible aspects of the nurse's role. It also includes those areas of nursing work which, for the patients, were perceived as 'vocational', such as love,

compassion and dedication, described by one patient as 'having a gift for healing'.

Having a gift for healing

Part of this gift was perceived as nurses' recognition that patients needed them to be there for them, to be available whatever the time of day or night,

> *...and that was the other thing I found, that if you came out of your room 2 or 3 in the morning or whatever, to go to the loo, somebody was there, you know, are you feeling alright, are you feeling sick or is there anything we can get you?* (Patient B.)

'Being there' for the patient was also demonstrated in other non-specific ways. There were four prisons within the vicinity of the area where the study took place, and it was therefore not unusual to have a prisoner, chained to two warders, admitted as a patient. This is known as a bed watch. Some of the other patients found this upsetting, and confused elderly patients occasionally found it difficult to understand. This patient described how in one particular instance she herself had comforted an elderly lady, but had every confidence that had the patient been on her own, the nurse would have reassured and comforted her,

> *the nurses there were very good, they would have said to her not to worry...* (Patient F.)

Another patient described how some nurses intuitively knew if their patients were unwell,

> *...they seemed instinctively to know if you had got a really, really bad head, and where you need the relief. You know some people have a gift for healing them. That's another thing, sometimes when somebody is near me I can sense whether they're really in tune with the body. See, I do believe some people have 'a gift for healing', if they go into nursing, that's excellent...* (Patient D.)

Physical human contact and the psychological support it infers was seen as particularly important in responding to patients' needs. This patient had been in extreme pain for some hours and was desperate for some rest.

> *...she (the nurse) gave me some pain relief and said I won't disturb you now, you can settle down and you can get some sleep now. But then it got to about 2 o'clock, and I had got to the stage where I just didn't know what to do with myself, and she came and she sat, and just something simple like touching somebody's hand to show them you're there,...and just that flicker of - like - human contact, that can reassure you...* (Patient F.)

She went on to describe that although there were social and cultural barriers to physical contact between people, the nurse had understood her need for comfort,

> *...there are so many different barriers put in place these days, of what people should and shouldn't do, whatever, ...and it must be very difficult to know what one person needs at any one particular time. Just somebody putting their hand on your shoulder if somebody is distressed - that sort of thing -, it's part to me - of - it's part of nursing, it's knowing when to do that and when to not do that, and being able to pick up on it - you see some people might have found it too personal, but to me it was what nursing is about, that human contact.* (Patient F.)

Human contact is not always merely physical contact, but recognition of empathic support for one human being from another. This ability to instinctively understand the patient's needs, the intuition which becomes part of the expert nurse's role, was described by Benner (1984). Intuition is a skill which develops with experience, however, its use in meeting patients' needs was an important aspect of forming a therapeutic relationship. Thus, patients' perceptions of healing and dedication contributed to those fundamental elements of the nurse's role that patients did not want to change.

Loving the job

Loving the job was felt to be part of nurses' dedication to their work. This patient believed that although over the years the hospital environment had changed, dedication continued as an integral part of the nurses' role.

> *...but the dedication from the nurses hasn't changed from all down those years, the young nurses coming up now are just as dedicated, and I don't think you can pay people enough for that to have that sort of dedication.* (Patient C.)

Dedication was a theme echoed by this patient, and I asked her if she thought there was an element of love in the nurse's role,

> *Oh, absolutely, you couldn't - that's the strongest thing really. Now I have come across nurses who, not very often, - I'm going back a bit in the past now - who weren't terribly happy, it could have been the way things were done in that particular hospital. They might have been under too much regimentation and not allowed to develop as they should...when I was in (name) hospital this time, you know there was total dedication all the way through...* (Patient D.).

Being compassionate and supportive to patients was seen as part of love for the job, and having the skills to understand human suffering enhanced nurses' dedication. Nurses were expected to understand the feelings of the patients they cared for.

> *...how can they do the job they do if they don't love the people they do it for? It's the type of job that you have dedication and everything else - a computer operator hasn't dedication, he is messing with something that's dead, it does what he tells it to do, or she tells it, but a nurse hasn't got that, she's messing with somebody who's alive and who's ill and poorly and afraid, and she's got to have compassion and I think that each and every nurse has got that...* (Patient C.)

Loving the job was seen as the reason nurses put their work before anything else, even their home life.

> *...and I think that's what nurses do in fact, love their nursing profession first, and the people who are in that bed first, before going home, before anything else. I feel so passionate about it,*

> *they are there for you, it doesn't matter if it's washing your bum, or making you happy, or coming and sitting on your bed when they have five minutes - which is very rare...* (Patient C.)

Patient C. felt that nursing as an occupation was reflected by the personality of the people who worked as nurses,

> *...they're not all the same, all different and our jobs are what we are, after all is said and done...I worked on the highways, I couldn't read and write 'til I was 50 odd, but I always worked on the highways because I couldn't do anything else, but when I swept the roads they had to be the cleanest roads, and in my opinion when a nurse did a job, they do it 100%...*(Patient C.)

Not all patients, however, agreed that nurses displayed compassion, and this patient identified what she considered a lack of perception of a patient's needs. She gave as an example the instance of a disabled patient who had been admitted into the next bed, and had difficulty in communicating,

> *..I think there was a lack of understanding about sort of a learning disability and I think there was this - they were very kind to her, you know - but perhaps there was a lack of perception that this person's needs were going to be different than other people on the ward that were, you know, fully aware of everything and could speak up for themselves.* (Patient B.)

Part of caring for patients relates to understanding what patients need. Hughes (1999), in attempting to determine exactly what nurses do, describes the nursing workload as 'unquantifiable'. Indeed, nurses have long been aware that the invisible parts of their role are perhaps those most valued by the patients, and the least valued by other professions as they are difficult to measure. The actual nursing activities may appear similar and thus quantifiable, but with the nature of nursing work, outcomes are dependent on recognising patients' needs. Thus, the seemingly simple procedure of monitoring a patient's vital signs of temperature, pulse and blood pressure, is carried out against the backdrop of the patient's previous

and current physical and psychological condition. The knowledge gained from this is then assessed and acted upon according to the nurse's professional judgement. It also includes responding to the patient's need for information. This patient's comment emphasises the shift in the recognition of patients' rights and needs to understand their symptoms and treatment.

> *Oh yes, well one time they wouldn't tell you what your blood pressure was and your temperature, and you know, people used to sneak a look at their charts, didn't they? They used to be very much down on you if you did that - in fact if Sister saw you doing it you'd get shot, but nowadays they tell you usually what the reading is, you know. It might not mean much to you until somebody explains it, but it is reassuring in a way, because you do know if you are progressing or not apart from how you feel.* (Patient D.)

Caring for patients

In the current consumer led society, patients, as the recipients of health care, are encouraged to take an active part in decisions affecting their treatment. To do this, they require information, education and support from those who provide that treatment. Empathy is an important part of responding to patients' needs, as is being truthful about serious medical complications. This patient recalled the scene which took place when he realised that the operation to remove a blood clot in his leg had failed, and he was facing a possible amputation of his leg.

> *...I could see me feet stuck out the bottom of the bed and she (nurse) looked at me and she went 'Oh dear, you know don't you Mr. (name)?' I said Oh, yes the blood's stopped going down to that foot, and she said yes, what do I think.? Now the doctor should have said or the surgeon, Oh well, Mr. (name), we can't just put you under because of your age, we are frightened to give you a general anaesthetic because of your age...he didn't say that, but the nurse did, she was there, she was there to comfort me as well as to advise me, and that to me, while I was laid there - I was afraid, not afraid of dying because I'm not afraid of dying, I know where I'm going, - but she was so concerned, she was really*

> *concerned, and I said, well, look staff (nurse) if I'm going to go, I'm going to go. I said, well I don't want to walk with no legs, I don't want that I said, so, you know, give me a general anaesthetic...*(Patient C.)

The patients demonstrate that empathy and dedication are highly valued, and genuine concern from nurses made them feel supported in the decisions they made. The image of nurses as a devoted workforce who love their job, is the sentiment held by many patients. Kendrick and Robinson (2002) explored tender loving care as a relational ethic for nurses as part of their nursing practice. Approached from an ethical stance, their argument proposes that love, empathy and the nurse's connection with the patient through the dynamic of caring confirms obligation and engagement. For the patients, this reflected strength in the nurse's role, but could cause discontent in those nurses who were less committed. Dedication in nursing was not perceived to have changed over time and this and other qualities, like putting their patients first and recognising their fears and vulnerabilities, were highly valued. Nurses were expected to carry out their role with compassion and loyalty, deemed primary characteristics for the role of nursing. This is supported by evidence from Cheung's (1998) study which examines the process of caring and identifies the epistemological and ontological basis of nursing through caring for patients. However, much of nurses' work continues to be constrained by time, but having time for patients was seen as a very important part of the nurse's role.

Having time

Having time to spend with patients was highly valued, and the invisible processes which took place during this interaction with patients were frequently difficult to describe. However, it was acknowledged that 'having time' meant being available for an unlimited period during which any concerns could be raised. This patient felt this was a particular feature of night nurses who were viewed as working without the time restrictions necessary during the day,

> *...I think possibly the difference maybe between the day and the night staff, is that one, the night staff have got all night in a sense, so they don't start a drug round and it's got to be finished by a particular time because the next shift are coming on. In a sense, when they are doing their evening bit, it doesn't matter really if it takes them from about 10 o' clock until midnight, because if they have done it all as they go round, in a sense you save time then..* (Patient B.)

The nursing workload is structured according to the length of time it takes to carry out a particular task, and although 'twenty four hour patient care' is promoted amongst nurses, it is usually accepted that all assigned tasks will be completed within a nurses' particular shift. Farrell (2001) describes these as task/time imperatives, suggesting that this leads to fragmented patient care. However, nursing work not only has to correspond with patient need, but also with the needs of the organisation and treatment required. Patients noticed that time was usually in short supply for the amount of work to be carried out.

> *..but all the time you are aware that the one big problem running through it was that the nurses didn't have the time to do the job in a logical sensible way. Everything had to be rushed and there were often small delays, which didn't matter, but obviously puts the pressure on the nurse.* (Patient H.)

Nurses may try to plan to spend time with a patient but this can sometimes be difficult to achieve due to the unpredictability of nursing work. Patients frequently want more time to talk over any problems or discuss their prognosis with a nurse before their surgery

> *I don't think they (nurses) get enough time to sit with the patient and talk about what is wrong with the patient, and what is going to happen to them what is going to happen to the patient himself, the same as going to theatre and things like that...*(Patient E.)

In most hospitals, there is a call bell system where patients ring if they require attention from a nurse, and these ring frequently. Patients observed this process and believed it took nurses away from their intended roles.

> *...they're not nursing, they're just answering bells. There doesn't seem to be enough time for the patient/nurse relationship.* (Patient E.)

The rationale behind this system is that patients are able to contact help when they are unable to do things for themselves. In order to maintain their privacy and dignity, attempts are made to keep their needs from the public view. Thus, answering a bell usually demands a response from a nurse which may often take time to fulfil, for example a change in the patients' position or assisting them with their food. However, the need for information and time to give and discuss it was more important to this man, who felt nurses had a comprehensive understanding of most conditions.

> *...they (nurses) should have more time to do their proper nursing, I mean they, with the experience they get to know everything, what most people have got, men or women, they know what the thing is, and I think they should be able to explain more in full to the patient and discuss it ,ongoing.* (Patient E.)

Prioritising the physical nursing tasks in order to complete the workload often means that the psychological elements are neglected. Williams (1998), examining nurses' perspectives of quality nursing care, identified four

elements of nursing time, abundant, sufficient, insufficient and minimal time. These described the pace of work and the actual workload, and were perceived to be directly related to the level of care delivered to the patients. Interestingly, she found that when nurses had insufficient time for their workload, certain patients would become the focus for quality care to the exclusion of others who received only minimal care, and psychosocial needs were given a lower priority.

Health and medical care in Western society is controlled by time, and people interpret time through concepts of time awareness, that is in relation to its passing. Clock and calendar time are the foundations on which nearly all the organisations in, and the organisation of health care, depend. Patients are allocated a time to see the doctor, who limits the time of the consultation, organises investigations within a time frame depending on the disease process, and reviews the patient's condition within a specified time. Time is culturally constructed and this is shown simply by such examples as agreement in meal times or working hours. Time for doctors limits their power but also expands it, depending on their position in the career structure. Thus junior doctors' time was constrained by their obligations to the senior doctors and the patients, but their time was perceived as more valuable than that of nurses. Frankenberg (1992) suggests that time inside the hospital organisation is anti-temporal, that is, distinguished from time outside, by the nature of what takes place when a patient is admitted. Patients are expected to accept a waiting culture, indeed the word 'patient' evolved through people waiting for medical treatment in the seventeenth century. They wait for a bed

to be available, to be admitted, they wait to see the doctor, to have investigations, for results or to have operations performed on them. The expectation is that nurses will fill the gap, taking their time to explain and answer any questions. Goffman (1968) in his classic text on asylums draws attention to procedures which limit the amount of time available to those who are confined or work in institutions or industry. Indeed, Goffman portrays the restrictions as commonplace in such institutions, where the patient is subject to communal living and concomitant regulation of time.

Starkey (1992) claims that time is a key element in doctors' commitment to the N.H.S., and that due to their professional status, they do not see themselves as subject to temporal constraints. However, developing public and political awareness has encouraged patients to view the medical profession as part of the N.H.S. organisation, and subject to its rules rather than exercising their independence. The organisation of work in health care is adapted not only to time constraints, but to the priority of need for specific patients. Adam (1992, p.153), states that "time is implicated in every aspect of social being". Furthermore, although invisible, time itself organises the rhythms of our physiological processes, such as eating, breathing, sleeping and waking.

However, some patients also perceived that a lack of nurses' time was a direct result of too few staff, adding to the pressure of work,

> *I think nurses should have more time to, from what I saw, to attend to whatever they felt needed attending to first and to be able to get through in a less pressurised way. It was obvious the nurses were working under a stress at times trying to get through*

> *too much, too quickly, which can lead to mistakes of course, and it was obvious that more (nurses) were needed...* (Patient H.)

Many issues contribute to stress in nursing, and recently one N.H.S. Trust has been issued with a warning from the Health and Safety Executive to tighten up its policies on addressing staff stress (Cooper 2003). Constantly increasing workloads, under which nurses perceive themselves as failing physically when these become unmanageable, and added to the psychological stress of caring for the seriously ill and dying patients, can appear relentless to both staff and patients.

> *...I think that's what's wrong, that they haven't got the time to do what they want to do, they haven't enough, - well I know you haven't enough staff...*(Patient E.)

Pediani's (1998) editorial discusses how student nurses frequently sit and talk with patients as part of the fundamental nurse - patient interaction, before they become acclimatised to a system where every minute is counted, and every action scrutinised for effectiveness. Prioritisation of the workload is learnt at an early stage in a nurse's career. Some tasks can be delegated to others, or consigned to a later stage in the shift. The direct practical aspects of patient care, estimated as taking longer, are usually carried out first, with more indirect roles such as giving information taking place later in the day. Francis-Smythe and Robertson (1999) explored the relationship between time management and time estimation. This involved estimating how long a task would take and keeping to a schedule in order to complete it within the given time frame. Their results suggest that people were less accurate at estimating how long a future task would take, and more accurate at estimating time passing.

The patients perceived the scarcity of doctors' time as acceptable, but nurses were seen as needing to fill the void left by them.

> *..sometimes doctors are in and out so quickly that somebody will think of a question they want answering after a doctor has gone, and then a trained nurse in my opinion could spend a little more time and sit down and explain it to the patient.* (Patient F.)

Most doctors spend a large amount of their time in clinics, conducting consultations with patients visiting the out patient department. Thus, the amount of time available to spend with patients on the wards is ever more constrained. Doctors tend to save time by reducing the amount of time spent with patients on the wards. This is possibly due to theirs, and the patient's, expectation that the nurses will provide information and clarification of any unresolved issues. As clock time and calendar time form the basis for time frames in organisations, such time is quantifiable, measurable and a marketable commodity (Adam 1992). However, as the accounts show, this study supports the conception of time variables in hospital, depending on the position of the participant, as nurse, doctor or patient. Patients viewed nurses' time as insufficient to complete their work, a view which nurses shared. Conversely, doctors saw nurses' time as greater than their own, and available for patients who needed it. Nurses' time appeared to have a different value to that of the doctors. Doctors were not expected to have an excess of time to spend talking with patients, but to compensate for this, the nurses were expected to provide answers to any questions which arose in the doctor's absence. Again this reflects the need for nurses to achieve a considerable level of knowledge in order to respond to these needs.

Various authors have discussed different aspects of time. Warren (1995) describes time from the patient's personal view, portraying how time "stopped" for patients in hospital, whereas Adam (1990) exploring time in relation to social theory, attests to the complexity of time, in that it must be considered within a wider perspective of temporality and chronology. Doctors are governed by linear time, which the patients accepted, whereas nurses' time is perceived as more flexible. Time, and its influence on nursing behaviour, is the cause of many constraints within nursing practice. Indeed Jones (2001) attributes the continuing medical dominance over nursing to the distinct relationship between clock time and medicine. Nursing time however, with its multi-dimensional and more flexible nature, is frequently difficult to measure against the same time frame as doctors, and is therefore perceived as less valuable (Jones 2001).

The patients' accounts support the assumption that nurses have the knowledge to explain the meaning of procedures ranging from simple blood pressure readings to major surgery. The patients recognised that in the current climate of healthcare with themselves as the focus, they would be given information regarding any procedures, and found the explanations reassuring. One deviant case however, was the patient who identified a lack of understanding in the nurses who cared for a patient with learning difficulties. Nurses in acute hospitals deal mainly with physical illness unless there is a dedicated mental health facility on the site, although their role encompasses psychological issues. Communication between the nurses and the patient with learning difficulties was less than adequate, and

although kind to the patient, the nurses were perceived as lacking the necessary knowledge in the mental health field to converse effectively. This highlights the importance of knowledge of issues which may arise outside the usual realm of the nurse's role.

The findings from the patients' interviews support the view that some nurses had a gift for healing, and that intuition played a meaningful part in the relationship between nurses and patients. The instinctive reaction of some nurses is to offer relief, either psychological in the form of reassurance or physical in the form of pain relief. This recognition of the patients' needs without the patient needing to ask, provides another instance of the use of invisible knowledge. Physical contact and the use of touch conveyed understanding and empathy and reassured those who were distressed. One patient's pain was improved by the nurse's understanding and the holding of her hand. However, nurses were expected to know when the use of touch would be appropriate and when it would not. The personal nature of touch is sometimes awkward in British culture, where the display of emotions is becoming less acceptable (Williams 2000).

Responding to patients' needs demonstrated the two different but interlinked aspects of caring relationships. Doctors were viewed as the dominant profession, responsible for the patient's treatment and management. Patients recognised their own need for the relevant information, and their right to be informed, but saw information exchange as part of the nurse's, not doctor's role. The importance of qualities such as empathy, trust, dedication

and commitment, were principles that were viewed as integral components and highly valued in the nurse's role, which patients did not perceive as changing. These contained many of the invisible aspects that were manifested through comfort, reassurance and support when needed. However, the issue of time appeared both as a background and foreground reason for change. Time needed to be spent with patients, who viewed this as valuable and rewarding, but the impression that time was constrained by the increasing nursing workload, in some instances left patients feeling disheartened by its absence.

Patients' accounts: overall findings

Patients in hospital, observing and being observed, have the ideal opportunity to witness the miniature social world, with all its relative idiosyncrasies, which they temporarily inhabit. The patients' perceptions centred on their views in this context. The relationships between nurses and doctors, and nurses and patients, were areas on which they focussed in depth. They believed that the nurse's role was subordinate to that of the doctor, but that nonetheless the role was changing through nurses' experience and exposure to more complex procedures. They identified a less institutional environment of health care, with freer flow of information about their condition, and expected that nurses would have the ability and knowledge to explain it. Although they wanted nurses to be well educated in order to give patients the correct information, some patients felt this excluded those with good practical skills rather than academic ability, to the detriment of both the patients and the nursing profession. The dedication and

commitment of nurses was not deemed to have altered, rather to remain a constant over a long period of change. The patients described their own needs in humanistic terms, the caring of one human being for another, admiring the value of trust, empathy and comfort in their relationships. However, the use of nurse's time and the constraints it was subject to in the working day, albeit for valid reasons, was an issue which raised many concerns for the patients in the future of health care. From the patients' perspectives, changes to the nurse's role are illustrated through the complex issues which affect patients in hospital, and their perspectives were similar regardless of their age, occupation and length of hospital stay. These are displayed in the following diagram, figure 10.

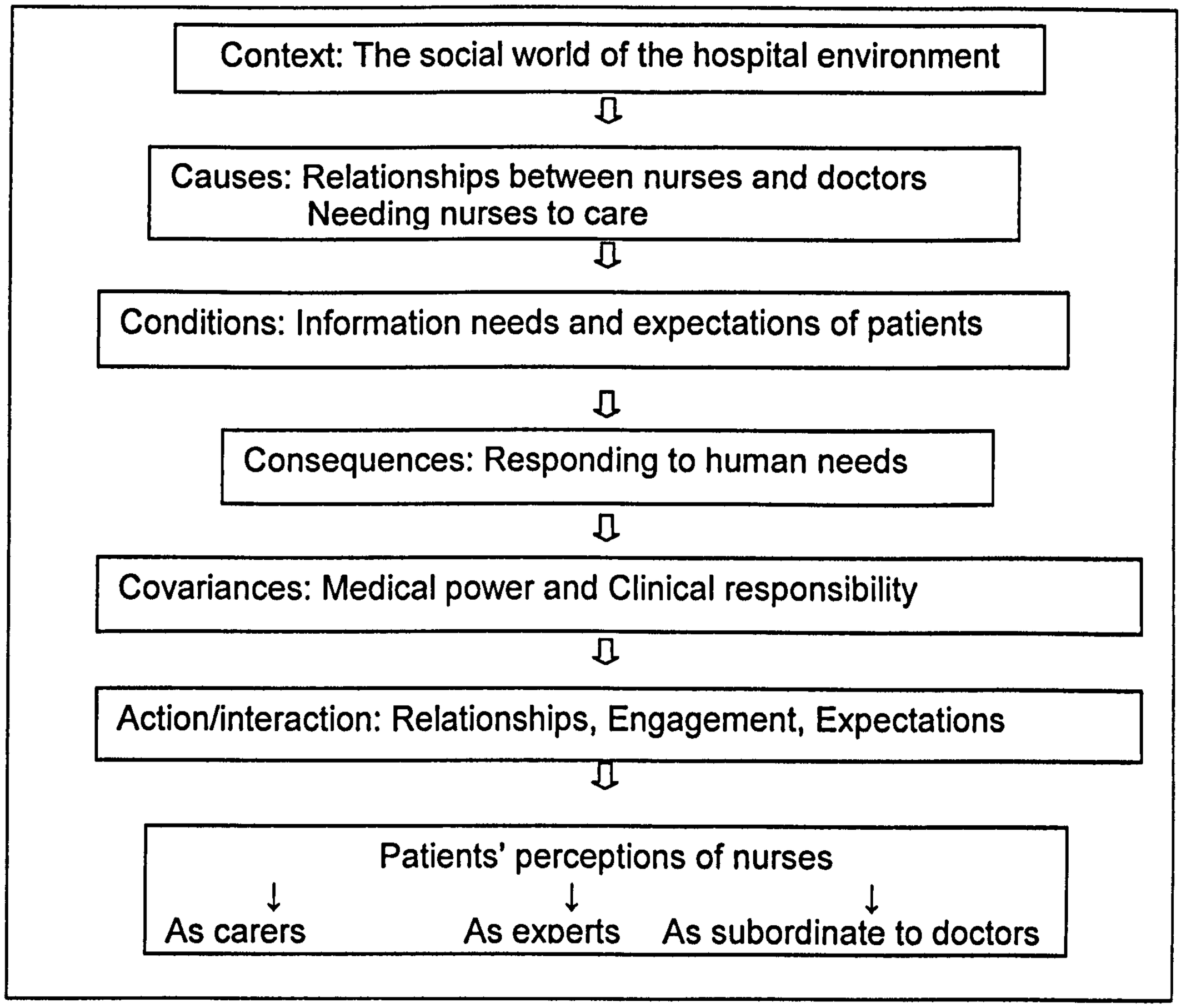

Figure 10 . Elements from patients' data displaying the multiple issues affecting the patients' perceptions.

This chapter has raised many of the issues comparable to those of the nurses and doctors, albeit as expected from a different perspective. Indeed, all three groups occupy the same context of the hospital environment, although they are situated in different positions in the provision of health care. However, there are limitations within the context of any investigation and these are discussed in the next chapter.

CHAPTER 6

LIMITATIONS OF THE STUDY

Introduction

Conducting research in the real world needs to be balanced between subjectivity and objectivity, purpose and achievable outcomes. Therefore the limitations of this study are acknowledged pertinent to that framework. Any investigation is constrained by limitations which restrict the scope and opportunity for exploring further the perceptions, understanding, knowledge and vision of the area under study. Boundaries such as time constraints, the context, available samples, and the type of methodology, exist, which may prevent the total view of an issue. I will discuss here the limitations which may have had a possible influence the study.

My background and the choice of subject

Breuer (2000) identified many complex characteristics which attract researchers to a particular subject. The choice of enquiry may be influenced by professional association and confined by departmental frameworks and scientific disciplines. Relevant topics for investigation are usually pertinent to current events, such as issues that are deemed significant socially and politically at that time within the subject area. Thus, my choice of subject was limited by the confines of the political climate at the time and the impact that reducing the hours of junior doctors had on the role of the nurse. In turn, this had an impact on patient care. Many issues appeared relevant at that time and could have been approached from different perspectives, and my background was both an advantage and a constraint. Several studies had

been conducted into the multi skilling of nurses, but little evidence was available on the perspective of nurses themselves. As a nurse, my background supported my initial investigation and encouraged my interest in the holistic view of the subject. It also facilitated the process of entry to the context of the study.

The researcher

Any research study is a process of learning and the acquisition of skills and knowledge for the researcher. I had some previous experience of using grounded theory, but the research process demanded the development of many other skills and capabilities. My ability to become fully conversant with the theoretical tenets of grounded theory posed a significant challenge. Personally, like most researchers, I was limited by the time constraints of conducting the investigation and balancing this with the demands of a full time job and a family. I found the plethora of information on how to carry out research with veracity and rigour limiting, as authors appeared to disagree on their stance when interpreting the canons of grounded theory. It is impossible to read every article of literature, and indeed, Holloway and Walker (2000) advise prioritisation and discrimination of the literature from the very beginning. However, the benefits of different viewpoints became apparent as the study progressed and increased my own understanding of the arguments presented by the various authors. I became more skilled in critically appraising relevant issues, and more discriminating in the use of appropriate data, both from the participants and the literature. Grounded theory requires interpersonal interaction between the researcher, the participants and the data. I was aware that my own perspective could have a

limiting effect on both, and was thus conscious of my own behaviour during the interviews and my preconceptions during the analyses. The benefits of my role as a nurse however, served to relax the nurse and patient participants, and to identify common ground with the doctors. It enabled me to explore issues which held some surprising viewpoints, and provided insight into areas I may not otherwise have considered.

The methodology

Qualitative methodology operates on the premise that the researcher represents and interprets the reality of the participants, and its principal limitations are discussed in the chapter on the research process. Supporters of the quantitative paradigm tend to criticise grounded theory for its small sample numbers, which may be viewed as limiting the generalisability and transferability of the results. Nonetheless, the lateral and in depth thinking promoted by this technique repudiates this argument through applying the substantial dimensions of the method to collection and analysis of the data. In any case, although the findings cannot necessarily be generalised, the theory or theoretical ideas can be. Indeed, Haig (1995) maintains that grounded theory as a scientific method is the most comprehensive methodology available in qualitative research, thus contributing to rather than limiting the results.

The setting

This study took place in one geographical area, although the staff worked in, and patients were admitted to, several different hospitals in the group which served a mainly rural population. It could be argued therefore that the ideas

about conditions, context and culture in these particular hospitals are applicable only to these specific settings and the place where an action or event occurred. These are limiting factors which can impact on any area of research. Each organisation is known to operate within its own culture, and this can be divided again into the particular culture of a specialism, ward or department. The study may have produced different findings had it taken place in large, urban inner city hospitals. The medical culture is different from nursing, and patients enter a diverse complex culture when admitted to hospital where the norms of society are frequently suspended. Thus, the balance of power between these three groups varies, and may present as a limiting effect on the data collection. I attempted to reduce the limiting effects by interviewing both male and female participants. I also ensured that the patients understood that they were assisting me with my research, and assured them that their views were very important. By conducting many of the interviews either away from their treatment areas, or outside of hospital premises, I attempted to ensure that the contexts in which the interviews took place were comfortable and neutral. I also presented an overview of grounded theory methodology to the mainly medical members of the Local Research Ethics Committee, in order to attempt to overcome some of their reservations regarding the numbers used in this type of qualitative methodology.

One further limitation of the setting to be considered is that my study was restricted to acute hospitals and did not include community nurses, general practitioners or those patients nursed in the community setting. Although this

may have provided further issues for investigation, the capacity required to include a sample of the primary care team for comparison is outside the scope of this investigation. Nonetheless, the findings from the studies of Gerrish (2000), Hallett and Bateman (2000) and McGarry (2003) have highlighted similar issues between acute and community nurses. These authors all identified the impact of policy directives as influencing the nurse's role and more significantly, outside the nurse's control. Indeed, according to Hallett and Bateman (2000) nurses in the community setting felt their role was limited and skills suppressed in comparison to the hospital setting where their role had previously included a high degree of responsibility and autonomy. However, although there may be differences between hospital and community based care, many of the findings from this investigation are generalisable as the organization and provision of care remains central to patient care (McGarry 2003).

Sampling

Grounded theory and the use of face-to-face interviews, requires that the participants are articulate and able to verbalise their thoughts and feelings. Prior to the interviews, the participants are given a minimum of information regarding the study in order not to influence their responses. However, this may have the effect of limiting the flow of conversation as the participants may previously have given little thought to their feelings. Conversely, limitations may become apparent with those volunteers who wish to give a negative view of the organisation for which they work, and use the interview as an opportunity to criticise their superiors or express dissatisfaction with the organisation. Although all data are relevant to the research, the interviews

were intended as an exploration of the subject area rather than personal prejudices. As a mainly rural area, staff recruitment and retention tend to remain static, both for senior nurses and doctors. There is also a higher percentage than normal of older people living in the area with relative affluence due to the high price of housing, potentially influencing their views in this particular study.

Sample of nurses

Limitations regarding the nurse informants include the grades of those interviewed. At the time of the study, my decision to interview the senior experienced nurses was influenced by the effect that the significant changes would have on their role. However, my decision to exclude more junior registered nurses and health care assistants limits the broader perspective of the results. The findings demonstrate that whatever changes take place within the role of the nurse affect all the strata of health care delivery, as in the domino effect. Thus, the perspective of these participants would give an added dimension to the changes in the nurses' role. I attempted to capture a wide range of experiences by including specialist nurses in the study, and this group could have been interviewed separately to general nurses. However, most of the specialist nurses who took part had either previously been ward sisters, or had worked within the N.H.S. for many years, and had a realistic understanding of the effects of change. The majority of the nurse participants were female, with the lack of male nurses employed in the region limiting their availability. Indeed, a wide spectrum of alternative samples could have included comparison of male and female perspectives, age groups and backgrounds to identify cultural differences, a feminist viewpoint

and quantitative comparisons. However, this would have the potential for diluting the significance of the data through being too broad a subject, and losing the richness of an in-depth study with fewer participants and foci.

Sample of doctors

The initial limitation of the doctor participants was the difficulty in locating senior doctors prepared to find time to give me their views. It took some weeks to arrange an interview time and date and this was likely to be cancelled in preference to more urgent appointments. All those who volunteered were from surgical specialities, although all except the very junior housemen would have had experience in medical specialities during their training. Some of the doctors I interviewed were not English and had worked or had their initial training in their home country. This may have influenced their view of the nurse's role and their expectations of it, as expectations vary between different health cultures. However, a vast number of doctors who currently work in the N.H.S. are from abroad, and therefore their perspectives may have increasing significance in the changes taking place. None of the doctors above junior houseman level were female, and it is well recognised that women rarely reach the upper echelons of consultant practice in general specialities. As a gender issue, this may have limited the data and influenced the doctors' perceptions and expectations of nurses.

Sample of patients

Limitations in this area were less evident as the patients were volunteers from all backgrounds, male and female, and presented from many different wards and areas. However, the issues of the power relationship between

patients as recipients of care, and nurses as contributors to care, may have had the potential to influence their perceptions in the hospital setting. Thus, conducting interviews in their own homes reversed these relationships. The power in hospital lies with the clinical responsibility of the consulting doctor, and patients frequently relate more favourably to nurses with whom they feel more at ease. Thus, the patients' perceptions of nurses may be limited by their hospital experiences, as is demonstrated in some of the interviews.

The results

Limitations include the extent to which the findings can be generalised in other settings. Ultimately the theoretical significance and generalisability of any empirical findings must come from more than a single study. Confidence in the findings develops through testing the relationships between the data and analysis, and making clear the path that is followed. Replication of a qualitative grounded theory investigation is recognised as difficult if not impossible, due to the individual interactions between the researcher and participants, particularly as the results are temporal to that specific context and those conditions and because the researcher is the research tool. It is unlikely that different researchers will have the same results in a grounded theory study. Although this may be viewed as a limitation, it is possible to follow the rules and settings of a particular study and to discover similar results on a more general basis. Hutchinson (1988) describes grounded theory as a method of critical social analysis, and the results from a grounded theory investigation maximise the realities of the participants from their grounding in the data.

In conclusion, the limitations of my study draw attention to the numerous and various issues that need to be addressed. I have attempted to approach these systematically and to remain aware of them throughout the study. My reflections on this process are described in the following chapter.

CHAPTER 7

REFLECTIONS

Introduction

This chapter shares my reflections on the subject, methodology and findings of my study. When I first set out to investigate the changing role of the nurse, it was as a result of issues which had been raised by my peers in the workplace. Working both as a trainer and as a clinical nurse clearly influenced my choice of methodology, as I was very interested in the feelings, attitudes and perspectives of those with whom I worked and nursed. Although I was aware that quantitative methods would provide me with higher numbers of participants and was looked upon favourably by both doctors and the organisation, these methods did not allow for the richness of the data to inform the research question. My post at that time had evolved as a result of the political agenda to reduce junior doctors' hours, and this reduction was its primary objective. Although I was not working within an academic environment, and experienced some difficulties in accessing resources due to the distance, working clinically allowed me insight into the conditions and context of many of the issues in the area I wished to investigate.

My initial literature review highlighted the number of official papers, both political and professional, that had shaped the role of the nurse over the decades. There appeared to be little research on what exactly the role of the nurse entailed, rather the literature highlighted specific roles taken on by nurses and their effects on the practical aspects of nursing. These were

particularly diverse in the changing N.H.S. culture at that time, when nurses were viewed as an available alternative workforce to junior doctors and the Scope of Practice document (U.K.C.C. 1992a) promoting the expansion of nurses' roles. As with any grounded theory study, the initial literature review is limited to prevent preconceived ideas influencing the collection of data. However, I experienced difficulty in finding relevant literature on the role of the nurse, particularly as nurses are the largest workforce in the N.H.S. This therefore appeared to be an area for scrutiny that required investigation.

Reflections on the methodology and the choice of Strauss over Glaser

As I explained in chapter 2 when I discussed the research process, I chose grounded theory to enable me to explore the richness of the participants' thoughts and perceptions, and to examine the influence of the context on their actions. Although grounded theory can be used in any field of study and by any discipline, it has its foundations in health care in the 1960s, when Barney Glaser and Anselm Strauss wrote their classic text, The Discovery of Grounded Theory (Glaser and Strauss 1967). Grounded theory became and remains popular with those working in health care, and its particular appeal for this present study lies with the holistic nature of the method and its systematic approach to research. The hospital ward and those that work or are cared for in that environment are constantly subjected to public view. The interactions which occur can be interpreted or perceived differently by each individual, and with its roots in symbolic interactionism, grounded theory allowed me to examine these in a particular social context. The health care environment is a mini social system, both for those working in it and those

cared for by it. Thus, grounded theory, which lends itself to the analysis of the social actions of, and on, the participants, considers all the peripheral issues which may influence a course of action or have a cause and effect on them.

During the course of this investigation, and through exploring the method in depth, I discovered that grounded theory methodology is subject to several different strands of interpretation, with each interpretation differing slightly according to the explanation of the authors. Indeed, the method appeared to continuously evolve and develop, as different authors fashioned their own research based on the founding principles of grounded theory rather than taking the purist approach. This may in itself be a reflection of the method, as a grounded theory researcher needs flexibility and an open mind, in order to explore alternative ideas during the process. Possibly because of my own background in nursing, I had a predisposition to include all information as data, and needed to restrain this tendency. My fascination with all the data about how the participants felt sometimes competed with its relevance. Although not always documented explicitly in the thesis, this has, nonetheless influenced the overall analysis in the true grounded theory tradition. However, as with all applications of a theoretical stance in a real life setting, my use of this methodology required that I examine the diverging positions of its creators and their later works (Glaser 1992, Strauss and Corbin 1990).

Although the central components of grounded theory outlined in their early work (Glaser and Strauss 1967) such as coding, continue to form the basis for this method, for more than a decade their ideas appear to follow opposing paradigms. Exploring Glaser's (2002) focus on abstraction I found that this predisposes towards the phenomenological intention of the method, whereas the scientific canons set out by Strauss and Corbin (1990) could be viewed as being the very issues that grounded theory was employed to avoid. Indeed, Glaser's (1992) criticism of Strauss and Corbin (1990) suggests that their version is not true grounded theory but an entirely different method.

Several authors (Babchuk 1996, Schreiber and Stern 2002) provide an analysis of the differences between Glaser's and Strauss' construction of the method. Although I collated a pool of data of grounded theory studies to assess the feasibility of its application to my area of study, I found that the majority lacked clarity and grounded theory had become more of an umbrella term rather than a pure methodology. My understanding of the need for flexibility conflicted with the need for a structured approach within systematic boundaries. Having explored these issues, I decided that the pragmatic and interactionist approaches of Strauss and Corbin (1990) proved more suitable for this study.

Schreiber and Stern (2001) assert that methodology is the technique which serves to link research and knowledge. In grounded theory, the researcher defers to the participants as experts in their world in an attempt to understand and provide a justification for what is happening. The role of the researcher

is to investigate the social construction of those worlds and to understand their actions and interactions. Strauss (1987) maintains that induction, deduction and verification are crucial to this process. Insights into the area under study are central to generating questions, and my own background served to aid the inductive technique. Deduction is the ability to compare and question lines of enquiry, to draw implications from the data for verification. I found this required constant interrogation of the data, and at this point the methodological proposition that all data are relevant assumes authenticity. However, Huberman and Miles (1998) warn of the pitfalls of some of the biases that can transpire. Hence, they suggest checking the data for representativeness, researcher effects, triangulation and assessing the evidence.

Throughout the study I attempted to review the key findings, following the trail set out by the participants, and constantly comparing the data. I searched for negative evidence, which appeared to be suggested through the data concerning the role of the specialist nurses, and the positive views of their knowledge in relation to all three groups. By interviewing three separate groups of participants, the potential for this was increased. There is always the possibility of a rival explanation for a phenomenon in the data, particularly with three separate groups. Nonetheless, their commonality of data provided strength for the emerging theoretical ideas rather than moderation of existing theory, and supported the underpinning of the findings. I did however, experience some false leads, and was conscious of the need for reflexivity. It is impossible for the researcher to remain apart from the data, participants or

field (Swanson 2001). Indeed grounded theory lends itself to the unique relationship which develops between the researcher and participants. I found that I was surprised by some of the senior doctors' data, where various issues raised were opposite to my own. This reinforced to me the claim that one has to experience another's role in order to fully understand it, and consequently widened my conception of their roles.

Denzin and Lincoln (1998) propose that qualitative research is judged against the post positivist criteria of its ability to generate theory, is empirically and scientifically credible, generalisable or transferable to other settings, and demonstrates reflexivity in terms of researcher effect or bias. Indeed, these criteria are similar to those advocated by Strauss and Corbin (1998), although they appear discordant with some of Glaser's (1992) concepts.

Transparency of method is crucial for verification in qualitative enquiry. Thus, throughout the period of investigation and analysis I have endeavoured to explain each step, clarifying the reasons for decisions taken and the measures demanded in the process of data analysis. The practicalities of carrying out research are not always emphasised in the literature, where the results of the data must, of necessity, take priority. However, they are a significant part of the process, as the researcher is a visitor in the worlds of the participants, and bound by the rules of conduct of that role. I found that there was a need on some occasions for extreme tact and negotiation in order to remain sensitive to the participants' issues. On one occasion, for instance, I visited a patient with two enormous dogs who were present during

the interview, and I was aware that this could influence the length of the interview, as their need for exercise would take priority with their owner. On another, I spent some time admiring the garden of the participant. I could record many instances where I was welcomed and accepted into the participants' lives, and this is an area which is neglected but which is a fundamental process in the collection of data. This also reinforces the necessity for reflexivity to examine the researcher's role in relation to the data collection and their relationship with the participants.

Given that Glaser and Strauss (1967) were the joint originators of grounded theory, it would be impossible to follow the method of either from a strictly purist approach. I have attempted throughout this investigation to use the framework provided by Strauss and Corbin (1990, 1998) as the basis for the methodological stance taken. However, it is difficult to exclude the many influences of Glaser, not only from this study but also from the many authors who produce canons for grounded theory based on his teachings.

Reflections on the findings

The findings reflect the influence of political directives, the speed of change in health care, in particular nursing, and the focus on the intangible core values of the role. During the time that this research has taken place, implementing the goals of the N.H.S. Plan (D.o.H. 2000) have become a priority. Many of these details have been further developed to provide a service which both the public and the government require. Although issues such as greater choice for patients, and achieving shorter waiting times are

to be applauded, the findings highlight the participant's concerns that the caring essence of nursing will be lost. Furthermore, the many issues relating to the changing role of the nurse demonstrate that nurses have a pivotal role in health care, and are able to develop in many directions. As established by this study, there are difficulties in attempting to retain all components of the role, such as basic bedside skills, as this can prevent development. However, it may be that in the future many alternative skills may be required to provide a service which patients now expect, both in the community (Jarrett et al. 1999) and in acute hospitals (Laing and Hogg 2002). Unfortunately this presents as a paradox for nurses who wish not only to retain their traditional roles, but also to develop new skills, and discover the difficulties inherent in attempting to do both.

In the concluding chapter these findings are discussed in relation to the current context of health care.

CHAPTER 8

DISCUSSION AND CONCLUSION

Introduction

This study set out to explore the perceptions of the changing role of the hospital nurse from the perspectives of three groups, nurses, doctors and patients, by using the methodology of grounded theory as the mode of enquiry. Grounded theory facilitated the emergence of these perspectives by providing details of the factors influencing changes to the nurse's role in the hospital setting. The key findings are discussed here to demonstrate the connection between the various factors affecting changes to the nurse's role, and to establish whether the role has altered or remained constant.

The perceptions of the three groups identify areas of political, social and medical influence on the nurse's role which have affected the different stages of change and influenced individual and role development. Thus, these changes over time can be described as a process, affected by the past, present and future. These perceived states of the effects of change have emerged as the focal points for the data analysis of all three groups, and are represented as a state of metamorphosis or stasis.

Comparison of the key findings

At this stage, the findings of the three groups, figure 10, are compared in order to present their similarities and differences, and to display the framework to support the emergence of the overarching theory: perceptions

of changes to the role of the hospital nurse result in metamorphosis or stasis depending on the specific influences which affect these changes.

Nurses	**Doctors**	**Patients**
1.Providing a service	***1. Working together***	***1. Changing healthcare environment***
Defining the role	Having a good working relationship	Expanding the nurse's role
Leading the team	Supporting junior doctors	Changing healthcare environment
Meeting standards	Respecting nursing knowledge	Differing trained and untrained roles
		Education and experience
2. Drifting away from the patients	***2. Retaining nursing***	***2. Building relationships***
Feeling the strain	Understanding the role	Getting to know the patient: the nurse/patient relationship
Fitting it all in	Maintaining clinical skills	Waiting for the doctor's decision: the nurse/doctor relationship
Needing resources	Caring for patients	
3. Being ambitious and getting on	***3. Challenging medical power***	***3.Responding to patients' needs***
Embracing the changes	Knowing your place	Having a gift for healing
Power and empowerment	Developing in the right direction	Informing the patient
Turning full circle	Specialist nurses are different	Loving the job
		Having time
		Reading the signals
		Caring for the patient
4. Making choices	***4. Defining the boundaries***	
Feeling the pressure	Drawing the line between doctors and nurses	
Making choices	Needing alternatives	
Weakening the nursing position	Holding ultimate responsibility	

Figure 10. The categories and constructs from all three groups.

As seen in the previous chapters, the sections describing the perceptions of each group relate specifically to that group. This discussion presents the connection between all data in order to clarify the process underpinning the findings. The following diagram figure 11, clusters the conceptual links as

similarities and differences between the three groups' perceptions. The arrow represents the interaction linking the process of the emerging theory.

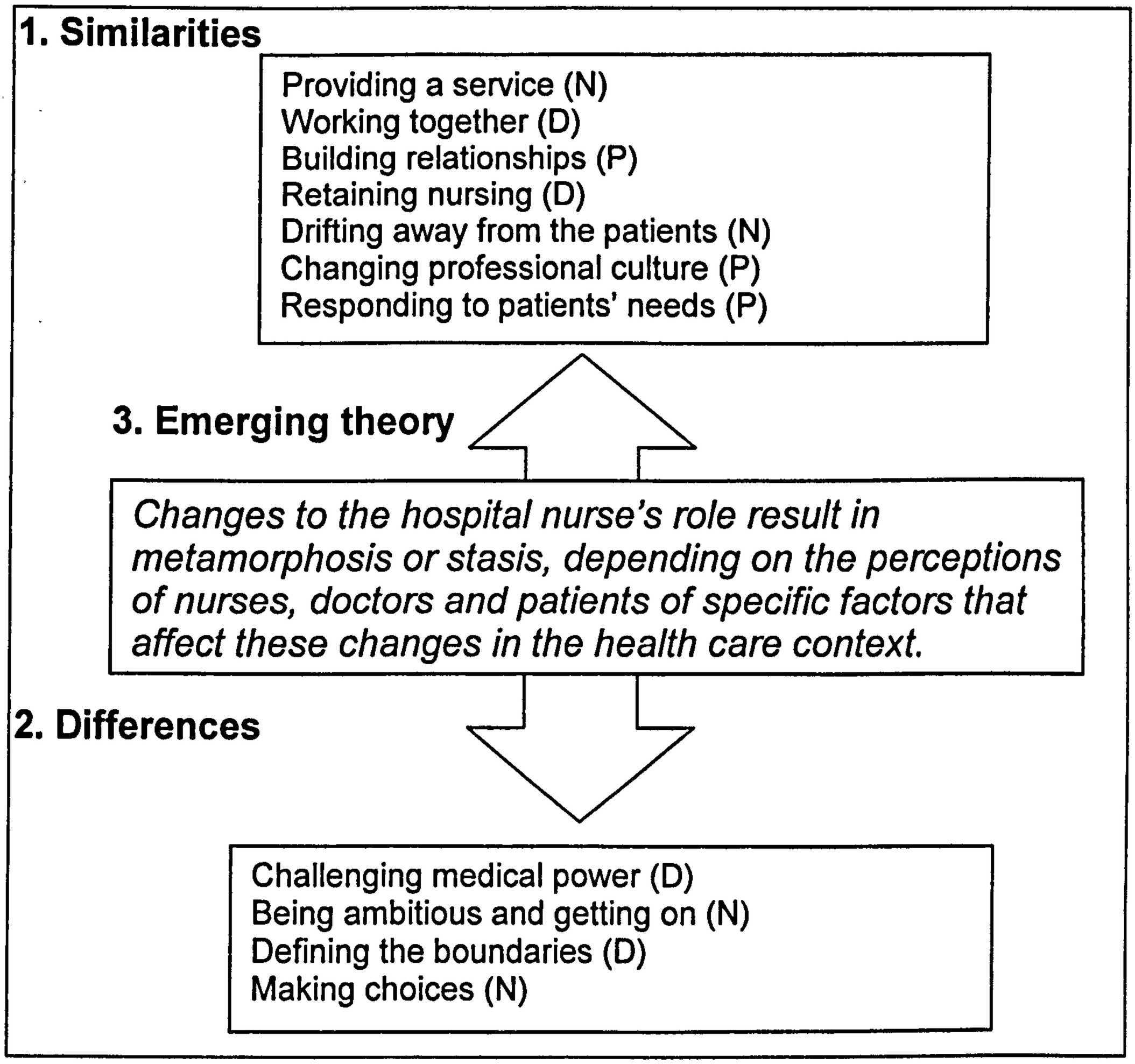

Figure 11. Connections between the constructs of nurses (N), doctors (D) and patients (P), forming the overarching theory.

The context of the hospital ward and changes taking place within the health care environment presented as reasons for both similarities and differences. Comparisons of the perceptions of each group show that the similarities between them are greater than their differences, although neither can be claimed as mutually exclusive, particularly as differences have been discussed within the constructs themselves in the earlier chapters. However,

as similarities provide the majority of associations, these will be discussed first.

Similarities.

Within this group of constructs the focus is on those issues which are perceived as constant for each group. Some similarities were shared between all three groups, although there were areas shared separately between nurses and doctors, and nurses and patients.

The constructs *'providing a service'* (nurses), *'working together'* (doctors), *'building relationships'* (patients), and *'responding to patients' needs'* (patients), identified strong similarities in their views of the nurse's role and the changes influencing it. For the nurses, *'providing a service'* to patients emphasized the importance and uniqueness of their role. The doctors identified this as *'working together'* to care for the patients, a significant part of the caring role, but to the patients, this was acknowledged as *'responding to their needs'*, a fundamental reaction by nurses to patients, and all three groups identified similarities which were an integral part of nursing practice. The constructs '*providing a service'* and *'working together'* have their basis in the reciprocal support between nurses and junior doctors, with the patient as the focus. The patients explain this through the effect of the '*changing healthcare environment'* where nurses and doctors work more closely together in the current context. The following comments are examples of comparable opinions from each group.

> *I think we are beginning to get an overlap in the (nurse's and doctor's) role with the clinical practice things. We can do some of*

the same tasks, which perhaps enhances our understanding of each other's role slightly, not fully, but it can make it slightly better, and I think that will progress. (Nurse K.S.)

I think the nurses do a really good job to be honest with you. I think that they know sometimes more what they are doing than we do and I don't think I could do my job without them. I'll always ask their opinion if I'm stuck and I don't have any qualms at all, and they usually come up with some pretty good ideas because I've only been in the job four months and I respect the fact that they've been here a lot longer. (Dr Y., H.O.)

The patients observed that nurses and doctors worked closely together, and that their roles were at times interdependent.

> *..perhaps it has become a bit smudgy between the edges, a bit blurred between what they, you know, like to be able to do, and what they can do and what they are expected to do, and it did seem a lot more orientated towards providing a service that met what the doctors wanted them to do, rather than what or where the patient was, unfortunately.* (Patient B.)

Similarly, nurses' perceptions of *'drifting away from the patients'* resulted from the influence of the *'changing healthcare environment'* within hospitals observed by some patients which led to a change in the professional working culture, and caused nurses to feel under pressure to complete all tasks for which they were responsible, frequently with inadequate resources.

> *When I first started this job, which was four years ago, I probably did about 80% nursing, actually doing day to day care for patients. It's gradually dwindled now, down to about 40% nursing and 60% divided half and half between teaching and management.*
> (Nurse K. S.)

These views were reflected by the doctors who perceived *'retaining nursing'* as considerably important for the role of the nurse in the care of patients, and felt that nurses should not seek to take on the tasks of doctors.

> *. ...I still think they are actually working within their role in the nursing profession and they should stay that way, because if they would like actually to change their role (to mirror the medical role), they'd better get (a) medical qualification and work as doctors.* (Dr. U., Reg)

This included preserving nurses' clinical skills and caring for patients in the traditional manner within a therapeutic nurse/patient relationship. The patients saw this as *'building relationships'* between themselves and the nurses, and was vital to their comfort and treatment whilst in hospital.

> *...well, you pick up a relationship through - I was in the hospital for three weeks, and I saw various staff nurses and sisters and ordinary nurses, - and the rapport between us was like - Oh, one family was going off duty and another family coming on, it was grand, it were really lovely because they had all got the same attitude, in different ways, but still as nice and still as professional. You see, they listen to you, you know, they listen to you...* (Patient C.)

Not surprisingly, the patients' construct '*responding to patients' needs*' identified many similarities within the three groups. Time was one of the issues important to each group although their conceptions of time and its use were different.

> *No, there aren't, (enough hours) and I do just feel that the more we do the more they expect of us anyway, and it almost feels there is going to come a time when you are going to have to take one big step back and say "hang on, I can't!* (Nurse O., S.)

The doctors perceived nurses as having more time than themselves although their contact with patients was from a different perspective.

> *The nurses, they tend to look after fewer patients and so they have more time to spend with their patients. Doctors tend to look at the disease and are tied up in theatre or organizing investigations...I think possibly the nurses have more time to know the patient better as a whole...* (Dr. W., H.O.)

Patients, however, appeared to measure nurses' time in relation to the amount of time that could be spent with them:

> *I don't think they (nurses) get enough time to sit with the patient and talk about what is wrong with the patient, and what is going to happen to them what is going to happen to the patient himself, the same as going to theatre and things like that...*(Patient E.)

Similarities in patients' and nurses' perceptions of the practice of nursing, caring, information giving and the ability to recognise unspoken patient needs focused on the essentially fundamental parts of the nurse's role. Both groups were reluctant to lose these integral elements that were difficult to describe.

> *...she (the nurse) gave me some pain relief and said I won't disturb you now, you can settle down and you can get some sleep now. But then it got to about 2 o'clock, and I had got to the stage where I just didn't know what to do with myself, and she came and she sat, and just something simple like touching somebody's hand to show them you're there,...and just that flicker of - like - human contact, that can reassure you...* (Patient F.)

This element of caring was significant to both junior and senior doctors, some of whom felt that caring was an instinctive quality in a nurse.

> *...at the moment I see the nurse's role, they are ever so much more caring than we are. I think doctors are just not caring enough as we breeze in and breeze out and I think...I am always surprised when the patients say thank you on their cards to the doctors as well because I don't really think we deserve it to be honest, they (nurses) are just so much more caring.* (Dr. Y., H.O.)

> *...it's in your nature to be a carer, to be kind, to be gentle, to be understanding, the number of O levels or A's you've got is unrelated to that. (Dr T., C)*

However, although the relationships between nurses and doctors were viewed by patients as undergoing only small changes as nurses were still required to wait for a doctor's decision regarding treatment, differences were emphasized more strongly between the constructs of nurses and doctors.

Differences.

There were key differences between the perceptions of doctors and nurses. For example, *'being ambitious and getting on'* afforded nurses the opportunity to develop their practice into an area of their choice. It meant

taking changes forward and feeling empowered to do so. However, the doctors were keen to *'define the boundaries'* of this development. Nurses' developments were constrained by some of the more experienced doctors who felt that nurses were stepping out of their allotted role. These comments highlight their different views.

> *...very positive, nurses taking on more things that in the past you would have to wait an age to get done because the doctor is very busy. It is much more patient-centred now where you actually focus on requirements of the patient and you can get on and do things. It is becoming much easier with the changing education...* (Nurse F.,C/N.)

The doctors' views differed from this; they felt that the role of the nurse was supplementary to doctors rather than independent of them.

> *I believe nurses have a very important role regarding caring for the patient, but it's only an additive role to the medical care. It shouldn't interfere, or shouldn't compete with the medical staff caring for the patient because I think caring for the patient is a responsibility and it should be clear which one is responsible.* (Dr. X., Reg.).

The doctors viewed as appropriate that specialist nurses, with whom they worked closely and had built a trusting relationship, developed to a more advanced level. This does perhaps raise the question as to which model specialist nurses should follow, and whether this is more aligned with medicine than with nursing. However, this issue may be an area for future exploration which is not examined in depth in this investigation. Thus, too much ambition and development in nurses could be construed by doctors as *'challenging medical power'* and a possible risk to their authority, and many doctors raised concerns that nurses did not have the knowledge to make appropriate decisions. To some nurses this appeared as though the role of the nurse had travelled in a circle, and returned to the traditional constraints

of many years previously, where doctors limited the developments of nurses to within specific boundaries. This allowed nurses to perform explicit tasks but prevented independent development.

> *Well, to me, I just feel as if we're going back twenty years, because we did all this twenty years ago when I started my training. I mean, we were doing I.V.s (giving intravenous drugs) when I qualified. I used to do cannulation, we catheterised male patients during our training, and now we've gone the whole circle again.* (Nurse R., S.)

The doctors felt it was necessary to *'define the boundaries'* in order to prevent changes in the nurse's role from impinging on areas where doctors held ultimate clinical responsibility. This view was evident at all levels, even with the newly qualified doctors.

> *I think nurses' work can encroach on doctors' as far as taking blood and that sort of thing go, but I think one of the major differences between the nurse's role and the doctor's role is responsibility. I think at the end of the day the responsibility lies with the doctor. That is probably part of the reason why nurses cannot prescribe drugs and doctors can. I suppose it causes hassle when the nurse has to come to the doctor and say can I have this or the other... (but) if there was a problem it would be the doctor that would be held responsible and not the nurse.* (Dr.W., H.O.)

The patients were aware of these differences in responsibility, and observed that although there were frequently good working relationships between nurses and doctors, the hierarchical structure prevented nurses from taking any action prior to discussion with the medical team.

> *...on the whole they seem on quite free and easy terms, I mean they seem able to discuss things. There is still that deference between the nurse and the doctor, - the doctor he has the main responsibility and if they perhaps don't agree with his diagnosis they are not going to say so unless invited to. Unless invited to give an opinion they won't voice it, because the consultants are another leg in the game, I think they are sometimes a little bit awesome.* (Patient D)

Some nurses viewed the changes as enabling them to choose alternative ways of working, *'making choices'*. However, these choices frequently meant that nurses would need to choose between administrative tasks and looking after patients. Constraints within the system of combining ward administration and nursing practice destined that those nurses who chose to progress into management lost the option of direct patient contact. However, many felt there own position was weakened by the pressure to delegate direct nursing care to the untrained nurse, thereby reducing its value as a unique role.

Thus, the similarities and differences connecting the three groups support the causes and conditions which lead to the perceived influences affecting changes to the hospital nurse's role. Consequently, they form the basis for the overarching theory of metamorphosis or stasis resulting from perceptions of changes to the role of the nurse.

Theoretical strands

A number of ideas emerged from the data to support the development of the theory of metamorphosis or stasis which relate to the influences affecting changes to the role of the nurse. These encompass the issues raised by the participants and what the changes mean to them. For clarity, these are listed below.

1. Most nurses find it difficult to define their role. When this occurs, others do it for them, particularly in the context of ward based care delivery. This sanctions the loss of elements of their role they wish to retain.

2. Public expectations also drive change, perhaps as a result of government and professional directives and policies.

3. When no medical staff are available, nurses are expected to fill the gaps without protest. Nurses accept this and consequently agree to perform a number of doctors' tasks.

4. Trained nurses experience frustration if they are unable to give direct patient care through lack of time due to an increasing workload, or through the need to complete administrative tasks. Removing these nurses from the bedside adds to their feelings of loss, as untrained nurses take over many of their roles.

5. When there is a demand for increasing technological and practical knowledge, nurses relinquish many of the functions in their role that they describe as the 'essence of nursing' in order to perform technical tasks.

6. If nurses' knowledge remains unacknowledged, both by themselves and others, this has a detrimental effect on their relationship with doctors and patients. When their knowledge becomes visible, as with specialist nurses, it becomes valued and implemented.

7. The qualities of a nurse, caring, dedication, kindness, and empathy remain as core values for nurses. Patients, doctors and nurses all recognise these as fundamental.

The emerging theory of metamorphosis or stasis

The key findings and theoretical strands from the data of all three groups support the two main points of the emerging theory, and are illustrated through the following section.

Metamorphosis

Metamorphosis of the nurse's role can be described as a transformation, a transition into a new role while incorporating aspects of the old. It considers those issues that reshape the nurse's role, developing and changing it through a process of growth and adjustment to many complex influences. For many nurses, metamorphosis of the role occurred through their own feelings of enthusiasm and motivation. Those who were anxious to embrace the changes and to be part of the ongoing developments, held positive views about their role, the organisation of the N.H.S. and their relationships with other disciplines. They viewed nursing as a strong profession, working alongside medicine rather than subservient to it. Government influence was seen as a catalyst for change, enabling nurses to take responsibility for their own developments and to implement the changes according to their own priorities. These nurses were able to identify opportunities for change which would enhance their practice and increase their satisfaction with their role. However, the constraints positioned by the government, medicine and patients' expectations were recognised as a limiting factor in the change process.

Nonetheless, the role of the general nurse may expand into many different areas, and has the potential for development into any chosen field. Government policy and professional directives clearly have an impact on the level of change affecting nurses' roles. The participants identify the pressure on the nursing role to change as a result of the increasing demands on the medical role. Nurses were seen by themselves, the medical profession and

the government as an appropriate workforce to carry out the tasks relinquished by overworked doctors. In particular, the doctors who had trained or worked in other countries saw the nurse's role in this country as following the established expanded roles of nurses abroad. They felt there were virtually no limits to the metamorphosis of such a role providing nurses were given suitable education and knowledge. Yet for others, this path appeared fraught with difficulties, with nurses losing the integral caring element of their role in exchange for playing doctors. Educationalists from both disciplines were viewed as promoting change in order to fill the gap left by the junior doctors. However, some doctors saw this as a change of attitude in the nurses to develop their skills professionally rather than replacing a doctor's function. For instance, the senior doctors perceived anatomical knowledge as important for nurses to prevent them from making inappropriate decisions, and they were concerned that limitations in this area could be detrimental to patients.

Specialist nurses, however, appeared to address more medically orientated issues of progression, although they had recognition from the medical profession of their own particular area of expertise. Their role was influenced by functioning at a level recognised by the doctors, and appeared to conform to a method of working which followed the medical model of health care. Consequently, this promoted trust between the specialist nurses and the doctors with whom they worked, and the doctors understood and identified the significance of support and information required by patients after diagnosis of their illness. Indeed, although perceived as possessing a

greater degree of autonomy than nurses working on the wards, all specialist nurses in acute care referred to a doctor for advice and direction. Thus, the trusting relationship between them is based on the acceptance that they will follow this direction, and consequently that their skills can be developed in one specific area of practice such as breast care or diabetes.

Some of the older patients recognized the transition of the role over a period of time, to correspond with advancing technology. Indeed, many were impressed that nurses understood and were able to operate the complicated monitoring equipment now in standard use in today's hospitals. Several patients observed that the role and the traditional hierarchy in nursing had improved. They also felt that menial tasks such as serving meals and giving patients water or tea, should no longer be carried out by a trained nurse.

Thus, role change and dynamic movement was constrained by the expectations of each of the three groups. This promotes stasis with a restriction on development and progress for nurses, and a preference for, and an adherence to, outdated systems of working. However, stasis also included a sense of loss, conflicting with current expectations promoted politically and professionally, and many of the identified areas of change were perceived as detrimental to the ideal of the nursing role.

Stasis

Nurses, doctors and patients all identified areas of stasis, where the role either did not change, or they did not want it to change, and the conclusions drawn from each group are linked in several areas. Some nurses had

difficulty in defining their role, but understood that this provided the likelihood for other disciplines or the organization itself to determine their role for them. Thus, many changes that nurses absorbed into their role were reactive rather than proactive, preventing the development of nursing as an autonomous profession. Evidence of stasis lies with those in each group who resist or are apathetic to change, or those who perceive the role of the nurse as continuing in its early undemanding mould, posing little challenge to other disciplines. This image of nurses mirrors similar portrayals in the media. Actors continue to present nurses as subordinate regardless of changes in the profession, and this has a profound influence on public perceptions of what it means to be a nurse. Both doctors and patients identified the caring purpose of nurses, with the expectation of their physical presence at the bedside. The nurse as the doctor's handmaiden may prove an anathema to many, but the data from my study demonstrate that the expectations of both doctors and patients, and some of the nurses, are that nurses are there to assist in a mainly secondary role. Stasis was promoted, from the nurses' perspectives, by those in their profession who were reluctant to challenge issues such as shortage of staff, pressure of work, lack of leadership within the organization, and their feelings of drifting away from giving direct patient care. This was compounded by concerns about maintaining a balance between home and working life, the financial implications of losing their job if they did not cope with the increasing workload, and feeling powerless to control the direction that nursing is taking. By accepting this lack of control in shaping their own future, and by allowing others to dictate their role, nurses risked remaining in a state of stasis with little or no development from within.

Areas of stasis as seen by the doctors included the need some nurses have to dispense with the responsibility for taking even simple decisions and always referring back to the doctor, thus perpetuating paternalism. Nurses were seen as needing to retain the fundamental caring elements in their role regardless of academic ability. Indeed, some doctors believed academic qualifications to be unnecessary, as they did not see nursing as an intellectual 'real' profession. The traditional practical nursing role does not require, in their view, that nurses attain a high level of theoretical knowledge and education. However, those doctors who anticipated and welcomed the changes recognised that nurses need to increase their knowledge in order to make safe and effective decisions.

Many of the patients' views corresponded with those of nurses and doctors, confirming that integral parts of the nurse's role such as trust, empathy, caring and dedication were expected to remain constant. Much of the literature supports these sentiments and it is recognised that most patients view nurses in a positive light, possibly due to the continuing perception of the vocational nature of nursing. The patients did not want to lose the caring which they perceived as central to the role, and preferred this to remain the same and not be obscured by other, more technical tasks. They saw changes taking the nurses away from the bedside, and being replaced by complicated technical equipment to monitor their condition. They felt that the current trend towards academic status potentially excluded those who would make good 'practical' nurses, but who did not have the educational ability to obtain a registration.

Stasis of the nurse's role appeared to be associated with a lower level of knowledge and expertise, however, development and change can occur when education and training provide a way forward. Perception of change by the participants is related to the visibility and appropriateness of particular knowledge and its value to the nurse's role. For example, computer skills are necessary for the modern day functions of nurses and doctors, but are given little value by patients, and indeed 'computer tasks' are perceived as time wasters. The ability to operate technical equipment, or the knowledge to understand and explain a specific treatment, is important but not obvious to others. However, there were characteristics perceived as integral to the nurse's role that remain fundamental and part of the original qualities of a nurse. The doctors described it as caring, the nurses described it as basic skills and the patients as a vocation or dedication to the job. Although each group described it differently, the perception of all participants is that the essence of the nurse's role is to care for others. All three groups deem caring vitally important; however, its definition as 'only' a practical skill by some of the patients and doctors negates its true value as part of the nurturing, compassionate relationship built between nurses and patients, and based on both experiential knowledge and on education. The knowledge, intuition and expertise required to respond to a particular patient's needs are frequently invisible, and therefore receive less acknowledgement of their true worth.

Implications arising from the study

My study can be seen in the context of current government policies and N.H.S. changes. Thus, reflecting on the research question and changes to the role of the nurse, the implications for the different perceptions raise several issues. There is evidence from the study and the related literature that integral parts of the nurse's role have changed over time, and that nursing is now driven by tasks, cure and technological initiative. Nonetheless, the fundamental core of nursing is seen as the caring role, which all three groups seek to retain however obscured this appears to have become. Implications for the future of the nurse's role are raised by the research question. This study demonstrates that some barriers between nurses and doctors remain, although their roles are becoming increasingly blurred in practice. Policy drivers from the government promote changes to the nurse's role, some of which are advantageous and some of which the patients view as detrimental to the traditional role of the nurse as carer and comforter. However, this lay historical image is no longer sustainable within the current resources of the N.H.S. Indeed, there are further indications that nurses will break through the barriers into areas deemed medical concerns through taking on nurse practitioner roles. Development for some may only be attained through using the medical model to gain the approval of doctors who use this as a measure of knowledge and competency. In order to do this, it appears they are relinquishing the essence of nursing, and passing this integral part of their role to the untrained support worker. The proposed regulation of health care assistants now under review, as discussed in current nursing journals (Nursing Standard, March, 2004), suggests that

these untrained staff need to reach an acceptable level of knowledge and ability in order to perform adequately when delivering direct patient care. This, in turn, removes trained nurses from the patient's bedside, as untrained staff with limited training will replace them. The development of the assistant practitioners' role operating at foundation degree level, is thought by many nurses to be similar in content to that of the earlier State Enrolled Nurse, a role which was frequently extolled as that of good practical bedside nursing. Nursing currently is not wholly a degree profession. This has implications for role expectation as a degree level profession would be required to function at a higher level. As patients' needs change and they are offered more choice of treatment, the role of the nurse has to change to accommodate this. This can lead to motivation and self-confidence in the nurses themselves of their ability to use what they learn, and to respect the roles of others.

Acknowledgement of the government's power over nurses through targets, publicity, and patients' expectations occasionally conflicts with the nurses' views of what their role is, and the caring nurturing element of what patients need when in hospital. Thus, nurses can appear relatively powerless whereas doctors retain their authority. Politically, respective governments support this autonomy of doctors, with changes in the medical profession such as the reduction in junior doctors' working hours, driving the changes to the nurse's role. This has certain parallels with other mainly female professions such as teachers and social workers, where large working populations of women undertake roles in the context of male dominated hierarchies.

The central principle of the N.H.S. Plan (D.o.H. 2000) - currently dominating the provision of services in this country - is that patients' needs drive that service, and patients should have greater choice and be more involved in planning health care. The service is being repositioned around the patients, with them as pivotal rather than peripheral. This points to a change in culture for both users and providers of services. Relationships between providers such as managers, nurses and doctors need to be strengthened in order to work across boundaries for the development of services. Patients themselves however, sometimes find it difficult to accept the expectation and responsibility that they are involved in their own care, and that their opinions are important. Many committees in hospitals and other areas of health provision are now required to have a patient representative amongst their numbers. In the past, patients have frequently accepted their treatment without question, but are now encouraged to participate in decisions. To do so, they require up to date, evidence-based information which they frequently expect the nurse either to provide, or to explain after this has been given by the doctor. The data from this study confirm that these areas require further pursuit and that the role of the nurse must continue to develop and change to accommodate the future service.

The future role of the nurse

According to the N.H.S. Chief Executive (C.N.O. Bulletin, January 2004), nurses, midwives and health visitors are improving the range of services available to patients and consequently reducing treatment times. Nurses are recognised as working in the front line, already with 42 'walk in centres'

seeing 100 patients a day and more planned for 2005. Direct Treatment Centres for patients who need routine surgery, for example operations on their knees or hips, are also providing an opportunity for nurses to become Advanced Practitioners. These practitioners deliver many of the standard services normally carried out by a doctor, for example pre-operative anaesthetic assessment to ensure patients are fit for surgery, in conjunction with their nursing role. Similarly, many Accident and Emergency departments employ Emergency Nurse Practitioners who see and treat patients that would in the past have been reviewed by a doctor. These nurses work within a strict protocol agreed by their employers. Nurses, who, in conjunction with midwives and health visitors, have more contact with patients than any other health professionals, are expected to lead the changes in the patient choice agenda. The strategy paper, Building on the Best: Choice Responsiveness and Equity in the N.H.S. (D.o.H. 2003) was published after a national consultation reaching 110,000 people. The public applauded the development of nurse-led services such as N.H.S. Direct, which will have a critical role in the future regarding out of hours care, particularly with the reduction of on-call time in the recent General Practitioner contract published by the Department of Health (2003). The paper suggests that by building on emerging best practice, nurses will be empowered to develop services to offer more patient choice in areas such as appointment times, treatment, when and how to obtain medicines, and by ensuring patients have the right information to make that choice.

This study has demonstrated that the changes to the nurse's role are influenced by the political agenda. Further policies continue to direct the roles of future generations of nurses with papers such as Agenda for Change (2003), and the National Service Frameworks introduced from 1999 onwards. Nurses are now prescribing medicines independently (D.o.H. 2004), selected from those who fit the criteria of being able to study at degree level. Therefore, as changes take place that influence the composition of the role, integral parts such as caring and comforting are in danger of being neglected. The value of the caring element is emphasised in this study by the nurses, doctors and patients, and provides a foundation for the role itself. The invisible knowledge required to perform this appropriately is less tangible, difficult to measure and often not recognised as important, both by those who do not work in the health care environment, and also by those in this environment who are not aware that knowledge is more than basic skills.

The future patient

The future role of the nurse is directly related to the future patient, and the Institute for Public Policy Research (I.P.P.R.) produces many reports and research on current and future health trends, which are available through the D.o.H. website (www.doh.gov.uk 2004). Kendal's report (2001) analyses the effects of the expectations of patients in the future. She identifies several prospective trends influencing healthcare, such as the wider changes in society with the rise in consumerism, the shift in family structures, advances in drug and genetic treatments and an increasing focus on primary care.

Although there is a general decline in acute communicable diseases due to improvements in hygiene in our industrialised society (Stanwell-Smith 2003), drug resistant diseases such as HIV/Aids and tuberculosis appear to be on the increase (Tanne 2002, Chan and Iseman 2000). Chronic diseases which develop as people live longer such as hypertension, diabetes and cancer will pose a large burden on health services in the future. Indeed, the East Anglian Cancer Intelligence Unit (1997) expect that breast and lung cancer will increase in women and lung, colon and prostate cancer will increase in men. They propose that by 2018, these diseases will be the largest charges on our health resources. Current estimates that the number of people over 70 years old will rise from 4.3 million at present to over 7 million in 2036, will have a consequent impact on the total cost of the care bill (Dargie 1999).

Major changes taking place in the N.H.S. seek to ensure the service becomes 'patient-centred'. Currently, patients relate their health care experience to the way in which health professionals have treated them, and time in consultation with them is seen as a precious commodity. With the increasing number of patients who will need treatment, available time will potentially become insufficient. Again, access to health advice twenty four hours a day through N.H.S.Direct and walk-in centres, is supplied by nurses to provide a service to those who are not able or do not choose to access a medical consultation (Thomson et al.2004). In order to continue this service, nurses are required to reach a specific academic level and a high level of knowledge. Indeed, the positive influence of more highly educated nurses on patient outcomes was identified by the study of Aitken et al. (2003) in

America with a sample of 10,000 nurses. This clearly demonstrated that improving the educational status of nurses to degree level effected a significant reduction in the morbidity and mortality of surgical patients. The findings of their study disproved conventional wisdom that years of nursing experience were significant, as it was found that patients were more likely to survive life-threatening complications when nursed by well-educated nurses.

This study demonstrates the influence of external drivers on the role of the nurse, particularly those of the current political agendas (D.o.H. 2000). Since the inception of the N.H.S. in1948, the role of the nurse has continued to change. The changes however, appear to be increasing in both amount and pace, with some local variations in the interpretation of government directives. Political pressures to curtail costs within the N.H.S. continue, but delivery of a quality responsive service to an ever-increasing population is considered a basic right of those who help to fund that service through general taxation. Graham's (2004) evaluation of the last 50 years of the N.H.S. suggests that economic viability controls its organisational structure, with attempts by successive governments to sustain a cost effective workforce. The implications for nurses therefore, as part of the wider workforce in health care, are that their role is subject to change through the pressures of reforming systems of care delivery to patients. Thus, achieving a balance between service delivery and professional development is a major part of the political agenda. The current government's vision for health care requires the provision of mechanisms for its achievement through development of the workforce. Indeed, as a nursing contribution towards this

development, the Department of Health provided guidance on the implementation of ten key roles for nurses (D.o.H. 2002), originating from the N.H.S. Plan. These include the admission and discharge of patients, minor operating procedures, ordering diagnostic investigations, accepting direct referrals, running clinics and prescribing treatments and medicines. These tasks highlight the many diverse directions promoting change for nurses.

The role of the nurse in hospital practice continues to be influenced by many complex issues. The landscape of the N.H.S. is changing, with amalgamations taking place between strategic and area health authorities and their responsibilities. Expectations by these authorities of meeting government targets drive the N.H.S. as a provider of services. As the largest workforce in the N.H.S., nurses are the largest group to be influenced. However, this does not directly correspond to their influence on their own profession or on others within the organisation. Thus, nurses are led rather than leaders of change. The rights of women in society have gained a greater emphasis over time, which do not appear to be adequately reflected in the nursing profession. However, the wider socio-economic picture also drives the role of the nurse, and dealing with change and uncertainty raises challenges and dilemmas in practice.

The influence of the global picture, where nurses in other countries are developing skills which are normally part of a doctor's role in the United Kingdom, affects the role of the nurse worldwide. As more overseas nurses come to work in this country, the effect of their different cultures and ways of

working again impact on the changes taking place in the nurse's role. Thus, nurses of the future may experience increasingly diverse influences on their role, possibly contributing to further tensions.

Tensions in the role of the nurse

Conclusions drawn from the findings demonstrate that there are many tensions in the role of the nurse. These tensions expose the areas where nurses, doctors and patients perceive changes, compared with areas that they do not want to change. The public's image of nursing, and the projected lay image of the role is rooted in history and media representation. The introduction of the Modern Matron led to many anecdotal references of the 'Hattie Jacques' figure of Matron depicted in 1970's films (Watson and Thompson 2003). This image of nursing is no longer sufficient for today's health care needs, and policies in the 21st Century demand a very different portrayal of the roles of nurses. The average age of nurses on the N.M.C. register continues to increase, and is described by Buchan (1999) as the 'greying workforce'. This, coupled with a worldwide shortage of nurses, forces a change in the role to deal with society's expectations and needs in health care. The N.H.S. is becoming more user-focused, with government policies imposed at all levels for the proposed benefit of those being treated. This has the effect of changing the roles of all those who work in health care, and has a cumulative effect on the hospital nurse's role. Those nurses who wish the role to retain the nursing image primarily as carers and comforters, which corresponds with much of the lay image, find that this is not sustainable in the current climate. They experience added pressures and

frustration as they attempt to fulfil both the old and the new functions of their role, and find that some parts then need to be discarded in order to accommodate service requirements. However, for many, this inconsistency contradicts what they perceive as their core role. This causes conflict and is mirrored in the perceptions of doctors and patients.

The level of change to the nurse's role appears to be increasing exponentially. Over the last decade many new nursing posts have evolved due to the changes in service need and the resources available to meet these (Laing and Hogg 2002). The role of the nurse has been subject to change since its formal recognition in the 1860s through the work of Florence Nightingale. The stages of change have progressed from dependence on medical knowledge and direction, through interdependence between the disciplines to the independent practitioner role of the consultant nurse or nurse practitioner. The wide variety of nurses' roles in providing care for different groups has led to nurses attempting to meet the needs of all rather than focussing on one area of practice. Hospital nurses portray the recognised image of the nurse, and today's nurse still retains the image of vocational centrality, influencing the expectations of both patients and other health care workers. However, with many in the ageing nursing workforce approaching retirement, the focus for the younger generation of nurses is on furthering their knowledge and education (Ayer and Smith 1998). Thus, changes to the nurse's role generate the potential for developing knowledge but, crucially, include the retention of the caring image central to their role.

Changing the focus of future workforce planning could introduce different roles for the health service to be delivered in new ways. According to Mott (2003) dedicated rehabilitation workers would enable many older people currently cared for in acute hospitals to gain quicker levels of independence and recuperation. However, although the government has pledged to break down boundaries between staff working in the N.H.S., the current divisions between occupational groups remain. The proposal that new types of health care staff are needed to improve the coordination of care, includes changing the content of all levels of education to ensure staff acquire and retain the necessary skills. Indeed the publication of the Knowledge and Skills Framework (2003a) clarifies the expected skills and specific levels of competency required to practice in the current healthcare environment.

Contribution to knowledge

The questions raised at the end of any study refer to the contribution the findings make towards offering new evidence in the relevant field. This study examined the changes identified by the accounts of the participants, the reasons for these changes, where and when they took place, who influenced them and consequently how the role of the nurse was affected. There are several key findings from this study which answer these questions, and contribute to the theoretical ideas surrounding the changes to the nurse's role. These are listed below.

1. The study hoped to provide information, insight and understanding regarding the effects of changes to nurses' roles, from the perspectives of nurses, doctors and patients. This has not previously been studied together

and demonstrates that the role of the nurse is crucial to the interrelationships between the three groups.

2. The key findings illustrate the similarities and differences between the three groups, and provide evidence of the stimulus for, and constraints on, the development of nurses.

3. The study provides findings which may be transferable for nurses working on acute wards or in a specialist role, which will be recognized by those working in health care.

4. It supports the evidence that the traditional and historical role of the nurse influences nurses', patients' and doctors' expectations, with nurses still viewed primarily as carers.

5. It identifies the potency of expectations, and attests to the influence of the government and the medical profession as drivers for change rather than the influence of nurses themselves.

6. The study raises questions regarding the suitability of using either the nursing or medical model in nursing practice, particularly in the role of specialist nurses.

7. The findings demonstrate that nurses' invisible knowledge is not formally acknowledged by any of the three groups, but is represented as caring without recognition or even full understanding of the basis of caring.

8. The study confirms existing literature that patients still expect and need the nurse at the bedside, and the effect that changes to the nurse's role have on these expectations.

9. It demonstrates a dynamic shift in the roles within the health service, with movement of medical roles to nurses, and nurses' roles to the untrained support worker, but not without some cost to all groups.

10. The study illustrates that, depending on the perspectives of those within each of the three groups, the hospital nurse's role is perceived as changing rapidly under certain circumstances, such as the influence of government directives, but remaining the same in that patients, nurses and doctors all expect the nurse's role to continue fundamentally as a caring role.

Recommendations for further research

The findings from this study have highlighted some insights into several key areas, such as the constraints influencing the roles of hospital nurses which conflict with their expectations of themselves and the expectations of others. However, there are many issues which could provide areas for further exploration, and reflecting on what could be learnt, the following summaries provide some key areas for development. For instance, the continuing reduction in junior doctors' hours and the consequent expectation that other disciplines will fill the resulting workforce gap, offers several areas for future investigation. These include the tensions that are highlighted in this study, in particular the conflict between the real and the ideal role of the nurse, as untrained nurses are now carrying out basic skills which were formerly the role of trained nurses. This exposes a dilemma as trained nurses attempt to retain their personal conception of nursing and their contact with patients, but this is in conflict with the demand that a large number of patients have to be expedited through the health system. With the moves to regulate the

untrained nursing support workers, this could be examined from both a national and an international perspective. For example, evaluation methods could be used to ascertain whether these dilemmas continue as nurses progress in their careers and if the resistance of nurses to losing the "hands on" part of practical work, compared with the value of other important aspects of practice, such as development and education, influence nurses' career choices.

The findings emphasize that the lay image acquired through tradition and history remains a strong influence on the public's expectations of a nurse. The public portrayal of the nurse is steeped in historical overhang, and nurses continue to be described as "angels" or "Nightingales" in the press and media. Ultimately this impacts on policy makers, noticeably through the implementation of such roles as a 'return to the modern matron', and part of the N.H.S. Plan (D.o.H. 2000). This is an area rich for further exploration, and feminist perspectives could have a role in subsequent research to disentangle the reasons for the continuing portrayal of nurses in this light.

An alternative perspective could be sought on the effect of the political influences which appear to have an impact on the nurse's role, although my study demonstrates that nurses are not always aware of them. For instance, a longitudinal study could explore the impact of the Modernisation Agenda resulting from the N.H.S. Plan (2000) on the future roles of nurses, by examining the effectiveness of, or impact on, nurses' roles in delivering the future health care agenda. This study recognises that many aspects of

traditional training and historical values remain significant to all three groups; therefore to address future workforce issues, new ways of teaching nurses could, for example be explored through action research. Similarly, as might be anticipated, government policy in relation to the medical profession continues to influence the role of the nurse. To sustain the continuing and proposed reduction in the hours worked by all doctors, from junior doctors to Consultants and General Practitioners, other or new disciplines will necessarily be expected to provide an alternative service to the public. With patient choice high on the political agenda, alternative solutions could be sought from both professional and public viewpoints, as well as policy makers. Patients want the ideal of the traditional nurse, but this is not what is required to provide the necessary service. This again links to the tensions posed by this study between the ideal and real role of the nurse, with conflicting expectations promoted politically to patients. Many different methodologies are now needed which facilitate the user voice, and many areas are being proposed. This study specifically highlights the expectations of patients, nurses and doctors and the tensions within everyday practice. Further investigation, for example an interdisciplinary action research study could examine areas of tension which are important to the patients, such as working relationships and responsibilities and preferences of information provision. The findings suggest that nurses are not autonomous, possibly due to the changing context in which they work. The increasing dominance of the economic and legal frameworks, the constraints of political directives and the expanding multi-disciplinary nature of the role has an impact on nursing as a profession and the codes by which nurses work. Although there is

earlier research concerning the professionalisation of nursing, little seems to be currently underway in the light of the contemporary practice context. Thus, the issue of autonomy is an area that could be revisited. For instance, the nature of autonomous practice is highly driven by the context in which it is carried out. In the acute, high profile care field there appears to be fewer opportunities for autonomous practice than in the community or primary care areas.

Currently, a King's Fund project led by Gough (2004) is researching the impact of a high percentage of foreign nurses working in hospitals in the London area. In view of the patients' comments in this study regarding the difficulty in understanding those doctors for whom English is not their first language, an ethnographic study for instance, could investigate the cultural influences of each of the three groups in relation to the role of the nurse. This may be particularly relevant in view of the number of nurses and doctors from abroad working in the N.H.S., and the increasingly multi-cultural nature of British society. Although it is not possible to replicate, this study may be built on with further exploration using the grounded theory approach to carry out a similar study in other hospitals. For instance, this methodology may be used to further explore the differences in the development of roles of general and specialist nurses, and to examine the issues significant to their working practice.

National Research Programmes

In 2005, the N.H.S. Service Delivery and Organisation (S.D.O.) plans to commission research programmes on workforce issues, evaluating models of service delivery and change management. This reflects the massive workforce changes taking place now and in the future. Research into the effect of these changes on the outcomes of care for patients, and the mix of skills required to deliver the promised service, are examples of political responsiveness to public need. The S.D.O. (2004) describes the lack of involvement of user groups as a major gap in previous exercises. The findings which resulted from the perceptions' of patients in my study underline the importance of including these groups in national research. User groups link with future changes in service demand, and together patients, nurses and doctors form integral parts of the cycle of health treatment. This study shows that many of their views overlap, influencing the way these services are provided in relation to both capacity and quality. The national research programme provides exemplars of further research to examine many of the larger issues. Individuals' views, however, relate to their expectations and experiences, and in totality may provide a significant effect on future change.

Conclusions

The conclusions drawn from this study highlight the paradox of change to the role of the hospital nurse through the elements of metamorphosis and stasis. Moving forward, while attempting to maintain the traditional and historical expectations of the role, is emphasized by the difficulties perceived by each of the three groups. Although there are many positive aspects of development, all groups wished an element of traditional 'caring' to remain, though their understanding of this differed slightly. This study has demonstrated the strong influences of the political agenda, the impact of the medical profession and the 'ideal' of patients' expectations on the role of the nurse. However, metamorphosis of the role involves moving into new areas of practice, and developing the role for the benefit of the patients. The concerns from each group that nurses will lose the traditional meaning of nursing draw attention to the need for nurses themselves to take responsibility for the direction of their role and profession. The following diagram figure 12, illustrates the significant issues relating to metamorphosis and stasis which emerged from the data.

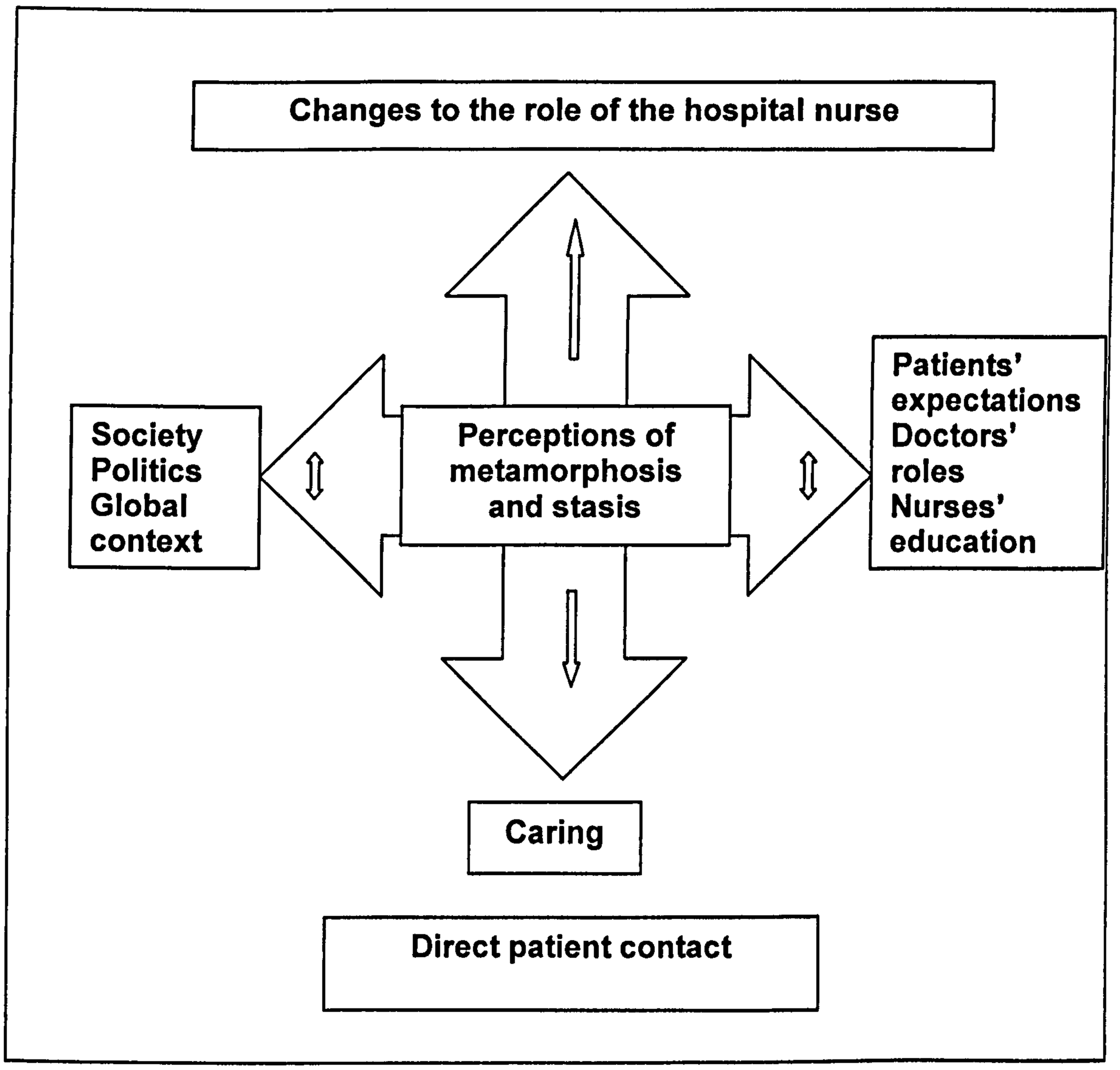

Figure 12. Changes influencing perceptions of metamorphosis or stasis of the nurse's role.

The aim of my study was to explore the perceptions of nurses, doctors and patients of the changes to the role of the hospital nurse. Through this exploration this study has demonstrated that for dynamic change, adaptation of the role is needed to provide a patient-centred service which meets societal demands, and the professional and personal needs of nurses as well as patient needs. The challenge for nurses therefore, is to retain their 'ideal' role in the reality of the contemporary health care context, without losing the key elements that form the essence of nursing.

Appendix 1

Request letters to participants

NURSES' PERCEPTIONS OF THEIR CHANGING ROLE

Dear Colleague

I am currently conducting a research study into nurses' perceptions of their changing role, how they see themselves now, and what their role will be in the future.

The aim of the study is to investigate the developing and changing role of the nurse within the current climate of health care provision. It will focus principally on the professional and personal experiences of those nurses involved in the changes, who work in acute and community hospitals. (For example, the effects of the Scope of Professional Practice, reduction in junior doctors' hours, multi - skilling etc.).

I hope to interview either small groups of nurses who are the same grade, initially with focus group interviews of three people, or on an individual basis with those who prefer it. The interviews will be unstructured and tape recorded, and will take place at a mutually convenient time and place. Informants may withdraw from the study at any time.

All the information will remain anonymous and strictly confidential, and the tapes will be destroyed at the end of the study. Data will be collected and analysed using qualitative grounded theory methodology. If you require any further information, please do not hesitate to contact me at the above address. If you are willing to be considered for this study, would you please return the tear off slip to me in the envelope provided.

Yours sincerely

Lesley Lack

Biographical details of nurse participants

Participants	Gender	Age range in years
Nurses		
A	female	30 - 40
B	female	40 - 50
C	female	30 - 40
D	female	40 - 50
E	female	40 - 50
F	male	30 - 40
G	male	40 - 50
H	female	30 - 40
I	female	40 - 50
J	female	30 - 40
K	female	30 - 40
L	female	30 - 40
M	female	30 - 40
N	female	40 - 50
O	female	40 - 50
Q	female	40 - 50
R	female	30 - 40
S	female	30 - 40

DOCTORS' PERCEPTIONS OF THE CHANGING ROLE OF THE NURSE

Dear Colleague

The nursing role has changed a great deal in the past decade, particularly with the implementation of the government guidelines to reduce junior doctors' hours. I am currently conducting a research study into the opinions of both nurses and doctors on the perceived effects of these changes within the working environment.

Do you have any views on the way in which nurses work which you would be prepared to share with me? The methodology is qualitative, using a grounded theory approach, and involves a tape recorded unstructured interview lasting approximately ½ to 1 hour. This would take place in a private room at an agreed time.

All the information will remain anonymous and strictly confidential, and the tapes will be destroyed at the end of the study. You are free to withdraw from the interview at any time.

If you are willing to be considered for this study, would you please return the tear off slip to me in the envelope provided, and I will contact you in the near future.

Your sincerely

Lesley Lack. R.G.N.

Biographical details of doctor participants

Participants	Gender	Age range in years
Doctors		
S	male	40 - 50
T	male	50 - 60
U	male	30 - 40
V	male	30 - 40
W	male	20 - 30
X	male	30 - 40
Y	female	20 - 30
Z	female	20 - 30

PATIENTS' PERCEPTIONS OF THE NURSE'S ROLE

Dear Patient

I am undertaking an investigation to look at the nurse's role in the current NHS climate. There are lots of changes taking place which are affecting nurses and the work they are doing. I have already interviewed several nurses and doctors, and I am now hoping to collect the views of patients, in order to understand how the role of today's nurse is seen by patients in hospital.

The interview would be approximately 30 minutes, and would take place at your convenience. This could be either in the hospital setting or at your own home after your discharge. It will be tape recorded and then transcribed at a later date. All information will remain anonymous and confidential and not disclosed to anyone. Any data discussed with my educational supervisor will also remain anonymous. You are free to withdraw from the study at any time, and any decision you make will in no way affect your care.

I hope that you will consider taking part as patients' views are a vital part of improving our service.

If you are interested in taking part, please return the enclosed slip in the envelope provided and I will contact you at a later date.

Yours faithfully,

Lesley Lack.

RGN.

Biographical details of patient participants

Participants	**Gender**	**Age range in years**
Patients		
A	male	70 - 80
B	female	30 - 40
C	male	70 - 80
D	female	60 - 70
E	male	60 - 70
F	female	30 - 40
G	male	60 - 70
H	male	60 - 70

Appendix 2

Letter of approval from Local Research Ethics Committee

COPY OF LETTER FROM LOCAL RESEARCH ETHICS COMMITTEE

(Name) General Hospitals NHS Trust

13 February 2001

Sister L Lack.

Dear Sister Lack

Title: **A grounded theory investigation of perceptions of nurses' changing roles from the perspectives of nurses, doctors and patients.**

Date of Submission: **15th December 2000.**

Date of Approval: **04th February 2001.**

Research Worker: **Sister L Lack.**

Ethical approval is given for this project to be conducted to the submitted protocol in (name of area) for a period of two years. If the project is not started within this time further approval should be sought.

You are required to notify us if any questionnaire changes significantly after the pilot.

You are required to keep raw data in hard copy for a period of ten years to avoid the fraudulent use of any data collected.

You must notify the NHS body under whose auspices the research will take place. In the case of (name) General Hospitals NHS Trust, this notification should be made to the Research and Development Manager. Your research must not proceed until the Research and Development Committee has given you their agreement if your study involves patients within this Trust. Your study will also be registered in the National UK Research Register. You should agree to make your results publicly accessible.

We wish you well with your project. You are required to provide this Committee with a brief report on progress of the project at least once a year.

Yours sincerely

(Signed name) Chairman, Local Research Ethics Committee.

c.c. District Health Authority,
Trust Research Department.

Appendix 3

Sample of interview

Excerpt from an interview with a patient

Q How do you see the role of the nurse, and the changes that are happening?

A Initially I would say it was probably the control of pain relief and medication that sort of thing. Helping to settle somebody in to the ward and showing them where they can find whatever they need to know, and then really the care and control of that person, be it from giving them the pain relief to then explaining whatever the treatment they then have to have, which has been sort of like prescribed by a doctor, because sometimes the doctors are in and out so quickly that somebody will think of a question that they want answering after a doctor has gone, and then a trained nurse, in my opinion could spend a little more time and sit down and explain it to the patient.

Q Do you find that the time factor is important, the time spent with the patient?

A Yes, because you can, from my own point of view there were times when I could concentrate and times when I was able to take in what was being said to me, and what was happening, and there was other times when I couldn't remember a conversation that I had had with someone, and if you are in a lot of pain then you don't always register what is being said to you to start with. So you need somebody really to take control of that and guide you through whatever stage you need to go through next, and then have the patience sometimes to tell the same thing two or three times. I notice the nurses were very good with the older people that were on the ward, because obviously they got confused with their tablets quite often and it was a matter of what's this one for, and what's this one for, and what's this one for and they were very good. They explained that even though it was a different shape or a different size to what they had been used to taking it was possibly the same thing, because that came up quite often when I was there. There was one of the ladies that I was with, because she was prescribed certain tablets by a doctor outside the hospital but when she took the ones that the hospital were giving her they were a different size or different shape and she got very confused, and even though she was 88 and she wasn't confused mentally, she was switched on enough to know that – well hold on a minute I'm not just going to take what is put in front of me, I want some explanation for this and the nurses were very good and they had a lot of patience with her and explained to her what was what.

Q Do you feel that is a vital part - patience?

A Yes, because there was one particular lady I was in with the first night, when initially the conversation was ok, then it became quite clear to me that she probably was very old and very confused and as soon as her husband left her it got worse, and I think if she asked me once

through the night how long I was staying and had they told me when I was going home yet, she must have asked me about 200 times and the nurses having to deal with that were very good, because obviously they were trying to balance my needs, knowing that I wanted to probably get some sleep and knowing that I was in pain, but not frightening her as well, and looking after her. This sort of conversation went on all through the night and it got to about 4 o'clock in the morning and one of the nurses said to her, 'Oh, so you are going to Bristol tomorrow, then Ethel?' and she turned round and said 'No, I'm not going to Bristol tomorrow', and she had told me like every 5 minutes through the night that was where she was going the next day, and I said 'Ethel you are'. 'No, I'm not, how do you know?', she said, 'You are, I said, you told me', and she didn't seem to have any short term memory, well that didn't become clear to me until after I had been with her for a couple of hours. Now obviously for the nurses and that, if you are changing shifts and you have only got a few minutes to see a person, you would have to have patience with somebody like that, because you could tell that person the same thing probably 8-10 times running and that, so the patience is a big thing I think.

Q What about observation?

A Yes, yes I was aware that that was being done

Q In what way?

A Um – as I was getting better it can be done quite subtly, just with suddenly coming in, sort of saying, how are you feeling, are you ok and just striking up some sort of conversation to -actually another approach was to come in and one of the nurses to sit down and say right, I have got to write this today, what can I write about you today? Do you want to tell me what sort of day you have had? So to me that was a bit more of a formal observation thing, whereas she could see that I was, - would be better enough to partake with that and other things like when I was in the first couple of nights, I was aware that every so often somebody would come in a just sort of move the curtain and just see if they could tell if I was awake or asleep, so that was good. You knew that there was somebody there all the time.

Q How did that make you feel?

A Quite reassured really, because even though they say, Oh, you know you can press the bell, or press the buzzer or shout or call if you want, it was nice to know that if I had been like one of the elderly people there and, you know, fell out of bed or something, you knew that they would know that somebody would find them, I would think. Having said about the observation bit, it is probably a different tact altogether but one of the old ladies that I was with, she was aware of the bed watches that were on, the prison officers and the prisoners and at one point she was absolutely petrified because it's a big hospital. Her eye

sight wasn't very good and she kept saying to me, 'There is a policeman out there and they are chained to someone'. Now I understood what was going on, because my husband works in the prison, so I explained to her that it was alright, I said 'It is prison officers and it's alright there will be somebody with that person all the time, you know, even if they go to the toilet and it's alright they won't come anywhere near you, you are fine'. But because her eye sight wasn't very good, one of the nurses was shovelling some ice in one of the things, and obviously you could hear this like strange noise with the ice, and she said to me 'Sue, Sue they're on the roof, quick they're on the roof!', because she couldn't obviously - she couldn't see very well, but she could hear this noise and she could see these people moving backwards and forwards, and I think at 88 that's quite scary for somebody, and the longer I was there I was aware there was quite a few of these bed watches taking place. Now I don't know whether it would be a good thing, maybe to see if the officers could wear say like just, maybe blue tops of something, or ordinary clothes, because that lady was absolutely petrified. Now I don't think they would notice, would have noticed as much if they weren't probably not in uniform, I don't know but she was quite scared.

Q So how did that affect the nurse's role, did the nurse reassure her or do you think that was left to you?

A There was only the two of us in the room, and I think she was quite happy because she was sort of like by the window and I was by the door, and I sort of explained to her what it was, but I think if I wasn't there, then it, obviously she would have contact with the nurse or whatever. The nurses there were very good, they would have said to her not to worry, but it's just little things like that that you pick up, being in a room with someone, and just seeing something from an elderly person's point of view rather than just your own, you sort of shrug your shoulders and think that's alright. Yeh, the nurses were fine about it.

Q Can I just take you back to where you say the doctors come round and they flit in and out , – how do you see the nurse's role in relation to the doctor?

A I think she is piggy in the middle really, because she has obviously got to try and explain, she has obviously got to explain to the patient what the doctor has said, but then I would imagine the doctor would say that's what she is there for, I don't know, I would imagine it's - um - very difficult for a woman being stuck in the middle because they will be asked questions from the patient and then there is only certain, I would imagine they have only got certain guidelines that they can go to. Obviously they can't prescribe medication without a doctor signing something, so yes I would think it is really difficult for them.

Q Do you see that as part of the nurse's role to explain what the doctors say to the patient?

A Actually it wasn't so much that - the doctor that I saw was very good, it was the Consultant that I saw on the Sunday. He was the one that just breezed in and breezed out. The actual doctor that I saw, the one that did the suction on my ear and prescribed the tablets, I couldn't have faulted him, he was good, he spent a lot of time . It was the Consultant on the - I think it was the Sunday morning, yes early Sunday morning I think it was, I can't think now - but um - it was the Consultant more than, if the Consultants haven't got the time to spend a few minutes with somebody then I think it's better they don't do it at all, that they let somebody who has got the time to deal with it, and then only if the patient requests to see them should they come back, because I would rather not see anybody that has not got time, do you know what I mean, you know, because the Consultant he sort of came in, picked up my notes, browsed through, I could hardly hear at the time, and he just picked them up, mumbled something at the bottom of my bed and I was sort of straining to hear what he was saying, and it was something along the lines of 'Have you suffered with this before?', and I said 'Yes a long time ago', and then it was like, 'mumble, mumble, keep your ears dry, make sure you use a dressing' and I thought, well what was that?, - was that now?, is that when I go home?, because I could only pick up on certain things and then it was like , well we will discuss that in surgery, we will discuss that at my like outpatients appointment, which I thought, well if you don't want to discuss it don't mention it, go away. But then I was in a lot of pain at that point. But, I think a lot of it is left to Doctors that are actually on the ward all the time, and the nurses to do a lot of the explanation, and I don't care who explains it to me as long as the person who is explaining it takes the time, and that's what I feel.

Q Do you think they have the time?

A Not always, not looking at the way the ward was run and the number of people that are in and out, and the change of shifts I think must take up a lot of the time. I know they do like shift change overs where they run through each patient, sort of, what's happened through the day or whatever. It must be difficult for a nurse coming in cold, say she has had a couple of days off, not knowing at what stage that patient is, whether they are getting better or whether they are not. It's an awful lot to keep - I would imagine - to keep on track, to keep up to date with. I certainly don't think they have got enough time to do the job that they are expected to do, let alone anything else. It is very difficult I think.

Q Do you think nurses are becoming more educated, do you think that plays a part in what they do?

A As long as they get the opportunity to use that training regularly, or that education that they have been given, as long as they are given the opportunity to use that on a regular basis, and as long as it is kept

up to date. There is no good training somebody on something and then not giving them the chance to use it for six months and then eight months later saying well you were trained on that ages ago, you can go and deal with that, that's not really any good to anybody. If you are going to spend a lot of time training somebody and educating somebody to be able to do a certain job, then you have got to make sure that they get a regular opportunity to do it.

Q Did it strike you that they had had a lot of further education?.

A Only in certain - I don't know - I haven't got a lot to compare it to, I don't know what it was like years ago, because I haven't been in hospital before to compare it to, but I know nurses get study days, and things like that so whether that's to keep up to date with the job that they are doing or whether it is to further education, I'm not sure.

Q You didn't get the impression that their role was more technological now?

A Well, I was aware of the nurses station having a computer and people being able to use that, but if it is anything like my experience with computers, sometimes they can be more of a hindrance than they can be a help, especially with my Surname, I mean it's only four letters -, well if you are trying to access something and you are busy and you look and you think its double M, and my experience of a computer is that if you don't put exactly the right letters in, it's going to tell you that that person doesn't exist or whatever, but obviously the technology is there and its coming into the job, but you can't beat the personal touch I don't think. You can't pigeon hole everybody and everybodys' illness, just because one person is suffering from the same person as another, their pain thresholds could be different, their backgrounds could be different, so nurses, you can't just give the nurse a sheet of paper and say right cover these 1-10 points. That nurse has got to be experienced enough to know that that person needs a certain approach and another person needs a certain approach.

Q Do you think experience is more important than training?

A No, you need a balance between the two, with being very experienced but completely out of date, you need a good balance.

Q What about the relationship with the nurse. We talked about nurse having time to sit with you and trying to take care of your pain?

A t didn't really fall to one particular person then, because of the shift change you do see a different person.

Q Would that make a difference do you think?.

A Not if the nurse was good at her job. No. Because if you have got the right approach and you are up to date and you are aware of the person that you are nursing, then you would know what approach to go on with. There was one particular nurse that was very very good, and she was on the night shift. I think it must have been, it must have been the Sunday night after I had had some sort of treatment and the doctor had done some suction, and I hadn't slept the night before because everyone was a bit confused, and I was really, really tired and really uncomfortable and she had only just come on duty and I said to her 'I am really tired I just want to go to sleep'. Now she picked up on that one comment and she said 'Alright, I will be right back in a minute' and she came, and it was only 10 o'clock - quarter past ten -, but she arranged for me to have all the medication that I needed and the antibiotics early, and she gave me some pain relief and said 'I won't disturb you now, you can settle down and you can get some sleep now'. But then it got to about 2 o'clock and I had got to the stage where I just didn't know what to do with myself and she came and she sat and just something as simple as like touching somebody's hand just to reassure them that you are there, because you get to the stage where you don't know what you are doing with yourself, and, you know, you feel that some of the medication that you have had is not working, and just that flicker of like human contact, that can reassure you, and then just being able to suggest trying different things. She was quite good, I think. But then the shifts change so quickly so it's quite confusing, but I didn't find any difficulty with any relationship with any of the nurses, even the male nurse that was on the ward. It was all quite good. Very good really.

Q Do you think the actual fact that she sat with you, held your hand, was that part of her role that you feel is an integral part . Something that is like the nursing part of it?

A Yes, because days there is so much red tape and so many different things, you know, like, well you shouldn't, I don't know, there are so many different barriers put in place these days, of what people should and shouldn't do and whatever, and it must be very difficult to know whether, it must be very difficult to know what one person needs and at any one particular time, just somebody putting their hand on your shoulder if somebody is distressed, that that sort of thing its part, to me its part of nursing, its knowing when to do that and when to not to do that, and being able to pick up on – you see, some people might have found it too personal, but to me it was what nursing is about, that human contact.

Q Reading the signals?

A Um – just trying anything to ease whatever discomfort or whatever pain someone is in. Even if it is not necessary - like a physical pain but an emotional pain, if somebody is, I don't know - bereaved - in

some way, even dealing with their family, not just the patient that they have been dealing with, that's a big part of it as well, I think.

Q That's interesting – that has come out before that patients seem to want the nurses to deal with the whole family.

A They seem to have to deal with everything. I just can't – you know – like playing with computers, to playing with people, to keeping records up to date, to signing and dating forms, its just, there doesn't seem to be any end to what they are expected to do. So many times these days there is like defined job roles, you know, it's an auxiliary's job to empty the jugs and fill the jugs and that sort of thing, but I got the impression if anybody was passing and said could I have a jug of water, wel,l whoever was passing would get it, you know, but obviously everybody needs like a defined job, but you can't define everything to the letter really.

Q Did you find a difference between the trained and the untrained?

A Only to the extent – like if you asked, I think if, I think there was a point when I asked for some pain relief and the lady I spoke to said I can't, I can't get that, but I will go and ask, I can't remember her name now, but I will go and ask so and so to bring that to you later. So it was obvious that like where it was kept under lock and key there was only certain people that were allowed in to get things so that was it. No, that was the only time I think I was aware of the difference, everyone was quite approachable, even people that come in with the Hoovers and clean up, it was just like – is it alright to come in now whatever? That was the only time that I became aware that not everybody could do every particular bit, you know, and then you think that next time I must remember to ask so and so for that, rather than just ask whoever turns up.

Q So, it's like a trained nurse could do anything really, is that what you found?

A Not could do anything, I think there were certain extra things that she had to do, not necessarily do *anything,* there must be limitations to what they are able to do. I would imagine if one particular type of tablet hadn't agreed with anybody I would imagine that they would have had to have gone through a doctor to get that changed or whatever. In my own case I was aware that they had to administer what was written down by a doctor, and that they couldn't change that without obviously consulting him.

Q So they are there to follow the Doctors orders?

A Medication wise, I think yes.

Q How much leeway do you think they have?

A I don't know - there must be, if it is anything like my job, there must be certain grades that can administer certain things, so I would imagine that if it comes down to just giving somebody a Paracetamol then I would imagine probably a nurse might be allowed to do that, but as for letting her loose with Morphine or something, I don't think she would be allowed to just suddenly decide to put somebody on something like that, so she must have some guidelines, I wouldn't know what they were.

Q They are not allowed to prescribe drugs, it is only a doctor that can prescribe. But what about in other ways, you know, in your treatment, things that can be improvised to make you feel better?

A They suggested like hot/cold pads that sort of thing – just trying to think what else – really just at one point when I got quite distressed it was just something as simple as moving to a different room, something you do with like a baby when they are upset, or whatever, you notice you are obviously distressed - here, sort of like lets go for a walk down to the day room or something. This was in the middle of the night, and then just spending a couple of minutes just to sit and chat with you, and then said, will I have a hot drink or something? Some people wouldn't probably class that as nursing, but to me it is because it goes back to like I said earlier, they are aware of the situation and it's the experience to know how to help that person. Going back to the last pregnancy, its something as simple as suggesting a hot pack or something, it's the sort of thing that is common sense, that you would do yourself at home, but sometimes if you are that ill you probably don't think to do, you just need to be reminded, or just have something suggested to you. Obviously that's just like a nurse on the ward, other nurses were like for outpatients' appointments and things like that, I would imagine their role is completely different.

Q In some of the interviews that I have done, the patients think that nurses love their job and consequently love their patients to a sort of extent. Did you find any evidence of that?

A I would imagine it's the same as any other job, you've got to enjoy the job and you've got people that go into work to take money and then come home. The experience that I had with most of the people there was they enjoyed the job and they did their job well. I think - not from my own experience like actually when I was in hospital - but a lot of peoples preconceptions of nurses can be affected by programmes like Casualty and things like that, you know, sort of like nurses following you outside and finding out your life history in two minutes flat. I think that can be a bit dangerous really, because that can lead people to expect too much, and in the real world it's not like that.

Q Do you think that's what it does, raises peoples' expectations?

A I don't know whether it raises expectations. It gives them a false sense of reality, you are not going to have an A & E Doctor chase somebody outside or something and that sort of thing. I think it is a little bit silly sometimes, and I think, - it sounds a bit derogatory but painting nurses to be like you said initially, love their patients, love their job and the real world is not going to be like that. People, nurses are going to have bad days, nurses are going to have their own personal problems that might affect their work and that, so you have just got to expect normality really. You could be aware that if you snap at someone and you are rude to someone, you are having a bad day, they might be a bit sharp back, and I think these days too many people expect to be able to be rude and abrupt to people without any come back. Just because somebody is a nurse and they are paid to look after you doesn't mean you can speak to them or treat them any differently than what you would anybody else. Like, I was aware when I was in hospital there was signs up on some of the glass screens, 'We will not tolerate abuse and physical violence' and things like that. I think that is so sad that it has come to a time when you have got notices like that, which I had to have when I worked in Social Security office. Well you would expect it for Social Security office, but in a hospital I think well, how could people be that rude to someone. So it is just scary, and then you know, if a nurse is a bit sharp back then I would image it's like complaints procedures and all that sort of thing. I think it's just get in touch with reality really, you know, in most things I would speak to people or try and deal with people like I would want them to speak to me, to deal with people the same as I would want them to deal with me. Whether that person is getting paid to do a job or not it's just the way it should be done.

Q Do you think that causes constraint somewhat as to what nurses do?

A The fact of people can be rude and violent –well it's got to, but again that comes with experience, going back to when I worked in Social Security Office, you can usually tell in about 5 minutes whether the sort of person you are dealing with is going to be the person that is going to probably thump you in the next few minutes. I think it can make their job even more difficult, definitely, because these days there are so many people taking drugs and solvents and all sorts of abuse, you could think to yourself you are dealing with one thing and then 5-10 minutes later you are doing something completely different. But obviously that's not in relation to what I had when I was in hospital, I would imagine say like a nurse in A & E part of the hospital would need more protection than somebody on a ward, I don't know, because I would imagine by the time they get onto a ward they would have been assessed and calmed down. It must be difficult having to treat somebody knowing what you are going to have to do to them might hurt and thinking if I hurt this person are they going to hurt me back. You know I would be a bit concerned, so I would imagine it was

safe to work in pairs for certain things. But that's just what I imagine rather than what I witnessed.

Q Is there anything else you would like to say?

A Only that the nurses on the ward that I was on were very good, they did look after me quite well, they were very busy you could tell that but I don't think I would want to do that job. It seemed quite difficult job really, there was like a wide variety of different things, like from the boring filling in of the forms to the actual hands on nursing side of things, because that was just like the role of the nurse on the ward, but I would imagine like a nurse in assisting in surgery or something like that – her job is going to be different again, I don't know if there are different levels or different grades or different pay scales for different things. I can only comment on the actual hands on nursing that I saw on the ward and that was good. There wasn't anything that I could like pick up and say I wasn't very happy with this, I wasn't very happy with that, apart from the brief visit by the Consultant. But I think he was actually going on leave so they said, one of the nurses didn't actually expect me to have seen him, and I said no he did pop in and pop out quite quickly. (Pause)

No I think I have covered most of it (Pause)

I think it is quite good the way they try and – even though its like mixed wards or mixed, its sort of like they regularly assess where there are so many women in, so they moved you from there to there, then we still have the maximum number of beds, that happened while I was there we moved down into another room and they moved the two men into another room, so they had like the maximum number of beds available, simple things like that, they have to be aware of. I think they picked up on the fact as well, like they said you can have your food in the day room, well there was only myself and Phyllis and neither of us was particularly comfortable going into the day room and eating with like 10-15 men and they were quite happy for us to take our meals sort of like in the room that they were in, so even things like that I would imagine could cause nurses problems,

No I think that covers it all really.

Thank you.

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