Incorporating participant objectivation: a nurse's ethnography of the practices of nursing

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Introduction and background:

Every day in clinical practice nurses work in complex, dynamic and uncertain situations. In the hospital setting, throughout the 24hr daily cycle of shift work, mediated by handover of patient status and progress, nurses attend to patient needs for care relevant to the course of the patient's hospital stay. Each nurse will look after several patients for the duration of the shift so that there may be unfinished, competing and/or conflicting patient needs for care occurring simultaneously. Somehow nurses mostly address all that needs to be done for this finite period of time, handing over in-progress and planned care to the next shift. To do this they juggle and balance within individual patient's needs for care and also between the needs for care of the several patients in their caseload i.e. they accomplish nursing.

Research into questions of how nurses provide care has been dominated by studies of clinical decision-making, but how nurses nurse 'within and between', the crucial but taken-for-granted character of everyday acute care nursing, has not yet been studied. As a registered nurse I came to this research problem through reflections on more than thirty years of practice enhanced by post graduate study. Consequently, the current study is observing nurse participants in practice and talking with them to see how they do this, exploring the question: "How do nurses accomplish nursing within and between patients' needs for care in acute care hospital wards?"

Bourdieu's Theory of Practice (1977, 1990, 1998)has being used to inform the research design and will be used in the analysis of the collected data. Bourdieu's theory of practice has been expressed as: "[(habitus)(capital)] + field = practice ...[which] can be unpacked as stating: practice results from relations between one's dispositions (habitus) and one's position in a field (capital), within the current state of play of the social arena (field)" (Maton, 2008, p. 51).

Habitus is “central to Bourdieu’s distinctive sociological approach” (Maton, 2008, p. 49), and has been seen as a disposition of social agents incorporating (unquestioned) beliefs and practices acquired by the agent over the course of their lifetime as a member of a particular society. So in a rather simplified expression of the concept, a nurse incorporates a disposition to carry out practices in a social arena according to her/his life experience, i.e. upbringing, education and practice experience. However, the efficacy of these practices is also affected by the nurse’s position within the social arena and the value/weight given to this position by the social arena (and the other social agents in the arena), and this constitutes nurses’ symbolic capital in this arena.

Many players and influences are incorporated in the complex and dynamic social space or field that is a hospital ward. The nurse works not only as a member of the multidisciplinary team but also in terms of a range of expectations. These expectations include (but are not limited to) national policy and legislation, organisational protocols and policies, professional standards and, naturally, patients’ expectations of the health care system. Bourdieu’s notion of field has connotations both of force field and also of a field of play, as in a sports field (Thomson, 2008), and is particularly useful in understanding the nature of this social arena, able to acknowledge both the many players and also the various influences on the players. “A field is a game devoid of inventor and much more fluid and complex than any game that one might ever design...[it] is a critical mediation between the practices of those who partake in it and the surrounding social and economic conditions” (Bourdieu & Wacquant, 1992, pp. 104-105). “In other words, *field* and *habitus* constitute a dialectic through which specific practices produce and reproduce the social world that at the same time is making them” (Thomson, 2008, p. 75).

In summary Bourdieu’s theory of practice (Bourdieu, 1977, 1990, 1998) is able to not only consider nurses’ embodied practices of nursing, but also to consider these practices in conjunction with the complex social arena in which the question for research is centred, well described as “the space where everything is happening at once” (Parker, 1997, p. 16). Then also, the reflexive nature of Bourdieu’s approach will be particularly useful in incorporating an objectivation of the participant researcher and the research into the study.

There are two main touchstones grounding the challenge that is the observation of the practices of one’s work by one’s colleagues: 1) to be ‘true’ to the study participants – to observe without prejudice/bias/pre-knowledge and to re-present their worlds the way they see them; and 2) to manage my own knowledge/understanding/habitus as a nurse. I see this as a many edged sword where it will enable me to see/understand some things in a way that no non-nurse could (and I will probably/possibly also see/understand things that another nurse, who does not have my interest in the topic, would not see), but it may also lead me to see things that aren’t there (belonging to my

habitus rather than the participant's), or I may miss things that are part of nurses' habitus (because they are so second nature). This paper outlines some initial work on this many edged view illustrated through an instance of participant practice: what happened, what was done, and what was and is the researcher's position in relation to these things.

Researcher or nurse?

The instance I will describe happened in the last 15 minutes of a two hour observation period (third of five planned) with one nurse participant – Ptraci. The setting is a surgical ward in a regional hospital where patient discharge and discharge planning are seen as an essential part of each patient's care. The time is late morning.

George is going home today. He sits quietly in the sun streaming through the windows, fully dressed including a cap, smiling when spoken to. Ptraci has been busy with another patient's discharge and accepting the return of a different patient back from X-Ray. Earlier she had been talking with the junior doctor about George's final discharge arrangements. Then together they had also talked with the George's wife about his appointment in the cancer clinic of a main centre hospital arranged for early in the next week. George is in his eighties and his wife is also elderly. He has recently had major reconstructive plastic surgery to remove and treat a cancer of the mouth. He is now unable to eat or chew food and his nutrition is being maintained by four liquid feeds daily, delivered using a large syringe via his naso-gastric tube. During the morning he appears to be a little unwell: a bit dizzy and weak – his wife is concerned and he is helped to lie down on the bed and his blood pressure (BP) is taken by Ptraci to check if there is a systemic cause. There is no immediate concern and George is encouraged to rest on the bed for a bit.

It is almost time to go. Ptraci administers the midday feed at 1130, saying that this will be easier for them both to manage in the transfer back home. She talks with George's wife, checking that she is now comfortable doing these feeds and then also provides a bag of syringes and medicine measures for them to take home with them. As the feed is finished George gets up from the bed and goes to sit in the chair again. Ptraci says she will need to check his BP one more time before he goes. George fumbles with the buttons on his cardigan to remove the sleeve for this to be done – his wife has gone to get the car – and I step forward to assist. It is at this point that I notice his head wound…

> *The other thing I need to write about is [*George's*] head wound – only visible as I went to help him with the buttons of his cardigan ... To do this I need to acknowledge that I had stepped outside the researcher/observer role, but it was a truly disgusting sight – purulent matter escaping from under all sides of the Alleyvn Adhesive on the top of his head ... had been completely missed in the morning – did he shower himself? He was old, tired, had been severely unwell, and was happy in himself and*

very keen to go home – and quite vague – his wife said about something else: he won't remember – for a question/comment that had been made a few minutes earlier. I pointed it out to Ptraci, who became v embarrassed – but I couldn't have left it… (Ptraci Observation record 3; Field diary)

Ptraci looks dismayed and checks the wound chart on the clipboard at the foot of the bed; the dressing was due on Wednesday but hasn't been done: "I wrote it in the notes" she says. She takes George's BP and writes it on the chart, telling him that it is excellent. Then she goes through the varied discharge arrangements with George's wife: discharge letter, prescription, various appointments (speech therapist, dietician, out-of-town cancer and surgery, district nurse visit, etc) and also the junior doctor's personal phone number (most unusual, and indicative of the complexity of the arrangements). Then she asks George whether it is ok to change the dressing on his head. With his approval she gets the dressing equipment, gently removes the old dressing and cleanses the wound, covering it with a new one. I am asked for an opinion (as a district nurse).

I would have stepped back again at that point but became involved as my district nurse[1] persona was appealed to about the dressings – what best to do.... Ptraci went to get the bits as above and cleansed it – but it wasn't a very good job as it was all through his hair... so I gave a hand and helped with the fixomull. He was quite relaxed throughout and his wife seemed happy that it was being done. I mentioned that it was free if the district nurse did it – it cost them $10 per dressing if 'the nurse' did it – I assumed it was the practice nurse[2].

*Then as it was time to finish and there was a heap of equipment for them to take to the car, I once again put down my nurse/researcher persona and offered to help – he managed to take the bag from me – Ptraci offered to ring them an orderly, but they didn't want to wait and after his low BP I thought it might be a good idea if they had someone with them ... anyhow safely to the car and I handed over the shower stool I was carrying and wished them bon voyage – and as I walked away I saw the senior district nurse and said – he's going to be one of yours – and she said, no, he wants the marae nurse[3] and not oncology – so [*the oncology nurse[4]*] is going to call in tomorrow explain ... she had only seen him in passing, but obviously he was well known... with his surgery and ongoing feeding issues not surprising...*

[1] District nurses have a community role, providing wound care to patients in their homes.
[2] Practice nurses work in GP practices in a variety of roles – wound care, immunisation etc.
[3] Marae nurses work from the marae, particularly focusing on aspects of Maori health;
[4] Oncology nurses provide care and liaison in the community for patients with cancer.

I passed this on to Ptraci – who was really surprised and said: but he doesn't look Maori (I had queried re his surname – ending in 'tangi' seemed like he would be Maori to me, and she had said he wasn't so had taken her word for it)

The thought came to me a couple of days later as I was reflecting on the stepping out of the researcher role – that I had touched/dressed his head without seeking formal permission... I had asked in the usual nursing permission way – are you ok if I do this – that doesn't wait for an answer, just an acknowlegemental thing. Normally one would ask respectfully and then wait until permission was given.... so I didn't feel good about that...

I think he was ok with it – he was dead keen to get out of hospital, but it could have been done better in a lot of ways... (Ptraci Observation record 3; Field diary)

Ptraci's practices of nursing

Ptraci is a young solo mother of a preschool child who nurses two or three days per week. As a 'part-timer' she is rostered in rotating shifts (i.e. morning, afternoon or night shift) to fill the gaps. In the surgical ward where she works, once the initial post-operative period has passed, nursing is focussed on encouraging patients to 'mobilise', to get going again after surgery. When we talked about this she said

and that is the fine line isn't it, of actually letting them be empowered to, I mean you know that's she's not the only person that's ever had this injury and you know that they have to do these things, but for her that's her reality and that's all she knows is what she's experiencing herself, and if she had just that little bit more confidence in herself, you know, each day she'll get a little bit better and you feel like a blimmin cheer leader half the time, cos you've got to "come on, you can do it, you can do it", ...and she can do it, she just lacks that confidence (Ptraci, transcript 1)

And another time she talked about how she thought about assisting patients with their 'personal cares'....

like being in hospital is a good place to assess whether they are actually safe at home, but then, in saying that you know if they are fit and able there's that, in hospital there's that culture that we're the bosses and they do what they're told because they're in a foreign environment and you know, 'n if I was saying well I'll come in and help you in the shower, well they'd most likely probably say, OK dear, but they're probably more than capable of doing it, so I'm just sort of more about empowering and making sure that they're... and it's not... I mean there's two ways of

looking at it, it's probably, people probably think oh that's cos you're being lazy and you don't want to do washes and showering people, but it's not that at all, that's not my motivation, my motivation is about, making sure that the patient's, ummm you know, umm empowered to be themselves, 'n you know umm I mean you don't want to take someone's, you know, autonomy away, I guess (Ptraci, transcript 2)

In this ward there is also an expectation around encouraging patients to discharge home. (There is a laminated yellow card on the wall at the head of each bed: Our Discharge time is 11am; Please arrange your Transport the day before). This came up in our conversations several times and led me to ask the following question:

SEL: And, 'n when you have, when you're looking after your patients are you thinking sort of about the discharge or about the patients?

Ptraci: Umm, thinking about my work, like you know how I say, I said about, you know what's normal for Mrs-whatever-that's-deaf because I don't want to take her independence away and put her on a walker frame or in a wheelchair when I know that she's totally capable of walking, and it's like, and a good question that I always ask therefore is do you still drive, because if they still drive, they're mentally able and physically able and then I always ask about what happens and what's normal at home as far as their cares, 'n you know, cos a lot of our patients are a lot older ... (Ptraci, transcript 2)

Ptraci had looked after George for two days the previous week, then had 2 days off, done a night shift on the Tuesday night and was back working on the Thursday morning on a day where one nurse had gone off sick and not been replaced; on a day when "*I just <u>knew</u> my workload was going to get ahead of me*" (Ptraci, transcript 3). When we talked about her previous care of George (whom she had characterised that day as one of two 'complex discharges'), in the conversation following the observation a few days later she told me:

*Yeah the thing with him was, he had come from [*the main centre hospital*] and no one had accepted him and he just turned up, so the ENT surgeons were really annoyed about that. And so he'd sort of just slipped through the gaps, and he wasn't known to Oncology because he'd been seen here and then gone straight to [*the main centre hospital*] and it was all really... he had this major reconstruction. And so I looked after him last week, it must have been, two days last week, and we started talking about, well, what's going to happen, because you can't, you know, obviously you need some sort of plan. So I had arranged that over the weekend, while I was... I think I was there? No I wasn't there on the Sunday, I, the Saturday, I was there on the*

> *Sunday, that he would start going out on leave... so he went out on leave between his feeds over the weekend and then the plan was... and then I started showing the wife how to do the feeds, and then she started doing the feeds 'n it was all... so we started discharge planning for him, proper discharge planning for him on the Friday and he was discharged on the Thursday, the following week, so that's a significant amount of time to actually, you know, lead up to actually walking out the door* (Ptraci, transcript 3)

After I had left the ward, she had also checked through all the notes to see what was recorded about the care of George's wounds. He had three: two from the major surgery, while the head wound was from prior to the surgery where the skin specialist had removed a skin cancer on his scalp.

> *And looking back through the notes no one else had mentioned his three wounds since I looked after him on the Sunday, or no the... yeah, I'd looked after him on the Sunday and this was the Thursday* (Ptraci, transcript 3)

Conversations with Ptraci

A 'log' of each observation session has been used to form a focus for the follow-on conversation with each nurse participant, and this is then later expanded with field diary comments to form an observation record. There had been some initial concern from participants about what I might record and how it might be used, so for the first conversation I talked about 'what I thought I saw' (in terms of what was accomplished) in contrast to what was recorded as being done.

Participants were surprised at this different view:

> *Ptraci: Yeah, no, I liked last time, how we read through it as we went, because I hadn't had it, so I've just gone through and made a few points that I thought, but, I mean, that's exactly … and I love looking at this, cos it is amazing, what you actually do, cos you think, oh it's a really boring day, nothing's going on, but you know, there's so much goes on, you don't realise, eh?* (Ptraci, transcript 2)

And one time when I asked how she was thinking about what she was doing Ptraci answered:

> *See, I'm not thinking when I'm doing this because this is just boring normal stuff that you just do to get through the day, but actually when you look at it you're doing a lot more preventative stuff, like you're preventing, you know, saving yourself work,* (Ptraci, transcript 2)

And while this might be a 'pleasing' response (Bourdieu, 1996) to a researcher interested in how nurses think about the accomplishments of nursing, I am also "present in my absence" (Rudge, 1996, p. 150).

The timing of the conversations was initially planned to take place as soon as possible after the observation, as I was aware that nurses could have difficulty in recalling what happened from one day to the next of the everydayness of nursing that I was seeking to explore. A minor example is as above where Ptraci has trouble remembering whether she worked the Saturday or the Sunday ten days ago. But as we learnt to talk together more freely, and I began to look more for 'stream of consciousness' recall, I left it up to the nurses to choose where and when we would talk. And it was this recall that seemed able to provide details of Ptraci's interactions with individual patients over a period of time outside the observation period and how she was thinking about this in her own words.

For my part I was not only learning to listen as a researcher but also learning to " improvise the pertinent questions" (Bourdieu, 1996, p. 23). In doing this I had not only the 'social proximity' of also being a nurse but also shared "presuppositions regarding the content and form of the communication" (p. 20). Wiltshire and Parker (1996) talk about conversations of nursing in the nursing handover, which ostensibly functions to transmit information, but has a "latent role [in] the transmission and containment of abjection"(p. 29). As Ptraci commented about the wound:

> *Oh, thank god you saw that, because that was hideous wasn't it? Cos when I've looked at it, I'd just looked at it like this 'n saw that it was all in place, I hadn't looked down on it, 'n he'd sort of moved and it was all sloughy, 'n ohhhh... it was revolting...*
> (Ptraci, transcript 3).

With those presuppositions (Bourdieu, 1996) I also understood her review of the notes afterwards – first as a check on what was remembered, then as a check on whether anything had been done by anyone else, and also as a check on 'nursing documentation' – where 'if it's not written down, it didn't happen' (hospital Incident Report Protocol).

Nursing subjectivities and sensitivities of this nurse researcher

This instance is the one that stands out so far in the data collection for the study. It was the moment when my habitus as a nurse overrode other considerations. It was not possible for me to not say something, to potentially let a patient go home in a state that should have been addressed by a nurse. Other nurse researchers (Borbasi, 1994, 1995; Rudge, 1995) talk about similar experiences in the hospital setting.

Another 'presupposition' in my observation and conversation sessions with Ptraci is my familiarity with the ward, where I last worked casually in 2007. So that we both know that although patients having ENT surgery, when admitted, are cared for on this ward, this particular type of surgery may

be seen only a few times per year. In the local terminology, he is almost an 'outlier'[5] patient. But also he is an (almost) 'outlier' patient with a non-related head wound that hasn't been monitored in the notes. So on a busy morning following a non-sequential work pattern where there is a reduction in staffing, and Ptraci's workload is 'going to get ahead of me', and there is already a lot to do for this patient, there is no time to look for the things that aren't already in the list.

The other thing that is common knowledge in New Zealand nursing is the sensitivities needed to nurse Maori patients, where government policy[6] is aimed at addressing health inequalities for this ethnic group and Cultural Safety (Ramsden, 2002) is included in the Registered Nurse scope of practice competencies (http://www.nursingcouncil.org.nz, Retrieved 13/8/2011). In practical terms this means approaching any patient identifying as Maori with respect, including specifically seeking permission before touching the patient's head. In practice, there will usually be a more relaxed situation, but it is prudent and expected to not take this for granted.

There are many such expectations as well as protocols and proscriptions on practices of nursing in the hospital setting. Immediately after the first observation session, I made a list of ten that I thought had directly impacted on the observations made in the two hour period, ranging from clinical guidelines for specific surgical operations to the requirement that nurses capture daily patients' smoking status for Ministry of Health statistics. But when I went through the policy folder I found there were more than twenty. When I talked about this with Ptraci she said:

> *Yeah, and you can understand how you can, you know like, accidentally, well not make an error, but you know like, omit to... can't find the right word... But how would you, how do you know there's a new... well like, I know you're meant to read them all, but there's so many... so, oh my god, and where do you start...*
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> ...
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> *You have to be safe and know that what you're doing, 'n have a rationale for what you're doing I guess...* (Ptraci, transcript 1)

[5] 'Outlier' is a term used within the hospital to describe patients who are being cared for in a ward that is not the home location of their medical specialty. It relates to managing bed occupancy, so that if the Medical Ward is full, less unwell patients may spend the remaining few days of their hospital stay in a surgical ward, the Rehab unit or even paediatrics. The difficulty is that staff in these other wards is less familiar with the care needed by these 'outlier' patients and aspects of care needed may be overlooked or missed. Senior doctors responsible for the overall care of these patients are also less likely to be able to respond in a timely way to any changes in patient condition, as outlier patients are usually seen (if at all) at the end of the round.

[6] "As a population group, Māori have on average the poorest health status of any ethnic group in New Zealand. This is not acceptable, and the Government and the Ministry of Health have made it a key priority to reduce the health inequalities that affect Māori. If Māori are to live longer, have healthier lives, and fulfil their potential to participate in New Zealand society, then the factors that cause inequalities in health need to be addressed" (http://www.maorihealth.govt.nz/moh.nsf/menuma/About+Maori+Health, Retrieved 13/8/2011)

In the interaction as it played out, it is also apparent that I am local to the hospital and area, knowing people in roles other than the nurse researcher role. I also work casually as a district nurse and this has been helpful in introducing me to participants and patients in their care, so that Ptraci is able to ask 'the district nurse' (as a colleague) for support in this awkward moment, and we then work together to reduce the unpleasantness for the patient. Sequencing on from that, once my research role has been put to one side, I revert to my nursing persona, and as a district nurse make a comment in passing to a colleague, which opens added dimensions to the situation. It is from her that I (and then Ptraci) learn that George is Maori and that there are further issues to be worked through in the community for him to be able to be successfully cared for there.

A further dimension is the apparent dichotomy between the Ethics consent granted by George the patient to 'researcher presence while being nursed', and my legislative obligation as a registered health practitioner mandated to practise only through continuing competence, although the tenor of ethics approval is particularly concerned that no harm shall come to participants or patients in the course of the research. A nursing ethics manifests in the initial response produced by my habitus.

I also know what it is like to work as a mother juggling shift work and child care; though I am from an earlier generation and my children are now adults.

Participant objectivation

According to Bourdieu: "Each of us...is encumbered by a past...and this social past, whatever it is...is particularly burdensome and obtrusive when one is engaged in social science" (Bourdieu, 2003, p. 291). He goes on to say that while the researcher must mobilise this past in the research, (s)he must submit these returns to the past to rigorous examination.

In seeking to study how nurses accomplish nursing in the acute hospital setting, the research interest makes a 'first break' with my social past, but to a degree this is still my social present, where I continue to nurse though not in the acute setting. I am aware that my experience as a nurse is fundamental to my research interest, where I seek, through attempting to explore "quite paradoxical situations that a philosophy of consciousness precludes us from understanding" (Bourdieu, 1998, p. 83) to reveal nurses' "feel for the game" (p. 98). In the observation sessions I record the participant's activity, trying to keep up with the many different things that can happen in brief instants and split-second interactions between players of the game. In the conversation sessions we have moved to talking about the 'observation log' as we might have done in the ward handover situation. Have I reverted too far into the 'native'? Are our conversations changing participants' understandings of their practices?

Bourdieu argues strongly for putting something of the researcher into the research, "but not...in a guilty, unconscious or uncontrolled manner"(Bourdieu, 2003, p. 288) and says that to understand

another, one should "never [ ] forget that they are all people like me" (p. 288), just that they do not have in their heads the "truth of their practice which I am trying to extract from observation of their practice" (p. 288). He then points out that the most difficult thing is "to avoid putting into their heads...the problematic I construct about them and the theory I elaborate to answer it" (p. 288).

My social past-present has been instrumental in enabling me to research, with my participants, the practices of nursing in the acute hospital setting. And while Bourdieu's notions of habitus and field (1977, 1990, 1998) have so far been key to my thinking about the research, this paper presents a preliminary account of the reflexivity and participant objectivation that are also necessary to this purpose.

In describing this instance of nursing, I have used Ptraci's own words and actions to speak to how she sees her practices of nursing around the care and discharge of patients in this setting, and then also about her care of George in particular. I am looking to see whether I have been 'true' to my first touchstone of re-presenting participant's worlds as they see them. Then in counterpoint I have explicated the many edged views that I have as this nurse researcher with this habitus in this field. In doing this I have begun the incorporation of participant objectivation into the researcher and the research. Whether I (and the research) am able to eventually explicate (these) nurses' feel for the game in such complexity remains to be seen.

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