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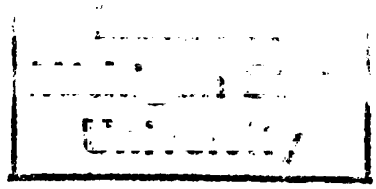

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EFFECTS OF HEALTH BELIEFS ON THE SYNTHESIS OF MEANING: AN ETHNOGRAPHY OF AN EMERGENCY AND OUTPATIENT DEPARTMENT

By

D. L. Stanley Light

A DISSERTATION

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ABSTRACT

EFFECTS OF HEALTH BELIEFS ON THE
SYNTHESIS OF MEANING: AN ETHNOGRAPHY OF
AN EMERGENCY AND OUTPATIENT DEPARTMENT

By

D. L. Stanley Light

Misunderstandings and conflicts in health beliefs often result in patients developing compromises between what nurses teach them, and what the patient thinks is most reasonable. The outcomes of nursing intervention are thus often less than either the patient or the nurse desires.

A better understanding of the factors at work which bring about such misunderstandings and belief conflicts should help to improve the outcomes of professional care. This study focused on:

1. how patients learned to function and made meaning out of the experiences in the setting.
2. how nurses and patients exchanged and processed information.
3. specific differences between nurses and patients perspectives of health, illnesses, and certain modes of treatment such as life style modification and medication therapy.

Ethnographic observation and interviews were used to collect data from one hundred and twenty-six nurse-patient

encounters, and eighty-eight patient interviews over a six month period.

Patients learned to function in the setting by following directions given by the staff and the use of more experienced patients as role models. Patients were assigned to one of three paths through the system's services depending on the urgency of the illness and whether the patient had arranged an appointment.

Patients and nurses regarded one another as belonging to groups which differed in beliefs and practices with essentially the same goals for recovery but differing in choices of method. Patients demonstrated and stated that they often do not follow instructions. For example, few took medications as instructed and stopped taking the medication when their symptoms subsided. None of the nurses in the study smoked and most followed exercise regimes. In contrast with the nurses, many of the patients were smokers and few exercised, even when exercise was prescribed. Nurses and patients also differed in what each group considered should be commonly held knowledge about health care.

The significance of the findings of this study to patients, health care providers, and teachers of health care providers is that they describe differences between what nurses and patients assume happens in their encounters and what was observed to happen.

To my mother Burnice M. Ross Hanes who taught me to persevere when something was worth doing and to my husband and son - Morton and Daniel for their constant support.

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In the fall of 1982, Dr. Charles Blackman assembled a band of educators from many levels of the educational system and a wide variety of fields of interest Michigan's Upper Peninsula to form the nucleus of a group to undertake higher level graduate studies through Michigan State University. Under Dr. Blackman's mentorship we became a functioning family mutually nurturing one another's growth and development. I give my heartfelt appreciation for Dr. Blackman's constancy, advocacy and personal guidance in my studies and as chairperson of my guidance committee.

My sincere appreciation is also given to Dr. James Buschman, my ethnographer mentor and friend who introduced our little family of scholars to ethnography and was unstinting in his support of my study from the preparation of the proposal through the development of this report.

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I express my special appreciation to the nurse practitioners, nurses, nurse administrators, and patients of the Rapid City Health Centre for opening their world to my

inquiry. The quality of care I observed at the Centre was quite high.

To Anne Cleary, Elizabeth Foley, Bruce Harger, and Mae Markstrom, the members of the Eastern Upper Peninsula branch of Dr. Blackman's little family of students, I give my heartfelt thanks for their constant support. As fellow students we shared the inherent conflicts of performing simultaneous roles as doctoral students, teachers, parents, and spouses. Traversing the 320 miles from work or home to class and back, we used the miles for a traveling seminar which provided each of us with broader perspectives from our different professions and individual readings.

To Mae Markstrom, my colleague in nursing, department head, and friend, I give my special appreciation for her support.

And to my husband for being so patient and believing, and proofing my many revisions. And to my son for believing "Mom" could do it, I give thanks that they are mine.

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THE PROBLEM

Introduction to the Problem

In recent years, the health care service encounter has been the subject of a number of complaints from patients, consumer advocates, and professionals. The encounter between a health care provider and a patient-client is the basic unit of service of health care delivery. Criticism of these encounters by patients and health care providers has usually cited insufficient patient response in terms of change in the patient's behavior. Patients complain that physicians, nurses, and other health care providers expect patients to understand too many instructions at one time, and are not allowed sufficient time to ask questions.

Demands upon health care providers are heavy resulting in limited time being available for each provider-patient encounter. Health care providers have responded to the demand for their services by developing routine systems for gathering and processing patient information in order that they can deal with each patient's problem efficiently.

The health care provider and the patient are strangers differing in subtle ways in both language and culture. The evolution of an individual human service into a profession

results in the profession developing its own subculture which both nurtures and impairs working relationships with that profession's patients.

Each category of health care provision, such as nursing, forms a subculture consisting of individuals with like interests, goals, social and economic status, language, artifacts (costume and tools), and an educational system for the enculturation of its new members. A transcultural interface results between the subculture of the professional health care provider and the culture of the patient. This interface has a structure which imposes cultural patterns shaping the social interaction of the encounter between the health care provider (such as a nurse or a physician) and his or her patient. Cultural patterning of working relationships both facilitates and restricts communication.

Statement of Purpose

A better understanding of the structural elements, function, and effects of the transcultural nature of health care encounters could serve as a base for the improvement of communication between nurses and their patients. The purpose of this study was to identify and examine how nurses and patients make sense or meaning out of what they communicate to one another.

Research literature in transcultural nursing is rich in the description of the health beliefs of many cultures, some of which make cross cultural comparisons (e.g., Leininger (1985), Brink (1971-1982), Tripp-Reimer (1980-1984)). Each inquiry in transcultural nursing is based on the assumption of the existence of a transcultural interface between the values, beliefs, attitudes, and customs of nurses and patients. Very little work appears to have been done to describe the nature of the interface itself. This research explores the nature of that interface and its effects on nurse-patient interaction.

Background of the Problem

The health professions have evolved techniques to control and facilitate the data-gathering processes of health history taking and physical examination for efficiency and time saving. This results in these processes becoming less individualized to the needs of any one patient than many health care providers would like their helping interactions to be. Assessment interviews, and the subsequent health teaching and counseling encounters between the nurse and the patient, often assume the structure of ritualistic behaviors.

Ritual

Kottak (1975, p. 349) defines ritual as a behavior which is stylized, formal, repetitive, stereotyped,

held in set places, and at appointed times. The behaviors of the staff personnel in this study setting quite often fit all of these criteria. Leininger wrote that rituals are the explicit activities by which an individual or a group within a culture achieves a different status or position (1978, p. 98).

What meaning these ritualistic interactions have for the nurse and the patient has not been explored. Malinowski felt that rituals served a purpose of allaying anxiety, but Radcliffe-Brown wrote that rituals create anxiety (Kottak, 1975, p. 181). Kottak contended that rituals can either allay or arouse anxiety.

Nurses are taught interview techniques intended to allay anxiety. The process of information gathering, the nature of the information to be shared, feelings of powerlessness in a social setting where another seems in control, and some inability to perceive the connection between experienced process and the purpose of health care seeking are all factors which provoke anxiety of varying severity in their patients.

The degree of anxiety aroused affects the patient's ability to focus and learn in order to work on problems (Peplau, 1952). Peplau also wrote that mild anxiety may facilitate learning, while moderate to severe anxiety seriously impairs it.

Ritual behaviors are sometimes automatically put into play in response to a specific set of stimuli. The gathering of subjective data about patients' health by health care providers is called history taking. Under the pressure of heavy patient loads and limited time, the process sometimes becomes a mechanical ritual causing important information to be overlooked. The health care provider concentrating on completion of the task may overlook body language such as facial expressions which may modify or refute the verbal information the patient gave.

Erickson and Rittenberg (1985) noted in their study of foreign medical school graduates that physicians sometimes interrupted the patient's response and proceeded to the next question effectively limiting the data they could have gotten. Fatigue and anxiety may also be overlooked when the health care provider focuses on the completion of his or her task rather than the information being sought.

The nurse-patient therapeutic interaction is a social action system primarily controlled by the nurse within constraints imposed by the health care facility and the systems of which each is a part. Parsons (1951) described social action systems as being structured upon three integrative foci: the individual actors, the social interactive system, and cultural patterning.

Each individual actor (nurse or patient) has his or her own expectations in terms of some kind of gratification from the other actor and from the interaction. The social system is a composite of the system which supports the setting and the creation of a milieu for the achievement of the actor's gratification. The cultural patterning at work in the therapeutic interaction is a complex amalgam of the folkways of the original culture of each participant and of the nursing subculture. It is also influenced by other care provider subcultures such as medicine, pharmacy, etc.

In encounters between individuals who differ culturally, each tests and experiences the folkways of the other's culture during the work of the interaction. Each participating actor has to preserve his or her own cultural identity while attempting to translate that of the other person in the process of carrying out the work of the interaction.

Members of cultures tend to be ethnocentric. Leininger (1978) defined ethnocentrism as:

> . . . the tendency of an individual (or group) to hold by feelings and beliefs that one's own lifeways are the most desirable, acceptable, or best, and to act in a superior manner to another culture's lifeways. (p. 492)

The members of a culture or subculture must <u>enculturate</u> new members with the lifeways of that culture in order that the culture or subculture will survive. Kottak (1982) defines enculturation as the:

> . . . process whereby individuals learn, through experience, observation, and instruction, their population's culture. (p. 344)

The service goals and ethnocentrism of the profession often motivate the health care provider to attempt a partial acculturation of the patient in the process of health teaching. Redfield (1936) defined acculturation as:

> . . . those phenomena which result when groups of individuals come into continuous firsthand contact, with subsequent changes in the original cultural patterns of either or both groups. (in Kottak, 1982, p. 293)

This ethnocentrism of the care provider is supported and legitimated by the social structure of the health care setting and by the need of the patient to obtain the care provider's services. A status hierarchy is created in which the care provider assumes dominance and control.

Status and Role

Parsons listed three analytical units of the social action system of interpersonal interaction (Parsons, 1951). The smallest is the "social act" performed by each of the participants. The second is the status-role, which is an organized subsystem consisting of the social acts of the actors. The third is (are) the actor(s).

Parsons (1951) defined status as the location of the actor within the social action system relative to other actors. He defined role as consisting of the "processual" or function aspect of what the actor does within the working

relationship. Linton (1945) applied the term role to the sum total of the culture patterns associated with a given status. Linton wrote:

> It thus includes the attitudes, values, and behavior ascribed by the society to any and all persons occupying this status. (p. 77)

Goffman (1961), formulating role theory principally from Linton, writes that role is:

> . . . the activity the incumbent would engage in were he to act solely in terms of the normative demands upon someone in his position. (p. 85)

Role performance, according to Goffman (1961), is the "actual conduct" of the individual assuming the role in an interaction. Status, wrote Goffman, is the placement of a role in the hierarchy of the system. Status also governs the pattern of interactions which specify the rights and duties of the person performing a specific role.

Health care providers are enculturated to behave and communicate in a set of patterns different from the people they serve. The patient and the health care provider entering an encounter cannot help but remark (although unconsciously) upon the transcultural differences between the "us" versus "them" of these cultural differences. Differences or strangeness tend to arouse defense mechanisms until resolved. Furthermore, in the interactional encounter between the "health care provider role" and "patient role", the role of the provider traditionally implies control of the interaction. Lack or loss of one's ability

to control the events of an interpersonal encounter adds to the sense of strangeness and impedes the work of the encounter.

Health care provider roles have come to assume quasi-parental roles in our society. Nevertheless, "Daddy Doctor" and "Mommy Nurse" roles are viewed by nurse theorists as disfunctional in that interactions shaped by these provider roles impair the development of the patient's ability (and possibly desire) to assume responsibility for self care.

Another feature of the transcultural interface consists of objects. Objects, according to Parsons (1951), are "things" in the social action setting: the building, furnishings and other articles such as equipment in the setting. In a transcultural encounter, objects are categorized as "ours" (or familiar) and "theirs" (strange and thus threatening until otherwise defined).

People in the setting who are noticed, but who have not assumed meaning in terms of role and status, are treated as objects. They are there, but are not significant in that the informants do not relate them to the threatening events of the health care encounter or to the threat to their health. The "people objects" cease to be mere objects when the perceiver can personalize them as having roles and status in the system.

Research in Nursing and Anthropology

Madeleine Leininger was the first nurse to actively study the role of culture in the nursing care process (Leininger, 1970). Her doctoral dissertation study of two Gadsup villages (1966) is the earliest well-known anthropological study by a nurse. She has "mentored" a small but growing group of qualitative anthropology-oriented nursing researchers who seek new knowledge, and ways of conceptualizing knowledge, relative to the care and cure processes.

The major nursing studies in this area have been focused on the health beliefs, traditions, and folkways of various ethnic groups, with each study differing from the ethnic identity of the researcher (e.g., Aamodt, Leininger, Tripp-Reimer). A few nursing anthropologists such as Hutchinson (1984) have studied what occurs during nurse-patient interactions and the interplay of their roles from the transcultural perspective. Anthropologists agree that a culture is least visible to the members of that culture (Hall, 1959; Kottak, 1982). Nurses, like any other culturally definable group, have little awareness of the nursing subculture. This seems to have resulted in few nursing researchers studying in the area of the nature of nursing as a subculture or the effects of that subculture on patient health care.

Research Questions

The goal of this study is to develop an ethnographic description of the interaction of cultural patterns of nurses and patients. The synthesis of meaning developed by the nurses and patients during these interactions is sought through exploration of the following research questions:

1. What do patients experience on entering the setting? How do they orient themselves to the other people and the objects in the setting?
2. How do patients learn how to function in this system? What do they have to know?
3. How do the nurse and patient perceive each other's roles?
4. What expectations do each have of the other during the interaction and how does each make his or her expectations known?
5. How do the social action patterns observed compare with the goals of the nurse and patient participants?

Methodology

The development of a body of knowledge upon which to base nursing practice makes multiple methodologies necessary because the nursing care process should be, and is gradually becoming, essentially holistic. The nursing process (assessment, nursing diagnosis, planning, implementation,

and evaluation) works well with both quantitative and qualitative methods of research. Both subjective and objective data are essential to arrive at correct medical or nursing diagnoses.

In research, the choice of method is based on the kinds of data to be collected and the type of analytical relationships being sought. The focus of this inquiry was on identifying meaning of events to the participants in the encounters. Previous studies have used ad hoc methods through questionaires or interviews following the event. The researcher decided to study the health service encounter by observing the actual events using ethnographic methods. Interviews were conducted as often as possible with the participants following observation periods to compare the participants' perspective of what happened in the encounters with the perspective of the researcher as demonstrated in the observation fieldnotes.

The Setting

The setting chosen in which to study the conceptual phenomena of the transcultural interface was the emergency and outpatient service of a health maintenance organization. The site is located in a city of about 80,000 in central Canada.

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Canadian procedures for health care delivery are quite similar to those in the United States except for the methods of funding. Many of the findings obtained in a Canadian

setting should be very similar to the those obtained in an equivalent type of health care facility in the United States. The dominant cultures of the two countries seem to have many similarities, as well as differences.

The national cultures of Canada and the United States are similar in that both countries were settled by people immigrating from the same countries and English is the language in most common use. Both national cultures have roots in the British Isles. The delivery of health care and patterns of nurse-patient encounters are very similar in both, as are the health beliefs of nurses and patients.

The cultures differ in that Canadians have retained stronger ties and more of the traditions of the British Isles, as well as some of those of France. Many Canadians are bilingual, speaking both English and French. The health care delivery system differs in that Canadians use a form of socialized medicine to provide pre-payment and equal access to care.

The site in Canada thus offered a setting very similar to an American site. Nursing care as a social action system in the United States and Canada are quite similar and thus the phenomena of the transcultural interface between nurses and patients should not differ to a significant degree.

Claude Levi-Strauss (1967) wrote that

> . . . ethnography consists of the observation and analysis of human groups considered as individual entities (the groups are often selected, for theoretical and practical reasons unrelated to the

> nature of the research involved, from those societies that differ most from our own). (p. 2)

Site selection was based on several criteria. Ethnographic researchers in nursing usually pick cultures other than their own in order that they may control unconscious ethnocentrism assuring the best level of objectivity they can bring to the work.

The choice of site was only slightly limited by the focus of this study. The inquiry required that nurse-patient encounters occur regularly and in sufficient frequency. Conditions in the setting (and procedures) had to be acceptable to the university committee responsible for the protection of human subjects. In addition, the ethics of nursing and nursing research had to be maintained.

The rights and confidentiality of the administration, the participating staff of the facility, and the patients had to be protected. The site also needed to be located within a reasonable distance consistent with the researcher's research budget (money and time).

Procedure

The Canadian health maintenance organization administration (medicine and nursing) and staff nurses in the Emergency and Outpatient Department (EOD) agreed to participate within stipulated conditions which were written into a letter of agreement.

Data collection was performed with the intention of the researcher to behave as unobtrusively as possible with very limited participation in each encounter. The fieldnotes, however, reflect that the researcher was drawn into participation by nurses and patients more than the original intent. Visits to the site, Rapid City Health Centre (a pseudonym) were made over a period of time from December 1984 to June 1985.

Some people visiting the site were observed entering the setting, or in the lobby of the building. One hundred and twenty-six encounters were observed between nurses and patients in the emergency and outpatient unit. Eighty-eight interviews were conducted with waiting patients. Some were repeated briefly following the nurse-patient encounter. Nurses were interviewed following the interaction as often as possible. Comparison was made of some encounters between physicians and their patients observed at the Centre and in an American college health center.

Research Instruments

The only instrument used was the researcher as observer/interviewer herself. Wooley (1980) described anthropological fieldwork or ethnography as a ". . . qualitative approach which records the way people really act in a variety of interpersonal contexts they create every day" (p. 7). The researcher's goal was to learn as much as possible about the nurse's and patient's perspective of

what went on in the interactions through observation and interview. Observations and conversations were carefully recorded in detailed fieldnotes which were rewritten and supplemented from recall as soon as possible after each visit to the site.

Subjects

The subjects were in a sense self-selected in that the participants determined for themselves whether to participate in the study, the nature and consequences of which they were carefully informed. The subjects were Canadian registered nurses and people coming to the emergency and outpatient department of their own choice or by assignment by the admissions receptionist.

Delimitations

No evaluation of the clinical competence of the nurse informants was intended or carried out. The participants in the study were informed that the focus of the research was to be confined to the nature of communication between nurses and their patients, and would not in any way include the evaluation of job skill performance or the ability of the nurse to demonstrate her command of nursing knowledge.

Limitations

One limitation was that the subjects were self selected and that there was no control group to provide the opportunity for comparison. Thus, generalizability is limited because

the findings can only be applied to describe and interpret the events occurring in this setting. No prestated hypothesis or control group for comparisons of findings was used. In addition, two types of bias must be considered arising from the professional identity of the researcher.

1. The researcher was expected to have some difficulty in eliminating personal bias as a nurse observing nurses. While conscientiously attempting to remain as objective as possible, unconscious subjective judgments could not be completely avoided.
2. Patients being interviewed were aware that they were being interviewed by a nurse about their health beliefs and nursing care. It is very difficult to prevent patients from consciously or unconsciously shaping their answers to some degree in response to this awareness of what the interviewer represents. Patients, for example, may have been reluctant to criticize health care providers.

In contrast to the researcher's effect on patients in interviews, most patient informants demonstrated very little concern about the presence of the researcher during the actual examination and treatment process. To most patients, the researcher seemed to represent just another white uniform. Most seemed quite intent on the purpose of their visit and

explaining their problem to the nurse. Their focus on their problem seemed so intense they usually appeared to forget a researcher was present.

Informant nurses seemed much more aware of the researcher and demonstrated some initial anxiety and tension. This effect seemed to lessen considerably as they became accustomed to the presence of the researcher after two or three periods of observations. The researcher was asked several times whether she had suggestions about the assessment or management of cases. She avoided giving such input as much as possible, but was frequently treated as a visiting nursing expert.

Reliability and Validity

Criticisms of the qualitative approach to research usually cite the lack of replicability and controls in those types of inquiries based on ethnographic or fieldwork methods.

Reliability

Kerlinger (1973) offered three approaches to the problem of defining reliability. The first approach defines it in terms of repeatability of outcomes:

> If we measure the same set of objects again and again with the same or comparable measuring instrument, will we get the same or similar results? (p. 443)

Repeatability is very difficult to assure in anthropological research because there is no way of knowing that phenomena

occurring in the setting are consistently the same. The instrument, the researcher, is the same, but is also changed somewhat in interaction with the informants in the setting. The procedure for observation can be carefully controlled to conform to criteria specified in the research protocol. But the events naturally occurring in the setting may or may not recur in exactly the same way.

Kerlinger's second approach to defining reliability is more applicable to qualitative research:

> Are the measures obtained from a measuring instrument the "true" measures of the property measured? (p. 443)

In qualitative research the instrument of measurement is the researcher. The data to be measured are the spontaneous verbal and physical or nonverbal behaviors of the participants.

Leininger (1985) contended that:

> In qualitative research, however, reliability focuses on identifying and documenting recurrent, accurate, and consistent (homogenous) or inconsistent (heterogenous) features, as patterns, themes, values, world views, experiences, and other phenomena confirmed in similar or different contexts. (p. 69)

The observations made in ethnographic research are as "true" as the researcher can collect in the sense that the researcher collects everything that can be observed in the setting subject to the inquiry. The raw data are preserved as carefully as possible in order to omit no observation which could lead to understanding what is going on in the setting.

Kerlinger's third approach to defining reliability is

to ask "how much error of measurement there is in a measuring instrument" (1973, p. 443). Applying this definition of Kerlinger to qualitative research, the sources of error in qualitative research are the accuracy of recordings of data in field notes and the truthfulness of informants in reporting their feelings, beliefs, values, as well as their ability to recall events accurately.

In this study the requirements of reliability were served by:

1. Explaining the purpose and procedures of the inquiry to participants.
2. Validating fieldnotes by asking the participants to confirm, "Was this what you said?" or "Was this what happened?"
3. Validating the researcher's perception of the informant's meaning of statements by repeating or restating questions.
4. By making as many visits to the site as possible.
5. By observing in as unobtrusive a manner as possible.

Validity

Waltz and Bausell (1981) stated that "in general, a measurement instrument is valid if it does what it is intended to do" (p. 60). Leininger (1985) contended that

> . . . validity in qualitative research refers to gaining knowledge and understanding of the true nature, essence, meanings, attributes, and characteristics of a particular phenomenon under study. Measurement is not

> the goal; rather, knowing and understanding the phenomenon is the goal. (p. 68)

Woolley (1980) wrote that validity in ethnography is ". . . determined by whether the researcher (the tool) reports accurately what people really say, think, and do." (p. 12)

Complete objectivity by a researcher is not possible because sensory stimuli are taken in through a "lens" of personal perception shaped by personality, previous experience, and ethnicity. Nevertheless, objectivity and thus validity was supported during this inquiry by recording events in as thorough and as accurate detail as possible.

Definitions

Two classes of definitions, conceptual and operational, were adopted, adapted, or developed as underlying support structure for the inquiry. Conceptual definitions describe, limit, and interpret fundamental elements and theoretical relationships of natural and construct phenomena. Operational (working) definitions describe, limit, and interpret specific terms as:

1. they were used in the work of the inquiry by the researcher.
2. they were used by the informants in this setting.

The definition of some terms used in the setting by the informants differs from the accepted definitions in current use in the nursing literature. For example, the term "nurse practitioner" has gradually been specifically defined by the American Nurses Association and various advanced practice nursing groups. Specific criteria have been developed for the "correct" application of the term by these organizations. Some of the individuals identified as nurse practitioners at Rapid City Health Centre do not meet all of the criteria.

The source of adopted definitions from the literature or the informants is listed following each definition. Those for which no source is listed were formulated by the researcher.

Conceptual Definitions

Enculturation:

> The process whereby individuals learn, through experience, observation, and instruction, their population's culture. (Kottak, 1982, p. 344)

License: Authority, power, or privilege granted by society to perform acts which are otherwise prohibited to members of that society.

Meaning: The personal interpretation of a phenomenon or phenomena mentally conceptualized and organized from stimuli (stressors). The personal development of meaning is constructed from culturally transmitted values and beliefs modified by personal experience.

Meanings are of two kinds: denotative and connotative. Denotative meanings are concrete descriptions of a term. Connotative meanings are the contextual framework for individual (personal), group, or sociocultural reference to define or describe a term.

Nursing: The diagnosis and treatment of human responses to actual or potential health problems. (ANA, 1984)

Perception: 1. The process of sensing or perceiving stimuli from the internal or external environment. 2. The result of the process of organizing and mentally processing information from perceived stimuli.

Semiotic: The analysis of the relationship between signs and symbols of communication with perception in the study of meaning. Three branches are listed in Guralnik (1972):

Syntactics: semiotic study of formal relationships between signs and symbols. This was described by Chomsky (1957) in the theory known as translational grammar.

Semantics: semiotic study of relationships between the denotative and connotative meanings of signs and symbols.

Pragmatics: semiotic study of practical relationships between signs, symbols and their users. This is a modernized form of semantics now

commonly termed ethnosemantics or ethnoscience.

Subculture: a group that deviates in certain areas or features with respect to values, beliefs, behavior from that of a dominant or parent culture with which they are perceived or known to be closely identified in daily life. (Leininger, 1985, p. 493)

Transcultural interface: The metasystem of interaction which develops between an individual of one culture or subculture and an individual, group, or objects in the setting of a different culture or subculture.

Operational Definitions

Nurse: (also, Staff Nurse) Any individual licensed as a "Registered Nurse" in the province of Canada in which this inquiry was undertaken.

Nurse Practitioner: In this setting, the term is used to designate individuals with advanced preparation in the diagnosis and treatment of actual or potential health impairment through the use of expanded or extended nursing skills. Extended skills include delegated procedures ordinarily restricted to licensed physicians.

Patient: An individual coming to the Centre for health care. The term "client" is preferred in the nursing literature; however, the staff and the patients themselves, in this setting customarily use the term

"patient" for such individuals and the writer chose to work with their term to avoid confusion.

Registered Nursing Assistant (R.N.A.): Any individual licensed to practice nursing in Canada under the direction of a registered nurse as an RNA. This category of health care provider is quite similar to that of the American Licensed Practical or Vocational Nurse.

Screening Nurse: The nurse or her relief assigned to screen patients in the Emergency and Outpatient Department. The nurse assigned to this position has undertaken courses in health assessment not usually given in basic nursing curricula (in the past). She determines to whom the individual patient will be sent for definitive diagnosis and treatment in the Centre.

Staff: Any individual employed at the Centre. This includes physicians, nurses, nurse practitioners, nursing assistants, clerks, administrative personnel, etc.

Overview of the Study

This study is divided into six chapters. The general premises and purpose of the study, as well as the conceptual and operational definitions used in the inquiry are included in Chapter 1.

In Chapter 2, the relevant literature concerning theoretical relationships between nursing, ethnography, role

theory, and cultural concepts is reviewed. In Chapter 3, the conceptual framework guiding this research and the methodology developed from it is presented.

The complex setting of the study is described in Chapter 4. The setting is complex because it consists of a larger setting, the "Rapid City Health Centre", and the focal setting of the study which is the Emergency and Outpatient Department (EOD). The role and function of the informants participating in the study are described.

The findings, the patterns and relationships emerging through the analysis of the data are described in Chapter 5. The summary, conclusions and recommendations developed from the findings are reviewed in Chapter 6.

An intellectual autobiography appears in the appendix. This additional material may be useful to the reader as it describes the researcher's professional background. It thus provides some perspectives about the research which may be helpful in interpreting this report.

CHAPTER TWO

REVIEW OF THE LITERATURE

Introduction

Review of the existing literature from the distinct bodies of knowledge of nursing, anthropology, and education was essential to define concepts and interrelationships between concepts as a basis for a theoretical framework for the study of the phenomena of the transcultural interface. Specialty subfields interrelating each of these fields of knowledge have been developed which support nursing and education in drawing from concepts and methodology of anthropology for specific applications in each of these fields.

The study of the transcultural interface required a search of literature pertaining to theory and conceptual framework development, role theory, culture and subculture, nursing as a profession, nursing as a subculture, and ethnography in education and nursing.

In addition, as the structural detail of the transcultural interface emerged, the appropriate literature pertaining to social action theory and the psychology of personality were explored.

Science and Theory Development

Science is defined (Guralnik, 1972) as a derivative of the Latin verb scire: "to know, discern, distinguish, base" (p. 1275). It is also defined in the same source as:

> . . . systematized knowledge derived from observation, study, and experimentation carried on in order to determine the nature or principles of what is being studied. (p. 1275)

Hardy and Conway (1978) offer three applications of the term science. The term is used to refer to "a body of well-grounded knowledge" (p. 2), specific methodologies of inquiry, and/or complex social systems of persons and the activities involved in building a circumscribed body of knowledge for the practice of a single discipline or profession.

Hardy and Conway (1978) also describe guidelines or norms uniform for all people involved in the work of building or adding to circumscribed bodies of knowledge. These norms are:

1. that the study of human behavior will be objective and empirical. (p. 3)
2. that the research must be critically scrutinized by other scientists. (p. 3)
3. that the ideas and techniques emerging in such work be shared. (p. 4)

4. . . . that recognition (value) of the work is based on the credibility and significance of the work, not on the person, time, or place associated with the contribution. (p. 4)

5. (scientists) be open to new developments and approaches. (p. 4)

Fitzpatrick and Whall (1983) state that:

> Nursing science is focused on the elaboration of relationships between person and environment in relation to health. (p. 1)

Nursing is generally agreed to be in a "beginning" state of development as a science and is generally considered to have attained the stage of "becoming" as a profession.

There is some question as to whether medicine and nursing have "sciences" of their own. They possibly may be applications of other sciences such as physiology, chemistry, physics, psychology, sociology, and anthropology. Nursing theorists, beginning with Nightingale (1859) and continuing into the present, agree that nursing is concerned with the study and alteration of the phenomena of states of human health (care process). This is in contrast with medicine, the focus of which is the cure of disease.

After Nightingale, little was done for the evolution of a circumscribed body of nursing knowledge or the study of the care process for almost 100 years until Peplau released her work in 1952. Since Peplau, a number of nursing theorists have published works expanding the body of

nursing knowledge (e.g., Orem (1971), Orlando (1961), Wiedenbach (1964), Henderson (1966), Roy (1976), and Rogers (1970)).

Theory

Kerlinger (1973) defines theory as:

> . . . a set of interrelated constructs (concepts), definitions, and propositions that present a systematic view of phenomena by specifying relations among variables, with the purpose of explaining and predicting the phenomena. (p. 9)

Chinn and Jacobs (1983) define theory as a "systematic abstraction of reality that serves some purpose" (p. 2). Chinn and Jacobs also differentiate between the terms "concept" and "construct." They define "concept" as a "mental formulation" describing real objects, properties of objects, or events (p. 200). A "construct" according to the same authors "is a type of highly abstract and complex concept whose reality base can only be inferred" (p. 200).

It follows then, that a nursing theory must describe a specific and eventually testable relationship between conceptual or constructural phenomena identified in health and/or the nursing care process. The nursing care process is the basic methodology of nursing practice. It is a scientific problem solving process divided systematically (sequentially) into the steps of assessment, diagnosis (identification and definition of problem(s)), planning of intervention, implementation of intervention, and evaluation.

Nursing

The evolution of nursing into a science and a profession is an essential prelude to understanding the complexities of nursing as a distinct subculture.

Nightingale (1859/1969) defined nursing as a profession. More recent nursing theorists have developed conceptual definitions of nursing from a variety of perspectives. Peplau (1952) defined nursing both as a therapeutic interpersonal process and a discipline. Orem (1970) defined it as a human service.

Fitzpatrick (1979) defined nursing as both a science and a profession. Newman (1979) defined nursing as a science which facilitated health while Parse (1981) described nursing as science and art.

The historical sequence of work by nursing theorists seems to correlate with changes in nursing's evolution as a profession. Nightingale initiated the evolutionary process by attempting to create a profession (specifically for women) out of a very low status occupation. Her goal was to meet the needs of society for better nursing care and to provide women with stable employment (Palmer, 1983).

Christy (1980) wrote that in the United States the first schools of nursing were opened less than a century ago. The schools were created, according to Ashley (1975), by hospitals as a source of supply of free labor to provide nursing care to the hospital's patients. Christy (1980)

contended that little nursing education actually occurred in these schools. Third year students functioned as "charge nurses" and clinical instructors.

The term "profession" was loosely defined until Flexner (1915) and nursing was called a profession without the autonomy to justify the use of the term. A more accurate term used during the early period by medicine, nursing, and lay people, was "trained nurse" and later "registered nurse". The primary function of nursing during this period was that of assisting physicians with the treatment of disease. Nursing education was considered an apprenticeship and took place in schools located in, owned by, and philosophically structured by hospital administration.

Christy (1980) disagreed that it was even a true apprenticeship. She wrote that virtually every American hospital, regardless of its size, opened a "nurses' training school". She contended that:

> The period when hospitals depended on nursing students for nursing service has been referred to as an "apprenticeship" type of education, it was not even that, for a true apprenticeship requires a "master" as the teacher. In nursing, we had students teaching students- or the blind leading the blind. (p. 494)

When most nurses were being prepared in hospital schools of nursing, nurses had little contact with academic scholars who might question their claims to being professionals. This gradually changed as universities began to open their own schools of nursing.

Etzioni (1969) used the term "semi-profession" to describe "those who's claim to the status of doctors and lawyers is neither fully established nor fully desired" (p. vi). He wrote that the semi-professions such as nursing should acknowledge their semi-professional status and adopt goals for its improvement. Simpson and Simpson (in Etzioni, 1969) identified several factors which would delay the evolution of autonomy for a semi-profession such as nursing consisting mostly of women. These were:

-discontinuous career patterns.

-less interest in scholarly work.

-varying motivation for working.

-coming from lower social status.

-different values and goals than men. (p. 239)

Flexner (1915) wrote one of the earliest descriptions of a profession which became the classic set of criteria for determining professional status. Shepherd (1948), looked at public health, and Bixler and Bixler (1959) looked at nursing, restated and expanded Flexner's original criteria. Each subsequent list of criteria became more complex and lengthy until Lucie Kelly (1975), with well applied use of Occam's razor, summarized them into the following simple list of the criteria of qualifications of a profession:

1. Provides services vital to human and social welfare.

2. Has its own special body of knowledge on which its skills and services are based, and continually expands this body of knowledge through continuing investigation and research.

3. Involves essentially intellectual operations, accompanied by large individual responsibility.

4. Educates its practitioners in institutions of higher education.

5. Establishes and controls its own policies and activities.

6. Attracts individuals whose primary motivation is service rather than personal gain and who conceive of their chosen occupation as a life work. (p. 158)

Kelly wrote that "even the most enthusiastic nurse cannot say that nursing has completely fulfilled these criteria, with the exception of the first" (p. 158).

Most people agree that the services provided by nursing are unique, and essential to human and social welfare. It is also generally agreed that families can care for their own health and sick members, but maintenance and recovery of wellness is more likely with the help of professional nurses (Stanhope and Lancaster (1984)). Serious illness often results in suffering, permanent disability or death without professional support of the care and cure processes.

There is a developing body of nursing knowledge which builds on philosophy, the arts, sciences, education, and applied science and technology. The development of this body of knowledge is very young. Except for Nightingale's work in the 1800s, the work of modern nursing has been in progress a

mere forty-five years. But, is the timespan of the work a criterion for qualifying as a profession? This writer contends that though the building of nursing's body of knowledge has been in progress a short time, it is expanding so rapidly that sufficient work is in place to partially meet the criterion. Nursing has its own refereed journal of research, Nursing Research.

Smullen (1983) contended that the distinctions between some specialized bodies of knowledge are unclear because they overlap. Medicine and nursing have considerable dependency on the other arts and sciences as knowledge bases to study health, disease, cure and care phenomena. The two disciplines are also mutually interdependent. Smullen (1983) considered nursing's difficulty in defining a specific area of knowledge as its own to be "the biggest stumbling block to its professionalization" (p. 52). Much of the work of nursing is under the direction of medicine or consists of psychomotor tasks, which require a considerable degree of individual judgment and accountability.

Nursing has independent, interdependent, and dependent functions within its professional role relative to clients and other professions. Implementation of the role is based on the nursing process which begins with assessment. No occupation can be considered a profession if it is completely dependent upon another as a source of the data

from which problems are defined, services planned and delivered. Professional nurses are now taught to perform comprehensive health history taking and physical examination skills, data analysis, and nursing diagnosis (problem definition) as a basis of the nursing process. From their analysis and definition of the problem, the process continues through the stages of planning, implementation, and evaluation of outcomes. This demonstrates that nursing has distinctly individualized its methodology of practice. Some believe this to be an optimistic sign of the profession's maturation.

The tremendous expansion of knowledge and technology in every discipline may increase the degree of overlap between all professions. Research in the smallest and clearly circumscribed field of knowledge may increasingly demand interdisciplinary teamwork for success. No single individual can possibly have all the skills the study of complex problems demand.

Nursing education has moved rapidly out of the hospital school into colleges and universities. Vaughn (1983) reported that the number of hospital schools (called diploma programs) has declined rapidly, although applications from prospective students for admission to such programs have not. Vaughn further reported that the curricula in almost all schools at every level had incorporated features to "facilitate career mobility" (p. 460). Nursing services

and consequentially educational programs, are knowledge and skill leveled. Thus, there are the following levels: occupational (aides and orderlies), vocational (Licensed Practical Nurse (LPN) and Licensed Vocational Nurse (LVN)), technical nurse graduates of associate degree programs (R.N.), and professional nurse graduates of baccalaureate or higher degree programs (also R.N.s). In 1984 and 1985, state nursing associations and state licensing boards were debating how to formalize distinctions between the technical and professional levels, both currently licensed in every state as registered nurses. The debate centers on whether the distinction needs to be made through licensure, special certification, or some other alternative (A.J.N., 1985). Nursing is only gradually establishing ownership of its profession (or profession coming into being). Rodgers (1981) contended that nursing is in a state of professional adolescence as it works through the process of defining its identity as distinctly different from medicine. Rodgers wrote:

> What I am suggesting, of course, is that the intensity with which we declare the difference between nursing and medicine is an expression of our adolescent need to separate from a parent who actively discourages individuation. (p. 480)

The resistance of medicine to the development of autonomy by the nursing profession is said to be stiffening (Johnson and Freeborn, 1986). Both physicians and nurses can provide considerable health care without the help of the

other, but better outcomes are achieved through colleagial care. Nursing is gradually establishing some control and ownership of its own work which may gradually qualify nursing as a profession.

The last criterion that the members of a profession see the work of the profession as a life work is not true of nursing. As a female dominated profession, its members "drop in" and "drop out" of practice in their lifetime of work as work competes with family and other interests (Kelly, 1975). Schlotfeldt (1978), however, is optimistic in that she senses a strong trend for change in the attitudes of nurses toward nursing as their life's work. She is optimistic about the professionalization of nursing citing the considerable work accomplished in defining the scope of nursing practice and a growing body of nursing research. She wrote that the trend toward job descriptions which include specific statements about personal and professional accountability is a favorable sign of the profession's developing maturity.

Professional Socialization/Enculturation

The literature is ambiguous in the differentiation between the concepts: socialization and enculturation. Some writers use the terms interchangeably as near-synonyms. Others seem to prefer one term to the other in usuage without defining it.

Linton (1945) defined a society as "an organized group of people, a collection of individuals who have learned to work together" (p. 56). He defined a culture as "an organized group of behavior patterns. . ." (p. 56).

The conceptual framework of personality components provided by Kluckhohn and Mowrer (1944/1976) differentiated between physical (environmental), biological, social, and cultural determinants of personality formation (p. 98). The social determinants are described as learning to perform tasks such as infant care, behave in social interaction, the procedures in a work setting, getting a job, etc. In contrast, cultural determinants are the distinctive values, beliefs, and attitudes of a group about tabus, definitions of health, causes of illness and death, remedies, rights of individual members, etc.

Socialization

Hardy and Conway (1978) wrote that of the many perspectives from which socialization is defined (anthropology, psychology, sociology) four basic elements emerge in common:

-what is learned.

-how it is learned.

-why it is learned.

-what are its expected outcomes. (p. 31)

But these perspectives apply equally well to enculturation.

Freiberg (1983) defines socialization as:

> The process by which individuals pass through age-graded social roles whose requirements they must learn. (p. 613)

It follows then that socialization in nursing refers to learning to perform the social tasks and procedures of the care process. These include how to enter the personal space of a client, perform therapeutic procedures, play the "Doctor-Nurse game", and carry out health teaching and health counseling.

Enculturation

Linton (1945) wrote that:

> The ascription of particular culture patterns to individuals on the basis of their specialized occupations is generally of a rather limited sort. (p. 68)

He felt that occupations and professions, while differentiated from the larger society in knowledge and skill were simply extensions of the belief systems of the larger society. However, when identifiable groups of people within a larger culture hold differing and even conflicting beliefs from that larger culture, it follows that the group holding the differing belief system constitutes a subculture.

Kottak (1982), defined enculturation as:

> . . . a process of conscious and unconscious learning involving interaction with others, to internalize, or incorporate, the culture of that population. . . (p. 6)

Arensberg (1978) described the work of ethnographers in studying social group variance in large industrial organizations. He said that ethnographic research demonstrates that different social categories (workers, managers, executives) exist within these organizations which have differing belief systems transmitted through the process of microenculturation.

The overt function of nursing education is to socialize an individual into the social role functions of nursing. In the process, the value systems of the society are probably expected (by the society) to be reinforced. However, the educational process also transmits a value system differing from the larger society.

Role Concepts

The study of role concepts in the literature is organized around two major perspectives: the functionalist (sometimes termed structuralist) and the symbolic interactionalist. Each of these perspectives can also be viewed from the three behavioral sciences: anthropology, psychology, and sociology. The body of literature concerned with role seems to be more of a "developing" conceptual framework rather than a theory or a set of theories despite almost a century of investigations in the field.

Functionalist Perspective

This school of thought views roles as "status-role bundles" a term which appears to have been used first by Parsons (1951). Parsons wrote that the "status role bundle" (p. 25) is a unit of the social system and was similar to the "particle of mechanics" (p. 25) used as a basic unit in physics.

Status delimited the position of the actor in the social structure. The term role was defined by Parsons (1951) as:

> what the actor does in his relations with others seen in the context of its functional significance for the social system (p. 25).

One person who's function in society is to build houses from wood is known the role of carpenter. His status is his social position in the hierarchy of his social group(s).

Functionalists, according to Hardy and Conway (1978) hold that " . . . institutions arise in society because they fill a specific need for the society in question" (p. 19). The conceptual framework of Parsons (1951) and Durkheim (1964) in writing about society, social forces, role, and status takes the form of a taxonomy as fixed as those used by botanists or zoologists.

Malinowski (1927) wrote that culture provides the institutionalized means of expression for human needs. Institutions such as mourning rituals vary greatly from culture to culture, but are alike in purpose and function.

Role and status are also institutionalized means of expression which are consistent in purpose and function, although the behaviors demonstrated by people of different cultures in the same role vary. Malinowski (1952) warned that the institutions of each culture are closely interrelated and that tampering with one institution would reverberate throughout the entire cultural system.

Meleis (1975) supports Malinowski's contention, contending that:

> Because it is inconceivable that a role can exist without a counter-role to reinforce and complement it, changes in one role necessitate complementary adjustments in the counter-role. (p. 265)

A chain of changes thus occur throughout the system. Linton (1951) described the dilemma of the person experiencing incompatible status-role convergence drawing upon examples from the classics such as the son/lover roles experienced by Oedipus. Situations that force a person to behave (perform) both independently and dependently, gracious and hostile, aggressive and passive occur frequently in the classic tragedies. Such situations also occur as realities of daily living.

Symbolic Interactionalist Perspective

Hardy and Conway (1978) describe the symbolic interactionalist theorists perspective as:

> . . . interpretation of roles and role behavior focuses on the meaning which the acts and symbols of actors in the process of interaction have for each other. (p. 20)

Hurley (1978) writes that society in order to achieve social goals (stability, group survival, etc.) uses its adult members in socializing or transmitting social learning to the young to enable them to perform adult roles. This includes guidance in developing and integrating a "social self" which involves the teaching of values, beliefs, and norms, as well as related cognitive material. Citing Clausen (1968) and Inkeles (1968), Hurley states that socialization for a particular social status and role is an interactional process involving the socializing agent and the socializee.

Hurley (1978) citing Turner, Mead, Biddle, Thomas, and Blumer, defines the following terms used by interactionalist theorists:

> Interaction: A situation in which at least two persons are involved in verbal or nonverbal communication.
>
> Symbol: A stimulus that has meaning for individuals and calls forth a response based on meaning rather than on some physical object.
>
> Interpretation: The meaning individuals give symbols used by another in the course of an interaction.
>
> Role-taking: The reflection of an understanding of the generalized attitudes of others in one's actions. (pp. 22-23)

The interactionalist approach (Hardy and Conway, 1978) states that the individual constructs and gives meaning to objects judgmentally.

In contrast, according to Hardy and Conway, the functionalist approach consider objects as acting on the

individual. Interactionalists state that reality varies as the actor "sees it" or interprets it. Interactionalists seem to place major emphasis on how the individual develops meanings of reality through interaction with people and objects. Functionalists believe (Hardy and Conway, 1978) that people act in terms of learned response.

Writers from both perspectives credit Ralph Linton with much of the formative work of the definition of role concepts. Linton (1951) wrote that status identified the position of the individual in the society's prestige system. Role designated " . . . the sum total of the cultural patterns associated with a particular status" (p. 77). A role description, according to Linton, includes the values, beliefs, and behaviors expected of a person within a given status position of a specific society. Role and status thus specify the ways a person is expected to behave in interaction with persons performing other roles within a society.

Linton also wrote that any given person could have multiple status and roles within a society during the same period of time. Most of the people in any given society will accumulate roles associated with family and societal relationships in addition to those associated with their work. Thus, a person would have a kinship role such as father, mother, daughter, son, and also a work role such as physician, nurse, teacher, carpenter, etc.

During the performance of each separate role the person would occupy a status appropriate that role's perceived importance. Linton (1951) cited, as an example, the person who occupied an employment status and associated roles in his or her workplace, but sets these aside at the end of the workday to take up other status and roles on arriving home. He or she takes up still others at his or her social club (member roles) or during recreational activities.

Properties or Aspects of Roles

Linton (1936) made the distinction between two conditions for role-status acquisition, ascription, and achievement:

> Ascribed statuses are those which are assigned to individuals without reference to their innate differences or abilities. They can be predicted and trained for from the moment of birth. Achieved statuses are, as a minimum, those requiring special qualities although they are not necessarily limited to these. They are not assigned to individuals from birth, but are left open to be filled through competition and individual effort. (p. 115)

Davis (1949) stated that ascribed status lays down the framework which guides the transmission of culture to the individual guiding the determination of his or her general life goals. Ascription also lends a sense of security to the person because competition is not required to obtain an ascribed position. He added, however, that most status positions are in part ascribed and in part achieved. Frequently, restrictions are associated with status which limit those who seek certain achieved positions (e.g., only

males can become priests in the Roman Catholic Church). Also, many ascribed positions require training to actually perform the role. Biddle and Thomas (1966) write that there are important analytic differences between how such positions are entered, maintained, and departed.

Conflict and Stress

Hardy (1978) explains the concept of stress from the fields of physics and engineering where stress refers to external forces which produce deformation and/or strain. In the health sciences, the force is usually termed the stressor, and stress is the physiological, psychological, social, spiritual, or cultural response of the person. Certain amounts of stress response are good for living things because they promote health (Dubos, 1965/1973). An excess amount of exposure to the stressor may be injurious to some degree which varies with the amount of time the stressor is endured. In some cases the stress response is maladaptive and becomes an additional stressor.

The rapid expansion of knowledge and technology have caused an acceleration and geometric increase in the amount of change people experience in today's world. Many of these changes demand alterations in role and status. Change thus frequently becomes a traumatic experience.

Both intrinsic and extrinsic factors involved in status and role constitute sources of conflict and stress. The degree of stress may be healthy in that growth and

development are nurtured or induced. The stress, however, may exceed adaptive capacity resulting in temporary or prolonged physical, social, psychological, spiritual, or cultural impairment.

Biddle (1979) points out that in rapidly changing societies, the members of such societies are required to take on new developmental tasks. The additional tasks are to learn to change and to adapt to changes within the society to retain one's share of control. The ability to adapt to change and grow within one's self is essential to avoid loss of one's active status and roles. The penalty for being unable to change in response to society's changes is that one must accept passive roles.

Hardy (1978) associates role stress with vague or impossible demands, change in the structure of the system or the occasioning of deficits in the individual performing the role. She lists several types of role strain: role ambiguity, incongruity, conflict, overload, incompetence, and overqualification. Hardy states that investigations of all but the latter two have been conducted. Meleis uses the rather broad term "role insufficiency" which she defines in such a way that it seems to include most of Hardy's categories.

Role Insufficiency

Meleis (1975) defines role insufficiency as:

> . . . any difficulty in the cognizance and/or performance of a role or of the sentiments and goals associated with role behavior as perceived by the self or by significant others. (p. 266)

Performance of the role is perceived to be inadequate to the "self" or to other actors in the interaction. The patient might experience some role insufficiency of self in attempting to adapt to the illness and a dependent role. The patient may perceive role insufficiency in the performance of a nurse when the nurse approaches a problem in a manner the patient did not expect. For example, the patient may not expect to treat him or herself when the nurse begins teaching him or her self care.

Meleis suggests the following situations demonstrate role insufficiency:

> -Moving in or out of roles in a social system.
>
> -Voluntary or involuntary additions or terminations of roles with or without changes in other roles.
>
> -The concomitant termination of a role or set of roles and beginning of a new role or set of roles. (p. 266)

Role insufficiency also results from poor role definition.

Lack of role definition which is perceived as role insufficiency has been experienced by many health care providers when a care provider expands an accepted role or implements a new one. When the nurse practitioner role is first introduced into settings, other health care providers

become confused about what the person in the role is supposed to do. The physicians sometimes perceive the nurse practitioner performing role functions traditionally owned by physicians. They may resist the change which then results in conflict. The nurse practitioner experiences role insufficiency because of differences in the way the profession and others define this role and its functions.

Hardy (1978) defines this particular kind of role insufficiency as role ambiguity. The social system participants have not agreed on relevant norms. In other situations the norms are ill-defined, vague, and unclear.

Lambert and Lambert (1981) formulated the following propositions based on their clinical research:

1. An individual who perceives a sense of power or control as a positive attribute will attempt to maintain control or power over factors that affect the individual.

2. An individual who is in an acute state of physical illness is more likely to demonstrate a sense of powerlessness than an individual who is not in an acute state of physical illness.

3. As an individual's significance in relation to members of the health care team increases, the likelihood of developing a sense of powerlessness will decrease.

4. A person who understands how the health care system functions is less likely to demonstrate a sense of powerlessness than is an individual who does not understand how the health care system functions.

5. As an individual's sense of powerlessness increases, that individual will be more likely to use bargaining behavior or threatening and aggressive acts to gain control of the personal situation.

6. An individual who values a sense of power will tend to comply less with health care therapies when experiencing a sense of powerlessness than will an individual who does not. (p. 13)

Seeman and Evans (1962) define powerlessness as the:

> . . . expectancy or probability held by an individual that his own behavior cannot determine the occurrence of the outcomes or reinforcements he seeks. (p. 773)

Wellness/Illness Roles and Nursing

Twaddle (1979) comments:

> Given the historical and conceptual links between status and role (Linton, 1936; Pierce, 1956; Parsons, 1951) it is surprising that relatively little attention has been given to the problem of conceptualizing health as a social identity. (p. 22)

Twaddle contends that health status has a direct relationship to social status writing that:

> Capacities, as we have noted, are a dimension of life chances, and health is, at least in part, a statement about present or future capacities. (p. 66)

The client's encounter with the nurse frequently carries the threat of possible change in capacity to continue one's life style with its associated roles and status. Nurse-patient encounters invariably involve a stressful situation. Most health care seeking patients are asking for help with an illness with unknown possibilities of disability, pain, and expense they would prefer to avoid. Pregnancy being the exception because the motivation for seeking care is different.

Illness always produces some alteration in role and status. The person who owns an occupational or professional role also may enjoy desirable status in the employing organization and in the home and community. Such an independent person would be very uncomfortable in the dependency role and status change imposed by a stroke (cerebrovascular accident). Such an illness with its chronic debilitating pathology would create devastating changes in independence/dependence patterns, prestige, and role relationships within the family.

Parsons (1951) contended that physicians often place considerable burdens on patients and their families in their attempt to comply with the physician's advice. There is always the question, implicit or explicit, "How do I know this will do any good?" (p. 442). Following surgery the patient may be told "you have to get worse before you get better" (Parsons, 1951, p. 442).

Twaddle (1978) points out that there is often a widespread consensus that one occupation is better than another. Rehabilitation following alteration in the ability to perform in one status/role rarely results in movement into a more prestigious occupation. Usually the rehabilitated person is forced into work in jobs which are less prestigious. Parsons (1951) wrote that this imposed severe and complex emotional strain on the patient and his or her family. There is a severe alteration in the

expectations of the patient his or her future lifestyle and career.

Role Supplementation

Meleis (1975) defines role supplementation as the deliberate (prescriptive) assessment of role insufficiency problems. Therapeutic intervention is attempted by the person experiencing the role problem (adaptive responses) or by a significant other, such as the nurse (p. 267). She suggests nursing intervention may take the form of role modeling (role clarification and role taking), role rehearsal, and reference group interactions.

Meleis defines role clarification as "Mastery of the knowledge or the specific information and cues needed to perform a role . . ." (p. 267). In the course of the life cycle an individual changes roles many times, discarding outworn ones, assuming new ones, and modifying existing ones to the individual's needs. Role clarification is the process though which an individual learns the norms of a role: the rights, privileges, limitations, as well as the expectations of complimentary counter-roles.

Role modeling provides the opportunity to observe others performing the role as well as reciprocal actions of persons in counter-roles. It occurs both spontaneously in natural settings and as a planned activity anticipating specific role needs.

Role rehearsal occurs naturally when an individual intentionally rehearses what the role is anticipated to be like in an encounter in order to anticipate complications and reduce threat. It also is often used as a planned activity by the individual or a helping person to improve performance and comfort in performing the role.

Reference groups, according to Meleis are effective in involving the individual with others who are themselves involved in similar role problems. Participants can share successes, failures, and work on ideas to solve problems incidental to the performance of the problem role and goal attainment (e.g., ALANON, AA, and Weight Watchers). A reference group provides the opportunity for anticipatory socialization of couples in the process of the acquisition of their new roles as parents. Role instruction by informed persons is supported by the group interaction involving a peer group in which each member is making similar role transitions (role loss or role gain).

Meleis (1975) contends that:

1. The earlier preventive role supplementation is offered, the lower the probability of role insufficiency.

2. The later therapeutic role supplementation is provided, the higher the probability that role insufficiency will be manifested. (p. 270)

Therapeutic role supplementation is effective in assisting clients through the mourning (grief) process resulting from change in status and role, especially that brought about by

altered health. The client cannot be expected to adapt to changed conditions well when the limitations (negative aspects of change) imposed by change are more comprehensible than any possible benefits (positive aspects of change).

Anthropology and Nursing

Anthropology is the study of humanity and human behavior. According to Kottak (1982):

> Anthropology is a uniquely holistic science: its concern with the whole of the human condition encompasses past, present, and future; biology, society (organized life in groups), and culture. (p. 4)

Many writers include personality with the above components of anthropological study (Bohannon, 1963).

Nursing conceptualizes humanity as a biological, psychological, social, spiritual, and cultural entity. M. E. Rogers (1970) placed the "holistic" nature of "man" first in priority in listing the five assumptions upon which her theory is based. She wrote (1970):

> 1. Man is a unified whole possessing his own integrity and manifesting characteristic that are more than and different from the sum of his parts. (p. 47)

Nursing practice according to Rogers is based on the concept of:

> . . . the wholeness of man and derives its safety and effectiveness from a unified concept of human functioning. (p. 124)

Rodgers writes that nursing and nursing care must be holistic. The phenomena of health and disease cannot and

should not be studied without consideration of all of the facets of the unitary whole human being (in terms of being both influencing and responding components).

Leininger (1970) states that both anthropology and nursing both are holistic in approach. The methodologies of each are also quite compatible with each other. The methodology of nursing (nursing process) includes entering the setting in which the patient lives, works, plays, or has come for health care; observing and interacting with people, analyzing data from these observations and interactions while attending all the facets of the unitary person. This method varies only slightly in procedure and focus from the ethnographic method of anthropologists. Following the example of researchers in education who have applied anthropological methods in their research, Leininger (1970, 1985) contends that ethnographic methods are essential to building nursing's body of knowledge. Leininger contends that an effective and holistic nursing process includes the relationship of the patient to his or her real world which would then include a cultural assessment.

Leininger (1978) developed a conceptual framework for cultural assessment called "Culturological Domains". Orque (1983) developed a conceptual framework for ethnic nursing care. Brink (1984), Bloch (1983), Tripp-Reimer (1984), and others have developed assessment tools useful in identifying health beliefs and other cultural influences on health.

These are most useful to nurses working with clients of another culture than their own.

Culture

Linton (1945) offers two rather reductionistic definitions of culture. He wrote that culture was "the organized responses of a society's members" (p. 5), and that it also was "the social heredity of a society's members" (p. 32). His third definition is more detailed specifying that:

> A culture is the configuration of learned behavior and results of the behavior whose component elements are shared and transmitted by the members of a particular society. (p. 32)

The latter definition by Linton connotes that culture is learned, shared, transmitted, and integrated which is supported by Malinowski (1922/1961), Mead (1929), Kottak (1982), Leininger (1978), and Tripp-Reimer (1984).

Tripp-Reimer (1984) writes that cultural patterns are both real and ideal in type. She cites that while we have speed laws and social norms about how one should interact with elderly people, people drive faster than the law allows and both neglect and abuse elderly people.

Tripp-Reimer (1984) describes several things which culture is not:

1. Culture cannot be equated with race.
2. Cultures are not static, but are dynamic entities in constant evolution.

3. It is difficult to change culture.

4. Individual variation occurs frequently within a given culture.

5. Everyone belongs to a culture. One's own culture is less visible to a person than the culture of others. (p. 228)

Tripp-Reimer comments that "culture defines dominant patterns of values, attitudes, beliefs, and behaviors" (p. 227). However, individuals and small groups within a culture can demonstrate their own idiosyncratic patterns of variance.

To exist as a distinct culture, according to Levi-Strauss (1963/1967), a culture must demonstrate "significant discontinuities" from the expected behavior of the rest of humanity (p. 288). A subculture demonstrates significant discontinuities (or distinctive difference) of a large group within the greater culture. Sets or groups of individuals varying distinctively from the larger culture may be:

> universal, continental, national, regional, and local, as well as familial, occupational, religious, political, etc. (p. 288)

Individuals may thus be members of several subcultures at the same time.

According to Saunders (1954), subcultures:

> . . . are fairly large aggregations of people, who although members of a larger cultural group (or in the process of transition from one cultural identification to another), have shared characteristics which are not

> common to all members of the culture and which enable them to be thought of as a distinguishable subgroup. (p. 248)

Subcultures come into being in a number of ways. An "empty niche" can evolve in the need system of a social group (e.g., health care or distinctive divisions of health care).

The western health care system has evolved many categories of health care providers and currently new ones are being created. Some of the categories or groups of health care providers are distinctive subcultures (e.g., medicine and nursing).

Medicine and nursing also contain subgroups or levels which correspond to divisions of labor. Nursing, for example, has occupational, vocational, technical, and professional levels. People of each division of labor share the beliefs, attitudes, values, and behavioral customs of the greater culture and of the nursing subculture. But they also hold some distinctively different ones. Nursing also consists of specialty groups associated with specific kinds of pathology such as neurology, cardiology, or orthopedics. Some nursing specialties are associated with divisions of labor such as community health nursing, critical care nursing, etc.

The transmitting, sharing, learning, and integrating of cultural patterns is very complex and must occur at such rapid rates that individuals vary in the degree of

"completeness" with which they acquire all the characteristics which distinguish a culture. Each individual shares and transmits his or her slightly differently learned perception of the culture which fosters change in the culture and the evolution of subcultures. Like biological evolution, cultural evolution occurs by means of the occurrence of successful (in that they insure survival) mutations in beliefs, values, and customs.

Values, Beliefs, Attitudes

People of every culture or subculture hold certain conceptually complex ideas as truths to be shared with, transmitted to, learned by, and accepted by new members of the culturally distinct group. These concepts are taught as integrated patterns consciously and unconsciously by mature members of the culture. They are considered "right", safety insuring, and comfortable to mature members of that society.

Tripp-Reimer's (1984) resynthesis of the way in which anthropologists conceptually structure culture is very helpful. She writes that:

> Values, beliefs, and customs are ordering mechanisms of human experience and behavior. Through them, group members share common orientations to life situations. (p. 230)

Customs are more easily observable to outsiders, and members of the group are more likely to be aware of them and able to describe them. Values are not visible and thus are difficult to assess except by inference from overt behaviors.

They are the foundations for beliefs, customs, and attitudes.

Values

Parsons (1951) defined the term value as:

> An element of a shared symbolic system which serves as a criterion or standard for selection among the alternatives of orientation which are intrinsically open in a situation . . . (p. 12)

Hartog and Hartog (1983) state that "value orientations" differentiate cultures and ethnic groups on the basis of:

1. Type of relationship of humanity with nature. Is humanity able to actively change nature, or must the nature of things be passively (fatalistically) accepted?
2. Views as to whether humanity is basically good or bad.
3. Social structure of interactions between status-roles. Whether interactions between status-roles are:
   - -rigidly hierarchical
   - -egalitarian
   - -communal
   - -sharing
   - -individualistic.
4. Orientation to time. Whether future oriented or present oriented.
5. Health/Illness value systems.
6. Age valuing differentiates groups on the basis of

whether a culture is predominantly "youth oriented" or "elder oriented".

7. Relationship of person to global society (gemeinschaft versus gesellschaft).

   -gemeinschaft is the community oriented view which stresses people relating to people (family, neighbors, village).

   -gesellschaft is the accomplishment and things oriented view. Often termed the modern urban view. (p. 911)

Tripp-Reimer (1984) used the term "activity orientation" which differentiates cultures into categories on the basis of whether they are oriented to doing or being. A "doing" people are more assertive and action oriented. A "being" culture tends to have an orientation which is more passive, reflective, and is perhaps more fatalistic in its perspective toward life.

Value-related conflict can be intrapersonal, interpersonal, or transcultural. An intrapersonal conflict is one in which the value orientation of the culture is in conflict with the person's experience of reality. A person becoming aware of his or her own physiological aging process experiences discomfort when his or her own culture has a strong valuing of youthful vigor and appearance. Feelings of imposition and restriction of the young are a source of intrapersonal conflict in a culture which values maturity

and life experience.

Interpersonal conflict arises between people with different personal perspectives of the same value system within a culture. Valuing the conservation of physical resources, such as money, is a frequent source of conflict between members of the same family.

Transcultural conflict is frequently experienced between business people of different nationalities. Hall (1959/1967) described problems which arise when well intentioned Americans often lack an awareness and sensitivity to the values, beliefs and customs of other cultures. Deficient transcultural communication skills, and a lack of valuing of others' rights to their own value systems have caused some global dislike of Americans.

Transcultural conflict frequently occurs between health care providers with a western orientation to health care and patient's with highly valued traditional health care beliefs (Leininger, 1985). In parts of the United States such as Northern Michigan, this writer has observed that some people believe strongly in the efficacy of the bread poultice. Public health nurses visiting homes and finding such poultices in place are frequently upset because poultices are not valued in western medicine. Transcultural conflict is more severe when one or both of the representatives of the two cultures involved in the encounter do not value the right of others to maintain,

protect, and perhaps espouse their own value systems.

Beliefs

People of a culture actualize the value systems of their culture through beliefs, attitudes and customs. Beliefs can be defined as perceptions of what a person, subculture, or culture hold to be the truth. Tripp-Reimer (1984) states that "beliefs include knowledge, opinions, and faith about various aspects of the world" (p. 234).

Beliefs are more easily assessed than values, though they consist of both conscious and unconscious components. Both are partially or wholly covert. Beliefs (and attitudes) shape and motivate visible behaviors. The behavior or custom can be directly assessed, but it is often difficult to identify or define the specific belief as causing a specific custom.

Beliefs can vary in the intensity of one's confidence in the truth of the belief. A belief may be accepted as an absolute and unquestionable truth. Such a belief will be defended whether supported by evidence or even in the presence of evidence to support the opposite. At such a level of certainty held by an individual, he or she is unlikely to reappraise that belief (or change it).

One's degree of conviction about truth stated as a belief also varies with the significance given it by the culture or the person. The person's life experience also affects the degree of conviction given the belief. A belief

is more likely to change at lesser levels of confidence (or conviction). At higher (more intense conviction) levels of confidence, change will probably occur only in the presence of a significant emotional event which is sufficiently upsetting to disconfirm the truth of the belief for that individual.

Attitudes

Linton (1945) defined attitude as the covert response to the activation of a value. Redman (1980) stated that most contemporary definitions of the term "can be classified as probability conceptualizations or intervening variable conceptualizations" (p. 100). Attitudes are sometimes identifiable through specific language behavior, facial expressions, or other body language. Communication of this type is probably unconsciously or consciously intended to make others aware that one is in a particular attitudinal state of mind. Attitudinal mis-communication is common in transcultural interactions.

Redman (1980) reported that the many studies of the relationships between attitudes and behavior have not measured significantly large correlations between attitudes and specific behaviors.

Overt Evidence of Values, Beliefs, and Attitudes

The overt "cap of the iceberg" of the anthropological model of the structure of a culture consists of the

culturally distinctive customs or behaviors evident to the physical sensory system of the observer. Customs include obvious culturally distinct behaviors such as greeting and parting behaviors, mourning behaviors, cooking, dress, and architecture.

Malinowski (1944/1964) stated:

> I shall, for the sake of simplicity, use the term custom to cover all traditionally regulated and standardized forms of bodily behavior. (p. 68-69)

Yet, not all bodily behaviors are visible. Physiological responses to a contravention of custom are at least to some degree covert. Consider the example of the person eating a meal in a culturally "foreign" household. If one is told that the food one is eating is one which is tabu in one's own culture, the person may experience nausea and either attempt to conceal the discomfort, or demonstrate it visibly.

E. T. Hall's (1966) in his study of proxemics, found that all animals have precise critical distances, sometimes measurable to the centimeter, which arouse the classic "flight or fight" responses when another animal intrudes on the individual's personal space. In human beings, critical distance is modified and differentiated by culture. Hall states that human beings have culturally distinct olfactory, visual, and auditory definitions of personal space. Infringement on that culturally defined personal space arouses discomfort (from the flight or fight response).

Hall (1946/1966) offers a photographic demonstration (between pages 58 and 59) of cultural differences in acceptable or desirable personal distance (visual). He concludes "Proxemic patterns are often excellent clues to cultural difference" (caption, plates 18 and 19). People differ culturally in the acceptability of odors such as perspiration, certain foods, and sewage. They also respond differently to voice volume. Culturally determined responses to these stimuli are both overt and physiologically covert.

Transcultural misunderstandings and discomfort are often brought about by lack of awareness of proxemic principles. One of the tasks of the nurse anthropologist, according to Leininger (1978) is to make nurses aware of these kinds of cultural differences because they significantly affect the patient's acceptance of the nurse's work in their behalf. Physical assessment and treatment often require closeness and physical touching. Some cultures have the ritualistic means to permit closeness and touching to a degree not otherwise licensed (permitted) for non-health care providers. These ritualistic means differ between cultures. The nurse, to be effective, needs to know how to avoid or adapt nursing behaviors which are threatening to the patient of another culture.

Meaning and Semiotics

The synthesis of meaning is a complex process. Sundeen, Stuart, Rankin, and Cohen (1985) state that personal experience, family upbringing, peer groups, and culture all influence the denotative and connotative meanings we give to a word or body language symbols. The word dog can be defined denotatively as an specific variety of animal. To one person the word dog connotatively means warmth, friendliness, and protection. Another person may connotatively perceive the word as inferring an animal which is noisy, dirty, and frightening.

Tripp-Reimer (1984) states that lay people and biomedical professionals demonstrate a semantic difference in the meanings they associate with the words health, disease, illness, and wellness. She states that biomedical people use an etic approach perceiving health as a dichotomy of "disease" or "not disease". The person experiencing an altered state of health describes health "emicly" in terms of the experience such as hurting, itching, or being frightened by the change.

Ford (1975) describes the social world as sets of "taken for granted meanings" (p. 171). She writes that people of the same social or cultural group assume that they share the same meaning for word or body language symbols. Yet, they can not share wholly each other's experience. Thus, there will be subtle differences in the connotative

meanings they develop from experienced stimuli.

G. H. Mead (1934) wrote:

> I have tried to bring out the position that the society in which we belong represents an organized set of responses to certain situations in which the individual is involved, and that in so far as the individual can take those organized responses over into his own nature, and call them out by means of the symbol in the social response, he has a mind in which mental processes can go on, a mind whose inner structure he has taken from the community to which he belongs. (p. 270)

Mead contended that the meaning an individual develops is shaped by the society or culture of which he is a member to the degree to which those responses which are acceptable to his culture seem reasonable to himself. Sapir (1931) and Whorf (1956), in what has been termed the Sapir-Whorf Hypothesis, expanded this to state that the language of a culture governs thought and meaning. The ability to express a concept in a given language controls the ability to use that concept. Modern ethnosemanticists have modified the theory to state that culture and language have powerful influences on thinking.

The Health Belief Model

> Becker (1974) writes that The Health Belief Model: . . . asserts that even when an individual recognizes personal susceptibility, action will not occur unless he or she also believes that becoming ill would bring serious organic and/or social repercussions. (p. 411)

Redman (1980) reviewed the literature concerning the model and reported that it was " . . . probably the most complete

theory regarding readiness to take health action" (p. 30). She states the model represents an example of the "value expectancy" approach.

However, the reports based on this model (Becker, 1974; 1975; 1977; 1978; Rosenstock, 1974) do not seem to incorporate reference to ways that different cultural value and belief systems affect health beliefs and the readiness to act, or the choice of action an individual will take in response to stimuli which signal the warning of illness.

Redman states that the model predicts people are unlikely to "take a health action unless" :

1. they believe they are susceptible to the disease in question.
2. they believe that the disease would have serious effects on their lives if they should contract it.
3. they are aware of certain actions that can be taken and believe that these actions may reduce their likelihood of contracting the disease or reduce the severity of it.
4. they believe that the threat to them of taking the action is not as great as the threat of the disease itself. (p. 30)

Redman also wrote that the model does not suggest any treatment modalities which would alter the patient's health belief system (p. 30). Rosenstock (1974) contended that changing models of health care delivery might be more effective than a direct attempt to alter health beliefs.

The clinical practice of this researcher and the observations made in the course of this inquiry suggest that

the health beliefs of an individual are a product of several factors: educational attainment level, previous experience with illness and attempts at intervention, different ethnic perceptions of a change in health status as a problem, and cultural beliefs about the causality of a disease.

Beliefs and Causality Research

Leininger (1985) reports that in her study of Southern rural whites and blacks, 92% of the subjects said "If you follow what is in the Bible, you will be well and stay well" (p. 204). Ninety-eight % of her respondents associated compliance with religious beliefs positively with maintaining health.

Primeaux (1977) states that many Native American cultures' beliefs about health focus on a concept emphasizing holistic balance for protecting and retaining health, though such generalizations must be made very carefully because of the wide variation in tribal beliefs. Winn's (1976) proposal for a tuberculosis treatment program for the Papago of Arizona, states that the Papago believe that sickness is caused by offending supernatural forces (e.g., ghosts of the dead). Vogel (1970, 1979) states that some tribes (e.g., Zuni, Hopi, Apache, Navajo, Pueblos) attribute illnesses to forms of witchcraft.

This researcher found in clinical practice with Chippewa patients that they believe that living in harmony with nature protects the individual from illness and puts the

person in a better state to recover from illness when it occurs. The Chippewa also believe that the mental state of the mind is very important in preventing sickness. A medicine man (member of Mide or Midewiwin lodge) told the researcher and her nursing students that it was very important to prepare the patient's mind for the recovery process.

Orque (1983) states that the Filipino (especially the Tagalog) perspective of the causes of illnesses rarely reflects the one cause/one illness pattern of western thinking. Abril (1977) wrote that Filipinos believe that illness may result from an imbalance between hot and cold areas of the body. Tripp-Reimer (1983) studied the health beliefs of urban Greek immigrants in the U.S. and found that they believed many illnesses were related to the evil eye.

Beliefs About Seeking Help for Illness

Spector (1979) commented that according to American health care providers, there are no alternatives to the western concept of medicine and nursing. Yet, many American consumers do seek help from other sources. The tremendous footage of shelving in any American pharmacy filled with over the counter drugs is ample evidence that the American health care consumer often tries self medication as often as they seek professional help. Monrroy (1983) described Raza/Latina ethnic group as often seeking help first (sometimes simultaneously) from a "curandero" or an

"espiritualista". Physicians and nurses should work to achieve the confidence of these patients so that the care provider will be told when alternative or traditional remedies are being employed. The patient's use of medicinal herbs may be in harmony or in conflict with the western treatment being prescribed. The patient may fail to carry out the western prescriptions to give the traditional remedy an opportunity to work.

This researcher found that many Chippewa were being treated by a medicine man at the same time they were being managed by a family nurse practitioner (FNP) and physician (MD) team. Many white patients admitted they were seeing a chiropractor simultaneously with treatment by the FNP and MD for low back syndrome. In Chippewa County (Michigan) many people frequently shop for opinions from more than one western physician.

Culture Shock

Culture shock is a stress response to immersion in a completely unfamiliar setting such as that found in a foreign cultural environment. The researcher's contention is that: the subcultural environment of the health care setting is as culturally foreign to the patient, as that of a country different than one's own.

According to Oberg (1954), whose original paper was the first to define it:

> Culture shock is that malady that occurs in response to transition from one setting to another; in which the individual is placed in an unfamiliar situation where former patterns of behavior are totally ineffective; and in which basic cues for social intercourse are absent. (p. 1)

The language, customs, and cues to acceptable behavior which the health care consumer encounters inside of a health care setting are distinctly different from the culture outside. The patient without experience in the language and customs in this setting, is dependent on the provider as a translator and guide as if he or she was a transcultural tourist. For the subjects in this study, the period of exposure to the foreign setting is short, a matter of one to three hours. Admission to a hospital as a resident patient produces a much longer exposure. Immersion in a totally different environment immerses one in a "bath" of totally foreign stimuli, few of which can be relied upon as orienting cues resulting in culture shock.

Oberg (1954) described four phases of culture shock: the honeymoon phase, the disenchantment phase, the beginning resolution phase, and the effective function phase (p. 3). In the honeymoon phase, Oberg stated that the person experiences excitement in the anticipation of being exposed to something different and to the opportunity of learning new things.

The person anticipating an encounter with the health care system and health care providers experiences excitement.

It is, however, excitement colored with the fear of learning that something is seriously wrong, that pain will be experienced and/or that for a period of time control over one's whole self will be put into the hands of others.

Thus, for the person coming to a health care setting there is a definite period of "anticipatory fear". Such fears are generally accepted by health care providers as phenomena which delay treatment seeking and influence negatively learning in the setting.

The second phase, Oberg writes, will not begin before the "traveler" is established in the new setting. The person entering the health care setting probably begins to experience disenchantment very soon after entering the setting. Phases three and four may actually never be fully resolved for the short term patient, because discharge from the hospital setting or completion of treatment in the emergency room setting often occurs before the patient has learned the ways of the setting. This may reduce retention of teaching done in the setting by care providers. It also may cause delay of return for follow up care or in the event of a new problem.

Brink and Saunders (1976) listed five categories of stressors experienced by the patient entering the health care setting: Communication, mechanical differences, isolation, customs, and attitudes, and beliefs. Even when the nurse and the patient share the same primary language, the patient must

adapt to a second language in the health care setting. Many of the familiar terms the patient hears have new and very specific meanings. Other terms will be completely new and unfamiliar.

E. T. Hall (1966) contends that:

> It has long been believed that experience is what all men share, that it is always possible somehow to bypass language and culture and refer back to experience in order to reach another human being. This implicit (and often explicit) belief concerning man's relation to experience was based on the assumptions that, when two human beings are subject to the same experience virtually the same data are being fed to the two central nervous systems and that the two brains record similarly. (p. 2)

The stimulus field may be the same, but the perceptual systems of the two people involved are quite different. Hutchinson (1984) wrote that people organize meaning from the stimuli they encounter rationally, technically, and emotionally. The resulting meaning the individual evolves to explain an event permits the individual to accept the event and live with it. The evolution of meaning for each human being is based on any anticipatory socialization of varying degrees available within the values and beliefs of the person's culture and learning from life experience.

The stimuli in the health care setting are mostly new to the patient and sensory overload is a result from attempts to process too many new stimuli at the same time. Brink and Saunders (1976) consider such things as dress, housing, furnishings, utilities, and the activities normal

to daily life as mechanical differences (p. 128). "Learning to manipulate the mechanical environment requires time and effort, and sometimes causes frustration" (p. 128).

The mechanical differences encountered in the health care environment are numerous. The simple process of understanding what is being asked in order to collect a sample of one's own urine can be complicated and embarrassing. Finding one's way around the facility makes one dependent on people who may give directions which are ambiguous. The common visual impairments suffered by many people make the directional signs, and the instructions which appear on them, difficult to read.

The customs common to the health care setting are possibly more frustrating than those of a foreign culture because of the phenomena in health care of requiring the provider's permission to do almost anything. Thus, an independent adult is told where to sit, when and where to walk, what to eat, etc.

Attitudes and beliefs of the participants in a health care encounter are very complex. The patient brings to the encounter his or her beliefs about the rights and privileges as well as the status of the "sick role" (Twaddle, 1979). Health care providers bring similar beliefs and attitudes about their own role, role functions, and status relative to patients.

Brink and Saunders (1976) stated that all five of these categories of stressors are external and imply change from the normal daily activities of one's own lifestyle. Possibly the most trauma from the experience for the patient is due to loss of control. Seligman (1975) found that a sense of lack of control of one's environment and one's own behavior were associated with deterioration (or additional deterioration) in one's health.

Brink and Saunders (1976) stated that the diagnosis of culture shock is based on the behaviors which appear in the disenchantment phase. They find similarities between the behaviors observed in this phase of culture shock and loss or mourning behaviors (p. 131). The patient's normal coping mechanisms do not synchronize with experience in the health care setting. The patient is forced to simply wait for a stranger to either give instructions or be told what is about to happen.

The degree of success in previous experience with other new settings or changes in one's lifestyle will affect the patient's comfort and ability to resolve these problems. Inflexible coping mechanisms increase the difficulty the patient will experience in adapting to care with some possible damage to self esteem (Brink and Saunders, p. 132). The relief of culture shock should become a priority of health care providers because it delays recovery and often contributes to the further deterioration

of health.

Rubin (1979) studied patterns of transcultural adaptation of Canadian trainees in international development assigned to two year assignments in Kenya.

Seven interpersonal and social communication skills generally considered valuable for such adaptation were compared to determine the value of each in effecting success or failure in adapting to another culture in terms of occurrence of culture shock. The independent variables were: empathy, respect, role behavior flexibility, orientation to knowledge, interaction posture, interaction management, and tolerance for ambiguity.

Rubin found that "The best predictor of culture shock was orientation to knowledge ($r = 0.705$, $p = 0.005$)" (p. 42).

> . . . persons who were most aware of the personal and subjective nature of their perceptions, knowledge, values, biases, and so on, experienced the most culture shock. Persons who tended to generalize their own perceptions, "truths", and values to others, conversely, experienced less culture shock. (p. 32)

Rubin's results were contrary to expectations for he reports that people who automatically assume the values, beliefs, and customs of another culture are wrong. Ethnocentrism then, protects a person from culture shock, because they do not perceive cultural differences as psychologically threatening. The person who actively compares the different cultural perspectives of his or her own culture with those of another faced across the transcultural interface, suffers

the most intrapersonal turmoil.

Rubin also found that people with strong task orientation behavioral patterns were less effective in adapting than those who showed such patterns less consistently. He points out that task orientation is highly valued in western cultures and thus is used very frequently as a selection criterion for cross-cultural assignments.

Rubin found that people who, in Canada were observed to be more non-judgmental, respectful, and relativistic in their orientation to knowledge, and tolerant of ambiguity were more effective in the field. Since these are factors he found to have a higher association with culture shock, one must conclude that vulnerability to culture shock is not associated with less effective function in the field.

Rubin's findings have considerable implications for training people for transcultural relations. They also have implications for the support of nurses and patients in making the adjustment to health care transcultural interface.

Ethnography

Erickson (1982) describes his primary interest as an ethnographer in what he calls the:

> situation-specific analysis of people's use of sociocultural knowledge in the conduct of face-to-face interaction. (p. 133)

Capera (1983) contends that quantitative research methods severely limit qualitative explorations of this nature which are essential to the study and improvement of human interactional process. Capera extends this contention further, writing that a qualitative approach is essential to study the interrelatedness and interdependence of certain phenomena. Leininger (1985) contends that an interdisciplinary approach such as has been established between anthropology and education, and has been barely initiated between anthropology and nursing (and medicine) is necessary to "go beyond past segmented views of phenomena" (p. 2).

Ethnography as defined by Leininger (1985) is:

> . . . the systematic process of observing, detailing, describing, documenting, and analyzing the lifeways or particular patterns of a culture (or subculture) in order to grasp the lifeways or patterns of the people in their familiar environment. (p. 35)

She defines a "maxi-ethnography" as a "large and comprehensive study of the general and particular features of a designated culture" (p. 35). She defines a mini-ethnography as a "small-scale ethnography focused on a specific or a narrow area of inquiry" (p. 35).

Ethnography in the Study of Education

There is an intrinsic relationship between anthropology and education. Anthropology explores how culture is transmitted, shared, learned, and integrated. And education, formal, nonformal, and informal, is the

purposeful process of transmitting, sharing, teaching, learning, and integrating the knowledge of a culture.

Erickson states that educational settings function as gatekeeping institutions and intercultural meeting grounds. In describing (1982) the interactions he observed during counseling interviews in a junior college he writes that:

> Yet the very ordinariness of the occasion and the constraints imposed on it by appointment of time, by organizational rules, and by general cultural standards and appropriateness of its conduct make this kind of occasion interesting in the study of communication face to face. (p. 5)

It is in the analysis of such ordinary human interactions that we can begin to identify the kinds of natural activities which facilitate and impair communication and interaction. Erickson writes that interviews are encounters between strangers, unequal in authority and unequal in familiarity with the conversational routine.

Erickson's description of the educational setting also describes nurse patient interaction rather accurately. The patient is usually unfamiliar with the setting and does not know what the expectations of a patient are in such a setting.

Erickson, Florio, and Buschman (1980) write that ethnography or fieldwork involves:

> (1) intensive and (ideally) long-term participation in a field setting.
>
> (2) careful recording of what happens in the setting by writing field notes and collecting other kinds of documentary evidence (memos, records, examples of

student work, audiotapes, videotapes).

(3) subsequent analytic reflection on the documentary record obtained in the field. (p. 2)

They describe the field method as being inductive in that while the researcher enters the setting of inquiry with certain presumptive questions and conceptual issues in mind, specific categories of observation are not identified. The field experience itself can change the direction and field of inquiry as the researcher forms certain perceptions and understandings about what is going on.

Erickson, Florio, and Buschman (1980) state that ethnography as a research methodology is most useful for getting at:

1. What goes on in the specific cultural (or subcultural) setting?
2. What is the meaning of what is happening to participants in the setting?
3. What do the participants have to know to function in the setting?
4. Is there a relationship between what is happening in this setting and the broader cultural settings of human beings?
5. How does what is going on in this setting differ from human behavior in other similar settings? (p. 2)

Stewart (1975) writes that most researchers in crosscultural communication tend to be theory builders who ignore the issues of cultural survival and implementation of transcultural communication. Hall (1959) wrote that "culture hides more than it reveals, and strangely enough,

what it hides, it hides most effectively from its own participants" (p. 53).

Bogden and Biklen (1982) describe field notes as a "slice of life" in the setting. The researcher records the arrangement of the physical environment of the setting, visual observations of participant behavior and conversations as accurately and in as much detail as possible. They suggest organizing field notes into observation, analytical, methodological, and commentary categories.

Hall (1959) wrote that culture is concerned with messages and that there are three components of the message: sets, isolates, and patterns. Sets are like the words of a message and isolates are the sounds that make up the words (p. 122). Patterns are like the grammar or syntax structure of the message. Sets are the most immediately perceivable and are analyzed for isolates. Isolates are the simple parts of communicative behaviors (verbal, gross, or fine motor) which can be identified as the structural building units occurring in different sets and analyzed for meaning within the culture to its participants.

Patterns, according to Hall, are "those implicit rules by means of which sets are arranged so that they take on meaning" (p. 143). He writes that a given pattern is only visible to certain people. Different individuals exposed to the same event or patterns have different perceptions (p. 148).

In contrast to Hall's linguistic-styled model, Schatzman and Strauss (1973) use a system of classification based on structure-function relationship:

> Probably the most fundamental operation in the analysis of qualitative data is that of discovering significant classes of things, persons, and events and the properties which characterize them. (p. 110).

They warn that the process of analysis cannot be completely preplanned or refined as done in quantitative research:

> Qualitative data are exceedingly complex, and not readily convertible into standard measurable units of objects seen and heard; they vary in level of abstraction, in frequency of occurrence, in relevance to central questions in the research. (p. 108)

Erickson (1982) advocates the use of "sound-image recording" (SIR) using sound videotape to capture a more complete record of the events in the setting. He personally counseled this researcher to make use of it in this inquiry, which unfortunately did not prove possible. Mohatt (1984) demonstrated the use of SIR at 1984 meeting of the American Anthropological Association. Using short segments of tape recorded on the Rosebud Sioux Reservation in South Dakota, he demonstrated classroom behavior of the children which was in conflict with Sioux custom. The adults on the reservation were very concerned about the non-Sioux behavior of their children. Mohatt demonstrated that some of the changes in the children's behavior was related to the method of teaching used in the classroom.

Emic and Etic Approaches

Kottak (1982) differentiates between these two essentially different approaches to the study of cultures. The emic strategy attempts to define the viewpoint of the informants in the setting. It attempts to understand how people in the setting perceive what is happening and why things happen as they do. The final objective of the emic approach is to determine the meaning of events in the setting to the people who live there. The emic approach requires getting closer to the subjects themselves. The emic ethnographer must develop relationships with people in the setting of sufficient intensity to permit a high degree of identification with their perceptions of what is happening. Essentially this is an "inside out" approach in contrast to the "etic" which views the setting from the outside looking in.

The etic approach is the outsider (observer oriented) approach relying on the ethnographer's trained skill to extract more meaning from events in the setting than the untrained participants in the setting would be expected to identify. Kottak writes:

> . . . culture-bearers are often too involved in what they are doing to evaluate their culture impartially.

and later:

> . . . they must be aware that natives may fail to admit, or even to recognize, certain aspects and results of their behavior. (p. 8)

The ethnographer using the etic approach first reviews the findings of others who have examined the setting. Then the setting is visited where selected data is collected. Ethnocentrism is a greater danger to the etic ethnographer.

The ethnographer must always be aware of the presence and effects of ethnocentrism in their interpretation of what they observe. The ethnographer is especially vulnerable to error in interpretation or overlooking data when examining events in the setting of a subculture similar to his or her own. Data collected from setting informants must also be examined for ethnocentristic bias.

Leininger (1985) contrasts the emic and etic view from the perspective of Southern Black Afro-Americans. The emic view, she states is that expressed when the informant talked about concern for "my" brothers and sisters. The etic perspective was expressed when the subjects described "strangers who care for strangers" (p. 38).

Ethnography and Nursing

Leininger (1985) points out that the quantitative nursing researcher begins with hypotheses and theory. The qualitative nursing researcher "expects to generate hypotheses and theory at the end of the study" (p. 41). She writes:

> Although the "ethnonurse" researcher always has some broad theoretical notions about the phenomena under study, the theory should not be generally tight and explicit . . . (p. 41)

Ethnography in nursing seems most applicable in the areas in which little or no knowledge exists about phenomena or existing theoretical relationships.

Leininger describes two separate positions on the issue of method presently recognized by nurse anthropologists. Some nurse anthropologists want to be certain that quantitative and qualitative methodologies are kept separate ("clean") in their research. She states there are both quantitative and qualitative separatists with limited tolerance for the alternative method.

The alternate position is taken by what she calls the "combination position" (p. 19). These researchers prefer to combine both quantitative and qualitative methods. Leininger writes:

> Combining or merging the two methods tends to fit the cultural norms of nursing in that it is best to get along , meet the expectations of others, and treat both methods equally. (p. 20)

Leininger urges open discussion on this problem which she states has been a silent but intensely felt issue. Open discussions should clarify the best applications of each method in nursing research. She states that the real issue is that the researcher should know <u>why</u> they are using one method in preference to another, or a combination of the two. To choose "without knowing the reasons seems highly questionable" (p. 21). The strengths of ethnography in nursing research are that the phenomena of the caring

process can be explored in context, defined, and clarified. "To tease out and grasp its hidden and culturally based values" (p. 22) is more amenable by qualitative than by quantitative methods.

CHAPTER THREE

CONCEPTUAL FRAMEWORK AND METHODOLOGY

The focal task of this research was to explore the naturally occurring events in nurse-patient encounters to identify culturally determined customs or behaviors. The purpose of the research was to determine to what extent the contrast in culturally different values, attitudes, and beliefs identifiable in participant nurse's and patient's overt behavior affected the fruitfulness of the interaction in meeting the patient's needs. In order for the interaction to be as fruitful for the participants as possible, the meanings each develops from the experience of the events in the encounter should be in agreement with the shared goal of each.

Conceptual Framework

Roles

When a person enters a health care facility he or she takes on the role of patient or client. The functions of the role appear to be to demonstrate some alteration in health, to answer questions asked of them, to submit to examination or treatment, listen to explanations about their condition, participate in health education, follow instructions, and be patient. The role of patient-client

gives the patient the right to behave as an unwell person. He or she may ask other people for more physical help, emotional support and even economic aid than is usual for people in prescribed wellness roles of a culture. The patient-client role excuses the person from work functions in the family and other social units of the culture.

Modern health care providers have a preference for using the role title client in an attempt to make the person experiencing an alteration in health more independent. The goal is to nurture regaining the abilities of independent self care. The role title patient seems to imply helplessness, dependency, and lack of responsibility for one's own recovery.

People in the patient-client role have been taught their health values and beliefs as children and apparently modify them very little as they become adults. The staff of the Centre refer to clients as patients.

In the "age of information" (Naisbit, 1982) people are bombarded with a variety of new health and illness information from all kinds of media. Some appear to be modifying beliefs about health they formed as children. Tobacco usage appears to be decreasing if the difficulty smokers find in locating a place to smoke away from home is a valid indicator. Liquor sales decreased in 1985 for the third straight year (New York Times, December 29, 1985).

The phenomenon of meaning is the definition and perception synthesized to comprehend a set of experienced stimuli. It is influenced by the emotional state during the experience and the intellectual analysis and interpretation of the event. It is highly individualized, but strongly influenced by the values and beliefs learned from the culture.

The role and functions of the nurse as a health care provider vary from one culture to another in the degree of autonomy an individual nurse may exercise. Generally, functions commonly expected of nurses in most cultures are:

1. the assessment of the patient's condition which includes monitoring health parameters over time.
2. the identification health problems (nursing diagnosis).
3. the planning of nursing care.
4. the implementation of planned care.
5. the evaluation of outcomes observed through alterations of the patient's health.

Implementation of the nursing care plan is carried out through several change agent subroles. The nurse is a direct care provider of nursing and medical treatments. He or she is also a health teacher and counselor, collaborator with other professionals and persons significant to the patient's recovery, referral agent building networks to nurture the patient's recovery, and patient advocate.

If the nurse's educational socialization resulted in significant changes in health values and beliefs differing from that of the culture of the individual's birth and rearing, then enculturation has occurred.

The Nurse-Patient Health Service Encounter

The nurse and patient will then meet and have to negotiate a compromise between two sets of health values and beliefs. But what if no negotiation occurs? Will the patient "patiently" accept the biomedical values of the nurse as superior to his or her own, deviating from personal custom and habit? Does the patient's exposure to new health information and beliefs from media conflict with the health teaching and counseling of the nurse? Will conflict in meanings be overt or covert?

Patients were assumed to need to develop meaning in order to handle stressors coming out of the alterations in their health as well as those from their encounter with people and things in a potentially threatening setting. Nurses need to develop meaning from the information given by the patient as signs (objective) and symptoms (subjective). The meaning the nurse organizes from this information is called a diagnosis.

Methodology

Meanings are obscure phenomena difficult to expose to inquiry. The values and beliefs which shape meaning are the least visible part of people's cultural heritage and often are invisible to the informants. When people are aware of their health values and beliefs, they are sometimes reluctant to disclose them to the analysis of others. They are often unaware of the response others will have. The health care providers and patient meet in the health service encounter with each person behaving in response to personal overt and covert cognitive and affective drives in the attempt to create meanings from the encounter.

Ethnography is especially well suited to the collection and analysis of contextual data and the identification of meaning. Ethnography is interpretive. As much data as can be perceived through the cultural lens by a trained ethnographic researcher are collected, sifted and analyzed as is possible to disclose meaning.

Luskin (1984) writes that:

> Since ethnography emphasizes the created meanings in and through interaction with the group, it is less likely to restrict meanings and context than, say, standardized aggregate procedures. (p. 20)

Hutchinson (1984) writes that:

> Unlike quantitative research which reduces the ambiguities and complexities of experience to numbers and averages, qualitative research based on anthropological assumptions takes account of human perceptions and feelings. (p. 87)

Setting

The original plan was to study nurse-patient encounters in any area health care facility. During the late stages of the development of the proposal it was decided to take advantage of a possible setting in which nurses and patients would have less opportunity to become well acquainted. More of the data would then relate directly to nurses and patients attempts to understand one another's meanings as strangers. The Emergency and Outpatient Department (EOD) within the Rapid City Health Centre met these criteria. The setting thus consisted of a focal small setting, the EOD, within the larger setting of the Centre.

Entry

The idea of using this setting was introduced to the Director of Nursing Administration first by phone call and then by follow-up letter. A meeting was then arranged with the director and her assistant during which the purpose of the data gathering as part of an inquiry for a dissertation was explained. The significance of the study to the profession and the improvement of patient care were also described. Assurances were given concerning the professional behavior of the nursing researcher and the maintenance of confidentiality. A letter of agreement stipulating the nature of the relationship between the researcher and the Centre and its staff was outlined. This

was signed at a second meeting. This agreement also described the process to be used to obtain consents from nurse and patient participants. For the protection of their patients Rapid City Health Centre has developed a specific policy concerning the confidentiality of patient information. In conformity with this policy, the nursing researcher signed a prepared statement agreeing to abide fully with agency rules regarding confidentiality.

This meeting was followed by a tour of the Centre with particular attention to the Emergency and Outpatient Department which would be the focal setting for the study. The staff present on this occasion consisted of a screening nurse, two nurse practitioners, and a registered nursing assistant.

Some concern was displayed by the nurses at this time which appeared to be related to the prospect of being observed in their work. They stated that they found the idea rather stimulating when the nurse researcher carefully described the purpose of the study. They were assured that their clinical performance was not being evaluated or compared with others.

Observations

One hundred twenty-six encounters between nurses and their patients were observed and eighty-eight patient interviews were conducted with waiting patients. Interviews were conducted following the encounters on thirty-nine

occasions. The follow up interviews were somewhat short because patients were invariably in a hurry to leave the Centre. A few comparison observations of physician-patient encounters and three physician-nurse-patient triad encounters were also observed.

Use of Self

Wooley (1980) writes that "the most important tool of the ethnographer is him/herself" (p. 8). This role requires that the ethnographer achieve entry into the setting and develop relationships in which the functions of observation and interview can be carried out.

The researcher encountered some difficulty in the beginning, in attempts to reconstruct the meaning of events to patients. To overcome this problem comparisons were made between patient's statements describing certain events, including the meaning of those events, with the researcher's perceptions of the same or similar events.

Non-participant methods were selected to support the maintenance of objectivity utilizing the "freshness" factor of the researcher's unfamiliarity with the setting of the Centre. Repeated visits to the setting gradually produced an identification of the researcher as a quasi-member of the Centre's social fabric with a somewhat undefined status but a fairly definite role evidenced by people in the setting being able to predict the researcher's arrival, departure,

and activities.

The researcher was sometimes consulted during the diagnostic process by the nurses in the setting. As this was seen (by the researcher) as a threat to non-participant objectivity, a serious attempt was made to limit such input by the researcher which was not always successful. At times the professional accountability of the researcher as a nurse required responding to requests for such consultation.

Some clients identified by the researcher and/or nurses, while agreeing to participate, were actually concerned about an intruder's presence during their encounter with the nurse. These people seemed to have assumed that their role of patient required acquiescence to any requests from staff members. They had previously been assured that they could refuse and that refusal would not affect present or future care.

The researcher and staff fully agreed that the process of inquiry came second to patient needs and comfort. The researcher and staff made the commitment to exercise a careful vigilance to identify patients who might not fully accept or understand their right to refuse to participate. The researcher tactfully withdrew from nurse-patient encounters each time the above situation occurred.

The Emergency and Outpatient Service selected as the site for the study refers major emergencies to the area's hospitals, and restricts its own handling of emergencies to

those of a lesser or ambulatory kind. On two occasions, however, people entered the department with what quickly became evident as major and very urgent problems. The researcher restricted her activities to background observer in these cases or left the room to allow space for nurses and physicians to proceed with their work.

Data Gathering Procedures

Each period of observation in the Emergency and Outpatient Service Department of Rapid City Health Centre lasted from ninety minutes to three hours. Care was taken to inform the staff in advance of all visits to reduce threat. During the first visits several positions in each examining room were tested to identify the least intrusive and most inconspicuous place from which to watch. Nurses and patients seemed most likely to forget or ignore the presence of the researcher when a white laboratory coat was worn. It is possible that the combination of the white laboratory coat seen against the white examining room wall made the presence of the researcher less visually intrusive.

A small ring notebook was used to record fieldnotes. Though the setting did not permit the use of audio or audiovisual recording devices, an audio cassette recorder was used during the researcher's travels from the Centre to flesh out the written fieldnotes. Fieldnotes were transcribed for completeness and clarity as soon as possible after leaving the setting.

Nurses and patients in the setting were, without exception, so intent on the business of their encounter that they usually ignored the notetaking activities. A small mountain of fieldnotes accumulated rapidly.

It appeared that patients were able to ignore the presence of the researcher more easily than the nurses. Once the encounter with the nurse was in progress, patients usually focused most of their attention on the nurse. Their attention turned to the researcher only when the nurse made a comment to the researcher or asked a question. During intervals in which the nurse left the room, patients talked to the researcher as if she were a staff member or was present to assist the nurse.

Nurses asked frequently about the progress of the study, asked for clarification of the purpose of the research and how their performance compared with other nurses the researcher had observed. Generally, it was explained that the services they performed were much different than those provided by nurses in other settings.

Emic Perspective

Patient's Perspective

One of the most difficult problems to solve was how to determine which data gathered from interviews and observations accurately described the patient participants' perspective of the experience. Were potential data being

missed in the observations and interviews because of the nursing bias of the researcher? How accurate were the researcher's impressions of the processes by which patients organize strange stimuli into meaning? To test the necessary emic rapport with patients needed by the researcher the following techniques were used:

1. During entry into health care settings the researcher observed patient responses to stimuli in the setting and "walked" through "how I would feel and think" in that new situation. The visible behaviors of the patient were used as a guide.
2. Patient activities extracted from early fieldnotes were roughly grouped into categories such as entering the setting, finding out where to go, waiting, answering questions and giving information, giving feedback to the nurse's clarifying questions, experiencing being physically examined, listening to health explanations and teaching, listening to instructions about tests, treatment, and medications, asking questions, arranging for future appointments, and departing the setting.
3. The possible meanings patients might develop from the new stimuli in the experience of the setting were developed.
4. Comparison of the researcher's perceptions was then made with those of patients.

Approaching the setting on the first day, people were observed arriving and entering the Centre. It was learned that patients were fairly easy to distinguish from staff and other visitors. Some patients were followed through this entry process to observe their actions and responses to the physical characteristics of the setting and first meetings with staff members.

The researcher compared these observations with personal experiences in other health-care settings and with informant descriptions of how they felt. Comparative observations were made

1. with the feelings and impressions of the researcher as a patient at the dentist's office during which the researcher experienced orienting oneself, waiting, and being treated by a health care provider.
2. while accompanying a non-nurse colleague to an unfamiliar emergency room in which both were strangers. (She was stricken with a medical emergency and actually needed care).
3. while interviewing patients in the Rapid City Health Centre.

Nurse's Perspective

Less difficulty had been anticipated in developing an emic sense of the nurse participants' perspective. Some problems were anticipated because of intergroup differences in meanings which exist between the subgroups within the

levels of professional nursing (diploma, Associate degree, baccalaureate degree holders representing different philosophies). Each type holds slightly different sets of beliefs and orientation to mission of nursing. The difficulty was expected in determining meanings precisely. Smullen (1983) contends that there are at least three subcultures within the subculture called professional nursing (p. 142). Each correlates with the type of school in which the sub-subculture's members were socialized into nursing. There is also a fourth group, consisting of the group calling themselves nurse practitioners and clinical specialists.

Many members of this group, including the researcher, are the products of graduate programs and value the independent role functions of nursing very highly. To develop an emic of the nurses' perception of stimuli in the setting the researcher conferred frequently with staff nurses to compare and confirm perceptions and meanings of events taken from specific interactions with patients. As specific beliefs and values began to emerge, the researcher shared her impressions and thoughts with the participants in order to obtain confirmation or to disconfirm the researcher's perceptions.

Analysis of Data

Analysis of the data from observations and interviews was carried out in two stages. The first stage consisted of an ongoing sorting, reflection and review performed throughout the data-gathering process. While recording fieldnotes, the researcher often noticed the emergence of some consistent organizing threads implying relationships running through several observed incidents. These were recorded as analytical notes. At the end of each day of data gathering, as fieldnotes were being transcribed, these analytical notes were sorted temporarily into categories related to the research questions, description and background of the setting and participants or new emerging categories. These early linkages consist of simple assertive statements which the researcher should consider tentative to avoid early mindsets which could cause missing some of the more important patterns and linkages.

The second stage of data analysis began as data gathering neared completion and the researcher was in the process of withdrawing from the setting. In this stage, the data were sorted into more permanent organizational categories and emerging relationships were confirmed or disconfirmed. Printed brochures, prepared as patient information by Centre staff, staff organizational charts, and manuals of clinical protocol were used to determine the underlying social structure affecting the delivery of

services and nurse-patient relationships.

Schatzman and Strauss (1973) write:

> . . . the fundamental operation in the analysis of qualitative data is that of discovering significant classes of things, persons and events, and the properties which characterize them. (p. 110)

Gradually, out of this analytical process a matrix of related patterns of meaning began to take shape. The conclusions of the study represent the more significant patterns which emerged. Finally, recommendations were developed out of this final stage of analysis which were communicated to the people in the setting and will be set forth in this report.

Exit From the Setting

Visits to the setting were begun in December of 1984 and this stage of the inquiry was considered to be completed in June of 1985 when fieldnotes seemed to become repetitious in content. The researcher felt that closure of the data gathering was indicated as freshness of perspective became eroded by increasing involvement with informants. Familiarity and friendships, while more comfortable than the previous role as visiting stranger, created considerable difficulty in attempting to remain objective. Separation was painful as the researcher had become close friends with the nurses and many patients.

CHAPTER FOUR

THE SETTING AND THE INFORMANTS

The setting selected for this study is somewhat complex in that it consists of a setting within a larger setting. The larger setting is a Canadian Health Service Organization. The setting contained within it consists of a single department, the Emergency and Outpatient Department or EOD. It is in the EOD that the events which are the primary focus of the study take place. The informants assisting the researcher in her attempt to understand the meaning of events in the setting are the nurses, patients using the services available within the setting, the administrative staff (especially nursing administration), and various other staff members.

All the nurses in EOD, the primary focus of the study are required to exercise a high degree of independent judgment. They are selected for advanced preparation and the ability to act independently. It appears that in a few other departments, such as obstetrics and orthopedics, some of the nurses are permitted to exercise a high degree of independent judgment, though others in the same department are not. Most of the nurses in most of the departments of the Centre do not appear to be encouraged to make decisions

or act independently. Some nurses said that their physicians actively discouraged them from acting independently.

The Health Centre: The Larger Setting

Canadians use the term "Health Service Organization" (HSO) for what Americans call a "Health Maintenance Organization" (HMO). In both countries, such facilities emphasize prevention of illness, early diagnosis, and health maintenance (emphasizing health education and lifestyle modification).

Services also include the treatment of illness and injury and the restoration of the ability to care for oneself. The services in HSOs and HMOs contrast with other types of health-service delivery which focus on illness rather than the maintenance of health.

Rapid City Health Centre was organized in 1962 as a physician group practice in response to the requests of local steelworkers and some others for a new kind of holistic health service. The Canadian physician who had the vision to guide and shape the original plan and policies remains a highly respected member of the medical staff. Several nurses remembered that he had to overcome considerable resistance from much of the professional medical community of Rapid City during the early days of operation.

In response to the introduction of a province-wide system of socialized health care in 1969, the services (and thus the staff, building, and equipment) were greatly expanded. The facility was opened to public use at that time and the number of physicians increased to the present number of about 40 (there were only 13 in 1963).

There are about 70,000 active health files in the facility's Record Library at the present time, a tremendous increase from the initial enrollment of 40 steelworkers in 1963. Many of the subscribers are Americans who travel across the international border to use the excellent professional services.

Funding

Payment for services to clients comes from several sources. Some funding is from direct payment for services through health insurance plans sponsored by employers and employees of several commercial and public organizations, (e.g., steel mill, forest products manufacturing companies, teachers, and other municipal employee groups). In addition, the Canadian Ministry of Health funds a part of the service on a user per capita basis. Some patients pay at least part of the fees for services themselves.

Americans have difficulty applying American third-party health insurance plans to services at the Centre because of poor communication and lack of formal linkages between health

insurance plans in the two countries. Canadians told the researcher they experience similar difficulties when traveling in the United States and deplore this lack of international cooperation.

The capital for the construction of the original building, equipment, and staffing was contributed by the founding subscribers and other sympathetic groups. Funds to expand and maintain the present facility, staff, and equipment come from patient fees, the Ministry of Health, and donations.

The Rapid City Health Centre is a fairly modern three-story brick building situated in a combination commercial and residential district. Rapid City is a Canadian city with a population of about 90,000.

The main entrance and main lobby of the building are actually at the back of the building (opposite the side of the building facing the street). Thus, the main entrance opens directly from the Centre's parking lot. The only entrance on the street side or front of the building serves as a service entrance for some staff and the transport of patients into or out of ambulances.

The main floor is divided into three parts. The center contains the lobby with two service areas, one with the desk for Admissions and Appointments, and another serving business needs such as accounts of patients. One of the clerks at the Admissions and Appointments Desk also is the

central telephone operator, receiving and transferring telephone calls throughout the Centre.

The pharmacy is located at the end of one of the main floor wings. The remainder of the main floor is divided into the departments of various medical specialties. The basement floor of the Centre contains physiotherapy, X-Ray, a staff lounge, medical records, and some of the medical departments such as oncology. The floors above the main floor contain the various medical and surgical specialties in addition to administration, business areas, and some large conference rooms.

Emergency and Outpatient Department (EOD): The Inner Setting

The Emergency and Outpatient Department (EOD unit) is located directly behind the lobby. This is a block of rooms consisting of a small waiting room, the screening nurse's examining room, one large treatment room, three small treatment rooms, and a restroom. The rooms are arranged with an L shaped hallway opening at each end. One end of the L provides direct entrance to the EOD from the lobby. The clerk at the Admissions and Information Desk directs patients to this entrance and instructs them to seat themselves "in the first room on their right", which is the waiting room.

The other end of the L shaped hallway connects the EOD with the Department of Internal Medicine. The proximity of this department provides the EOD nurses with the means for physician consultation fairly quickly when needed. The most senior of the medical staff has an office in this department. He is the most supportive of nurse practitioners of all of the physicians at the Centre.

A small alcove has been constructed on the inside bend of the L to serve as a nurse's station. It is just big enough to seat three people at a high wall mounted desk for charting and telephoning. A service window equipped with sliding doors was constructed between this nurse's station and the waiting room apparently to provide direct communication with waiting patients. The researcher never saw this window open or in use. The sliding doors were always closed. Nurses in EOD said that their work requires such frequent use of the phone, that opening and closing this window became too much of a bother.

> Nurse Practitioner: If somebody forgot the window was open while they were talking on the phone about a patient's private business, it would be awful, eh? (Preliminary survey visit fieldnotes, 10/2/84).

Many people phone the Centre for health and illness information and these calls are frequently referred to the nurse practitioners in EOD. The phone also is used for consultations with physicians.

Informants

The informants participating in the study were all Canadian citizens (except one patient with immigrant status from Turkey) who are members of the staff of the Centre, or patients using the Centre's services. English with some distinctly Canadian flavor was the first language of most of the participants.

The fieldnotes reflect frequent use of "eh?" at the end of many statements.

> Nurse: You'd think they (lay persons) would all know about that, eh? (Fieldnotes, preliminary survey visit, 10/2/84).
>
> Patient: But he (his physician) didn't tell me that, eh? (Fieldnotes, 1/4/85).
>
> Nurse practitioner: If you keep it elevated like this the swelling will go down, eh! (Fieldnotes, 12/20/84).
>
> Admissions clerk: Oh! My! What's the trouble here, you must have cut yourself, eh? (Fieldnotes, 12/13/84).

A consultant of the researcher noted that each time this expression is used the speaker seems to be asking for confirmation of the statement (J. Buschman, personal communication, January 1986). It also frequently seems to be used by the speaker to emphasize the statement to which it is attached.

The Centre provides a full array of the traditional medical services employing approximately 40 full time physicians. In addition to the physicians, there are an

administrative staff, the nursing department (the largest group), physiotherapists, a dietitian, laboratory and X-Ray technicians, medical librarian, and a pharmacy staff. There are also a large number of people performing a wide array of support functions such as maintenance and the running of the snack bars.

Patients

People coming to the Centre for services are called "patients" by the staff and by patients themselves. The medical diagnostic categories of the one hundred twenty-six nurse-patient encounters observed are illustrated in Table 1. Seven patients were observed during at least one return visit to the Centre. One of these was observed during three return visits.

Few major emergencies are seen in the EOD at the Centre. Most of the patients seen during the period of data gathering complained of some form of infection (54.8%). The next largest group of patients came with a chronic disease such as hypertension, other cardiovascular, allergy, or gastrointestinal bleeding (23.8 %). Health maintenance such as family planning and immunizations accounted for 9.5 % and an 4.7 % of the observed encounters were for acute skin diseases. Only 7.1 % of the encounters dealt with emergencies such as injuries. The patients who were diagnosed as having gastrointestinal bleeding did not

demonstrate bleeding of the severe type usually categorized as emergencies. The nursing administrator said that the percentages from this sample were fairly representative of the data reported from the Centre for previous years. The data for this study included periods of time from two years (1984 and 1985). The nurse practitioners reported that there was usually considerable seasonal variance in the types of cases seen. The study was conducted during the winter and spring months.

Table 1

Medical Diagnoses of Patient Informants.

Diagnoses	Encounters
Infections	69
Upper respiratory	39*
Sexually transmitted	09***
Urinary tract	10
Gastrointestinal	09
Eye	02
Hypertension (referral and monitoring)	22**
Injuries	09
Burns	2
Lacerations	4*
Fractures	3*
Family planning	11
Skin diseases (rashes and warts)	06*
Gastrointestinal bleeding	03
Cardiovascular disease	03
Immunizations	01
Allergies	02
Total	126

* Each asterisk represents the return of a previously observed patient informant.

Patients come to the Centre for professional help for their health problems. They needed to learn how to use the Centre's services to accomplish their goal. This meant finding out who to ask for information and how to find the correct department. They also needed to learn where to wait, how to identify the various kinds of staff personnel, and how to follow the terminology of instructions. Learning to follow instructions requires developing shared meanings. Both staff and patients need to process information to form a synthesis of a meaning. The results of synthesis must then be shared in so way that each person understands the other.

The nurse, or any other staff member involved must be able to understand what the patient means when describing symptoms. The patient needs to understand what he or she is being asked. The patient also needs to understand instructions.

Patients must begin the synthesis of meaning from the moment they enter the Centre's doors for the first time. People who are new to the setting are fairly easily identified by their behaviors in attempting to orient themselves. "Old" patients with prior experience in the setting enter the building having learned at least where to go. They usually pass through the lobby quickly and head off apparently to some department where they had arranged appointments. "New" people are dependent on

objects in the lobby, such as signs, or other people in the setting to orient themselves. The clerk at the Admissions and Information desk is usually the first human being the new patient uses in orienting him or herself.

Admissions and Appointments Desk

When a person approaches the desk, one of the clerks fairly quickly asks "May we help you?" or "How may we help you?" Persons (old or new) with previously arranged appointments respond with the information that they have an appointment, often naming a specific physician, department, or nurse practitioner.

The clerk was observed to check an appointment schedule. Confirming the appointment, she then completed an encounter form which was given to the patient. She then gave them directions about how to find the appropriate department. Sometimes the appointment schedule failed to confirm the patient's statement that an appointment had been arranged. When the clerk could not find an appointment listed in the schedule, she would call the department in question to determine if some special arrangement had been made for this particular person. One clerk told the researcher:

> Some of our Docs just tell the patient to come back on such and such a day without telling anyone else. We have most of 'em trained well; but when they forget, we just work the patient in where they will have the least waiting. (Fieldnotes, preliminary survey visit, 10/2/84).

Old patients have a medical record, and the clerk always contacts the Medical Record Library to have such records sent by courier to the appropriate department. Patients usually are not seen by the clinical department until the record arrives.

The clerk's routine for managing new patients is more complex. The person who is new is asked whether he or she is enrolled at the Centre, or plans to become an enrollee of the Centre. Becoming an enrollee does not prevent a patient from going anywhere else he or she prefers to go for services. It simply means that the patient has selected the Centre as the primary source of health care.

The following sample is typical of the new patient's experience at the Admissions and Appointments Desk:

Clerk: May I help you?

Patient: I called earlier about seeing a Doctor about _____.

Clerk: Are you new with us? (Some clerks ask: Have you seen a Doctor here before?)

Patient: No, I'm new here. Does that make a difference?

Clerk: No, but we will need to start a chart for you, and I have to ask you some questions.

(During ten admissions encounters observed, the patients seemed to become less at ease when they heard they were to be asked more questions).

Clerk: Do you have your S-I-N card with you? (Spells out acronym for Social Insurance Number). (Fieldnotes, preliminary survey visit (#2), 10/14/84).

The SIN card is the Canadian version of the American Social Security card which is called a "Social Insurance Number Card" (SIN). Most patients have brought their SIN card with them which they hand to the clerk after searching it out of their wallet or purse.

During this conversation the clerk has retrieved a packet of forms which makes up the new patient's chart or medical record. She stamped each form and wrote headings identifying the patient on each. Each patient who enrolled at the Centre was eventually mailed an identification card. The identification card was used to impress any future forms needed. Each patient was given a medical record number which was displayed on his or her card.

Each Canadian province has its own health insurance plan. The new patient had to furnish an identifying card for the specific province's health plan which would be called upon to pay for any services provided by the Centre.

Clerk: Do you have your _HIP Card? (This is the identifying card for this Province's Health Insurance Plan. The clerks always used the acronym and invariably had to explain what the letters of the acronym stood for. The first letter of this acronym is the first letter of the name of the province, e.g., OHIP for Ontario Health Insurance Plan, AHIP for Alberta Health Insurance Plan, etc.).

Patient: A-A I think so. Which is that, A- _HIP, eh? (HIP pronounced hip).

Clerk: Your _____ Provincial Health Insurance Plan Card. Do you have it with you, eh?

The patient usually found the appropriate card.

The typical admissions interview continued for several minutes as the clerk asked questions concerning other identifying information, social and family history, previous health history and source of previous treatment, etc. The interview is the first step in becoming an old patient.

Patients were then given an encounter form and directions to the department where they were to be seen. When patients were "walk-ins", the clerk tried to categorize the health problem and then attempted to have the patient seen by the appropriate department. This usually meant the patient had to be "fitted in" (sic) between other appointments. Most walk-in patients were sent to the EOD to be seen first by the screening nurse.

Nursing Staff

The nursing staff consists of an administrator, her assistant, about five nurse practitioners, approximately eighty registered nurses, and some of registered nursing assistants. The nursing administrator, while the study was in progress, retired shortly before data collection was completed. Her assistant then became the administrator, and a search commenced for a new assistant nursing administrator. Five of the nursing staff had a baccalaureate level education. There were no nurses with degrees above the baccalaureate level. Most of the nurses were prepared

in diploma programs of the traditional hospital school or Canadian colleges. Diploma programs are non-degree.

Most of the nurses seemed to have semipermanent assignments in a specific medical specialty, and were usually assigned to work with a specific physician or group of physicians. Each department or medical specialty had its own waiting room and nurse's station. Each physician had his or her own office.

The researcher found that nurses could be sorted into two groups based on the degree they implemented independence in their nursing practice at the Centre. The degree of independence permitted in their practice varies with the departments and medical colleagues to which they are assigned. It varies also, according to each nurse's individual preparation for independent function and desire to practice independently. It is commonly accepted by the nursing profession, that almost every setting in which professional nursing is practiced offers ample opportunities to implement independent nursing practice.

The first of the two groups consists of staff nurses who describe their work as physician-focused. This group seems to include the majority of staff nurses at the Centre. When asked about their work with patients, they often began by describing how they assist their physician, circling back to that focus when the researcher purposely asked questions about their authority to teach and counsel.

The second group consists of nurses who demonstrate a fair amount of independence. This group includes staff nurses who appear to have assumed independent responsibility for applying their knowledge of nursing to meet patients' informational needs. There is a fairly wide range in the degree of autonomy demonstrated by the members of this group: from nurse practitioners who are permitted and assume the most, to staff nurses who are permitted some independence (mostly traditional) and implement it as fully as possible.

There was limited time for the researcher to devote to nurses who form the first group. All of the nurses who are members of the apparently less independent group are assigned to departments other than the the focal setting which was the EOD. Some of these nurses sought out the researcher, however, as they felt that the researcher should be interested in looking at their practice as well as that of the nurses assigned to the EOD.

The researcher arranged a series of interviews with four of these staff nurses, each working in a different department. Each interview was followed by an invitation to tour the interviewee's department which was accepted.

All four of the sample nurses of this group emphasized the function of carrying out physician's orders, in contrast to such independent nursing functions as health assessment, patient teaching, or patient counseling. The following

statements by one of this group were typical.

Nurse: My day starts with making everything ready. I check the Dr.'s office and the examining rooms to see they are all, all right. And then I make sure we have everything.

Then, I check the patients' appointments to see who is seeing the Doctor.

When the patients start coming, I get them ready to see the Doctor. I do the tests he (the physician) wants, give some of the medicines he orders, or get it (medicine) ready for him to give.

Researcher: Do you teach or counsel your patients?

Nurse: Sure, I explain anything they need to know. I tell them how to take care of themselves and follow the Dr.'s orders.

Researcher: Do you feel that you are permitted to decide about what a patient needs very often?

Nurse: Well he'd (the physician) not like that, eh?

Researcher: Would you like to be able to make more decisions?

Nurse: I'm not sure. Sometimes I would, but I am really pretty busy with what I have to do now. And after all, he is the Doctor, eh? (Fieldnotes, 12/16/84)

The main themes of this set of interviews seemed most concerned with the tasks of an average work day and to meet the physician colleague's need of assistance. The sample is quite small and thus generalizations must be made very cautiously about the degree to which these four nurses represent the larger number of staff nurses at the Centre. The researcher sensed that these four nurses were representative of most of the more dependent group.

Independent judgment and action by nurses seemed to be the exception at the Centre rather than the rule.

The most assertive of the four staff nurses interviewed in the more dependent group described a little more assumption of authority and implementation of independent nursing functions.

Researcher: I seem to hear you saying that most of your work has to do with the physician's orders. Can you do some things without asking your doctor?

Nurse: I hear what you are asking. I read about nurses doing more on their own, but if your doctor doesn't want you to interfere, it makes for a bad working relationship.

Researcher: I see, h-m-m. (pauses)

Nurse: I do ask them [patients] if they understand his orders, and I help them prepare the questions they want to ask, when they are afraid to ask, eh?

I do some nursing assessment on my own too. Sometimes he's [physician] pleased with the things I can tell him I've found. Sometimes it just upsets him.

Researcher: Do you feel that you will find more ways to act on your own as time goes on?

Nurse: I don't think that I'll have much chance for that, eh?

Looking at her watch she terminated the interview at this point, stating that she had work to do. (Fieldnotes, 3/7/85).

The nurses in the more dependent group ranged in age from twenty-eight to fifty-one years. Three had completed their studies in hospital diploma schools of nursing. The fourth is a graduate of a community college nursing program. Their educational programs were all approximately three years in length.

One of the staff nurses who is possibly the least independent of the second (more independent group) described a fairly heavy daily schedule working with two physicians. She seems to place a higher value on nursing activities in which she actively assesses and meets patients' needs in contrast to the focus of the first group on assisting the physician.

> Staff Nurse: We are always in a rush, but I make sure to ask if they have any questions. I go over the physician's instructions and teach them how to carry them (the instructions) out.
>
> Researcher: Do you give any instruction of your own?
>
> Staff Nurse: Of course, there are lots of things they need to know a physician doesn't think to tell them, eh? And then a nurse knows lots of little things a person can do to help themselves, don't they? (Fieldnotes 1/8/85).

This nurse said she also orders laboratory tests for patients which she feels are indicated. She states that the physicians with whom she works have chided her occasionally about reading their minds and once about playing doctor when she gave them data from the tests she had ordered.

The services offered by the Emergency and Outpatient Department (EOD) consistently demand a very high level of independent decision making by nurses. Thus, all of the EOD professional nurses fall into the more independent second group. All of the nurses assigned to this department have taken advanced coursework in nursing. The EOD nursing staff consists of two nurse practitioners, a screening nurse, and a registered nursing assistant.

The screening nurse receives patients sent to the Emergency and Outpatient Department from the Admissions and Appointments clerk. The admissions clerk selects people to be sent to the department on the basis of:

1. having an acute problem, but lacking a previously arranged appointment.
2. advance arrangements for special procedures to be performed (on an outpatient basis) such as suture removal, application of a cast, some immunizations, and follow up monitoring or nursing care.

Patients who come to the Centre without an appointment for help with a new problem are assessed by the screening nurse to determine the nature of that specific problem (termed the chief complaint). She assesses patients sent her and determines which of the Centre's services best meet the patient's needs. She makes arrangements for the patient to be "seen" by the EOD nurse practitioners, physician (by specialty), or the physician on-call. She follows

protocols, but also has considerable latitude for making independent decisions. She teaches and counsels within the specifications of the protocols, but also covers many areas of the patient's health needs which are not specified in the protocols.

> Screening nurse: They [doctors] can't think of everything a patient will ask, can they? A nurse should know most of the stuff patients need to be told without asking the doctors. Some doctors don't even know all the things patients should be told.
> (Fieldnotes, preliminary survey visit, 10/2/84).

She arranges appointments for patients to be seen by herself for routine monitoring of blood pressures, family planning (including making a change in birth control pill prescriptions), and immunizations.

Three nurses employed by the Centre are graduates of programs which prepare nurse practitioners. One is a graduate of the Northern Nurse Program (University of Alberta), a program which prepares nurses to staff nursing stations in remote medically underserved parts of Canada. One is a graduate of a baccalaureate program which prepares nurse practitioners, and one is a graduate of an American university certificate program for nurse practitioners (non-degree).

The nurse practitioner is a new role created to provide expanded and specialized nursing services (role expansion) and some medical services (role extension). Role expansion means to perform new functions that are not customary

functions of the traditional nursing role, but are well within the definition of the nursing care process. Role expansion requires the acquisition of knowledge and skills beyond that provided in current basic nursing education.

Over time what has been new becomes traditional practice. Physical examination skills were once considered an expanded role function. Such skills are currently becoming accepted as a basic part of baccalaureate nursing education. Expanded role functions are generally restricted to protecting, maintaining, and restoring health.

Extended Role role functions are those which are properly those of another profession and are taken on through negotiation and collaboration. Thus, Nurse Practitioners perform some curative functions such as suturing, applying orthopedic casts, or drug prescription in collaborative practice with physicians. Extended role functions are usually carefully defined by collaboratively developed protocols.

Documentation of Services

Each time an individual patient comes in contact with any department of the Centre, pieces of paper are generated to record the event. The compilation of all this paper results in an artifact called the medical record. The researcher reviewed about fifty different patients' records in the course of the study.

Each of the records examined contained documentation of financial arrangements (insurance forms), visits to each department where patients had been examined and treated, physicians' and nurse practitioners' orders (including medications ordered), laboratory test results and progress notes. Each progress note was found to be very concise (often terse).

> Condition improving.
>
> BP 146/90. Will continue present medication. Return 1 month. (Fieldnotes, 12/4/84).
>
> Dysuria (means painful urination), tenderness over bladder, Imp. UTI ("Imp." means impression or diagnosis) (a presciption followed). A laboratory test on the patient's urine supported the diagnosis of UTI or Urinary Tract Infection. (Fieldnotes, 12/4/84).

The medical records examined recorded much fewer comments by nurses. Nurses' notes frequently consisted of no more than data such as a blood pressure, temperature, or a dressing change. Almost all progress notes added to the medical record in EOD were recorded by nurses (since EOD is primarily staffed by nurses). The notes were as brief and concise as those of physicians.

Coincidentally during the period of data collection for this study (1984-1985), the importance of the documentation of nursing practice for the purposes of financial reimbursement and protection from litigation was being discussed by the nursing leadership in the area in both Canada and the U.S. The Assistant Director of Nursing at one of the hospitals in River Falls stressed careful and

detailed charting in a discussion with American nursing faculty whose students use her hospital for clinical learning experience. An in-service nursing education director of an American hospital told the researcher's nursing students that:

> The rule is "if you didn't chart it, you didn't do it" and that can be pretty bad because the court will assume that you didn't carry out an order, or teach or explain something important to a patient if you didn't document it in the patient's chart. (Fieldnotes, 10/16/84. Conversation of In-Service Director of _____ Hospital with nursing students in regard to the implementation of new U.S. federal guidelines for Diagnosis Related Groups).

It seems significant that nurses at the Centre of both of the independent and dependent groups of nurses recorded activities related to some treatments, but did not record such things as the teaching and counseling activities observed by the researcher or described in interviews. This may reflect a lesser value of such nursing activities. Many notes by nurses, found by the researcher, recorded making measurements of physical parameters and the performance of treatments such as dressing changes.

Terms of Address used in the Setting

Nurses generally called each other by their first names and were often addressed in the same way by physicians. The nurses were never heard addressing physicians by their first names and it seemed they always prefaced the physician's name with the honorific term Doctor.

Patients seemed to address physicians, without

exception, using the prefix "Doctor". Physicians addressed adult patients during first visits using the appropriate proper pronoun prefix and last name. They addressed patients with whom they were more familiar using only the patient's first name. The adults in the setting always addressed children by their first names.

Nurses usually spoke to patients using the appropriate form of address and the patient's last name such as "Mrs. Smith" or "Mr. Smith". A reciprocal first-name relationship developed between some nurses and some old patients. Medical records of such patients were often thick, implying that the patients had visited the Centre many times.

Volume 2

CHAPTER FIVE

THE EXCHANGE AND PROCESSING OF INFORMATION BY NURSES AND PATIENTS

Solving a health problem requires that the patient develop a sense of meaning out of the symptoms experienced and be able to describe that meaning to the health care provider from whom he or she is seeking professional help. The health care provider, such as the nurse, must develop meaning in the form of diagnostic statements from the subjective data the patient reports as symptoms. The health care provider supports or disconfirms the meaning or diagnoses he or she develops from the patient's subjective reporting, through the analysis of objective data called signs.

The health care provider must then communicate the meaning of the diagnostic statement(s) back to the patient and teach the patient how the problem is to be solved. Impairment of the processes of synthesis and sharing of meaning between the care provider and patients appears to arise from:

1. unshared language symbols and meanings.
2. conflicting health beliefs.
3. time limitations on the length of the encounter.

4. competition for the patients' attention to health teaching from patients' simultaneous need to learn their way through the health care system to obtain and use its services.

Arranging to Use the Centre's Services

An admitting clerk reported that 75% of people coming to the Centre for services either telephone for an appointment or are given an appointment at the time of a previous visit. The other 25%, called "walk-ins", simply come to the Centre and ask for services. The clerk is trained to be able to distinguish the urgency of only a few health problems. She sends or takes a person with any obvious emergency such as a wound or chest pain, and anyone with a condition she is unable to classify directly, to the EOD screening nurse.

Old patients who "walk in" may be fitted into the schedule of the physician they customarily see. When this is not possible, the clerk arranges for the patient to be seen by the screening nurse, who will arrange for them to be attended by a nurse practitioner or the "officer of the day," a physician assigned to be "on call".

Learning Where To Go

One of the first norms of behavior which patients learn is that they must not explore the setting on their own in the same way a person can walk about in a supermarket or other settings. Inside the front door there are signs

explaining what they should do or where to go. Most patients are intercepted inside the front door by an information and admissions clerk, given directions where to go and told where to sit and wait. From the point of entry, staff members instruct patients about almost every step they are permitted to take in the building. The instructions are so specific that patients usually ask staff members for permission when they want to go anyplace other than where they are directed to be; for example, asking, "Do I have time to run down for coffee?". This ritual is important to avoid losing one's turn in being called for examination or treatment.

Patients also learn by observing old patients, and testing whether they will be allowed to behave in the way they observed other people acting. Learning the folkways of life in the Centre begins during the process of being admitted and/or getting an appointment. It continues through learning the norms of behavior in waiting rooms and receiving treatment. During each step, patients lose a little autonomy over self, recovering it as they leave the Centre.

How Patients Learn the Roles of the Staff in the Setting

In order to find out what to do in the setting, patients first had to learn how to identify other people and their roles in the setting. In this setting, staff nurses and the screening nurse wore white uniforms, nurses' caps

and nursing school pins, and an identification tag readable, for those with normal vision, from about five feet away. The patient could usually identify nurses by their caps. Some patients confused other female personnel in white uniforms as nurses in departments where the nurses do not wear a distinctive nurses' cap.

Physicians were mostly male, wore mid-thigh length lab coats, a suit, or simply a white shirt, a tie and dark trousers (never a stethoscope). If the patient had any doubt about who a physician was, it would always be dispelled when either the physician introduced himself quickly with "I'm Doctor _____" or the nurse introduced him as "This is Doctor _____."

Nurse practitioners wore long lab coats over street clothing, nursing school pins, nurse practitioner identification tags, and stethoscopes. They never wore nurses' caps. The nurse practitioner role was an unfamiliar one to some patients. The screening nurse usually explained who nurse practitioners (NPs) were and what they did. The NP usually repeated the same explanation when she first met a new patient.

Other staff members such as the nursing assistants wore identification tags and white uniforms. They always introduced themselves to the patients: "I am Janet, a Registered Nursing Assistant and I will . . .", explaining what they would be doing for the patient.

The encounter form gives some advantage to the staff member in the first moments of a meeting. The staff member learns the patient's name from this form, while the patient is dependent on a brief introduction to the staff member and a name tag which is difficult to read. The staff member always addressed the patient by name, while the patient frequently forgot the names of staff members other than physicians. They seemed to resolve this by simply avoiding use of the staff members' names when addressing people such as nurses. Only one patient was heard in the course of an encounter to ask the nurse to repeat her name. The patient said, "I forgot your name and I can't read that," indicating the name tag.

Erickson, Florio, and Buschman (1980) write that the significant question is: what do people have to know to function in the setting? In the health care setting this question becomes: how do new patients learn to become old patients? They seem to do this by:

1. asking questions of people in white uniforms and, less often, of people in street clothes.
2. going where they are told to go and doing what they are told to do.

The Patient's Path Through the System

The patient's path through the care system of the Centre varies according to whether he or she has arranged an appointment and also, with the urgency of the problem as shown in Figures 1, 2, and 3.

Figure 1. Path of the patient through the system when the problem is an emergency.

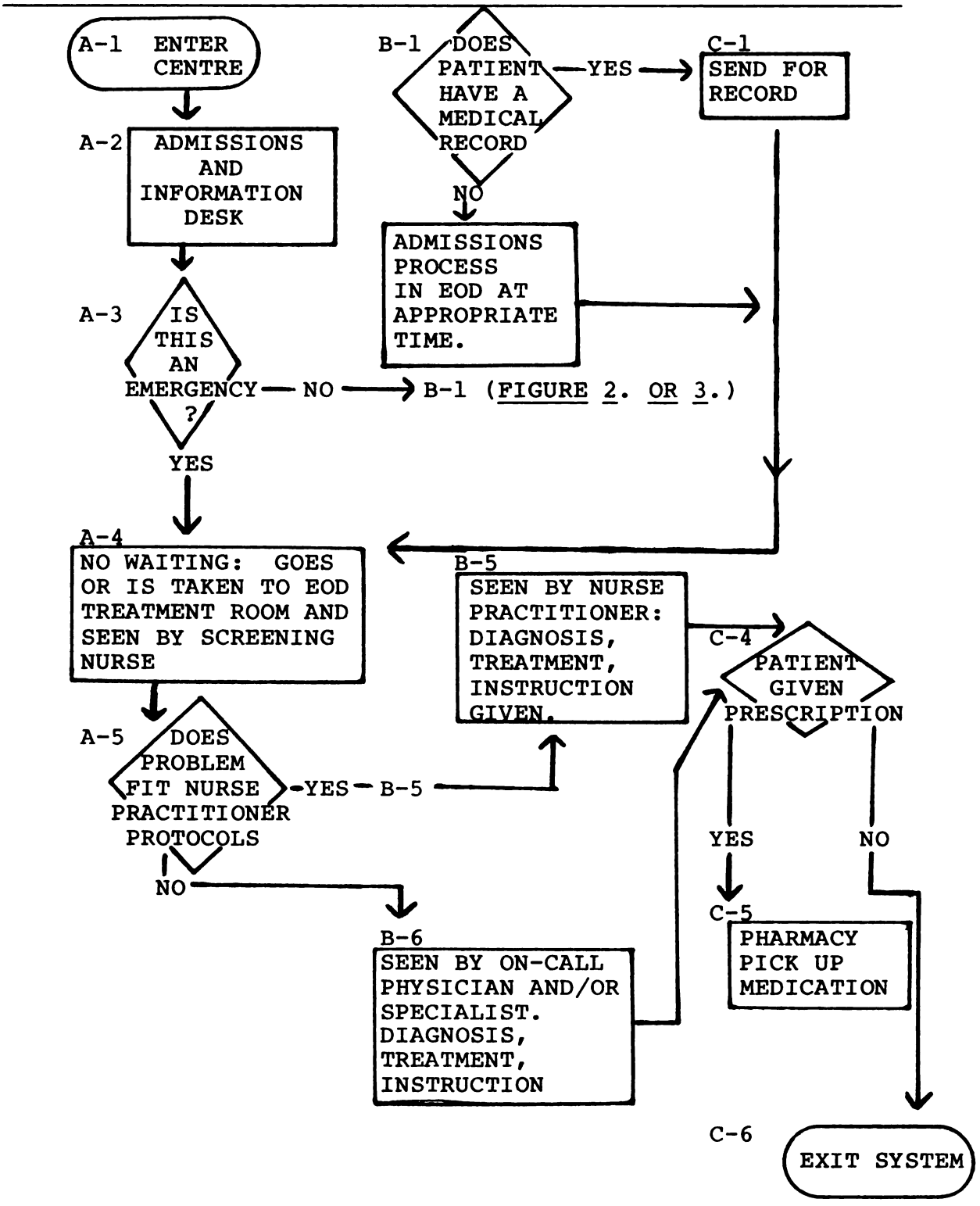
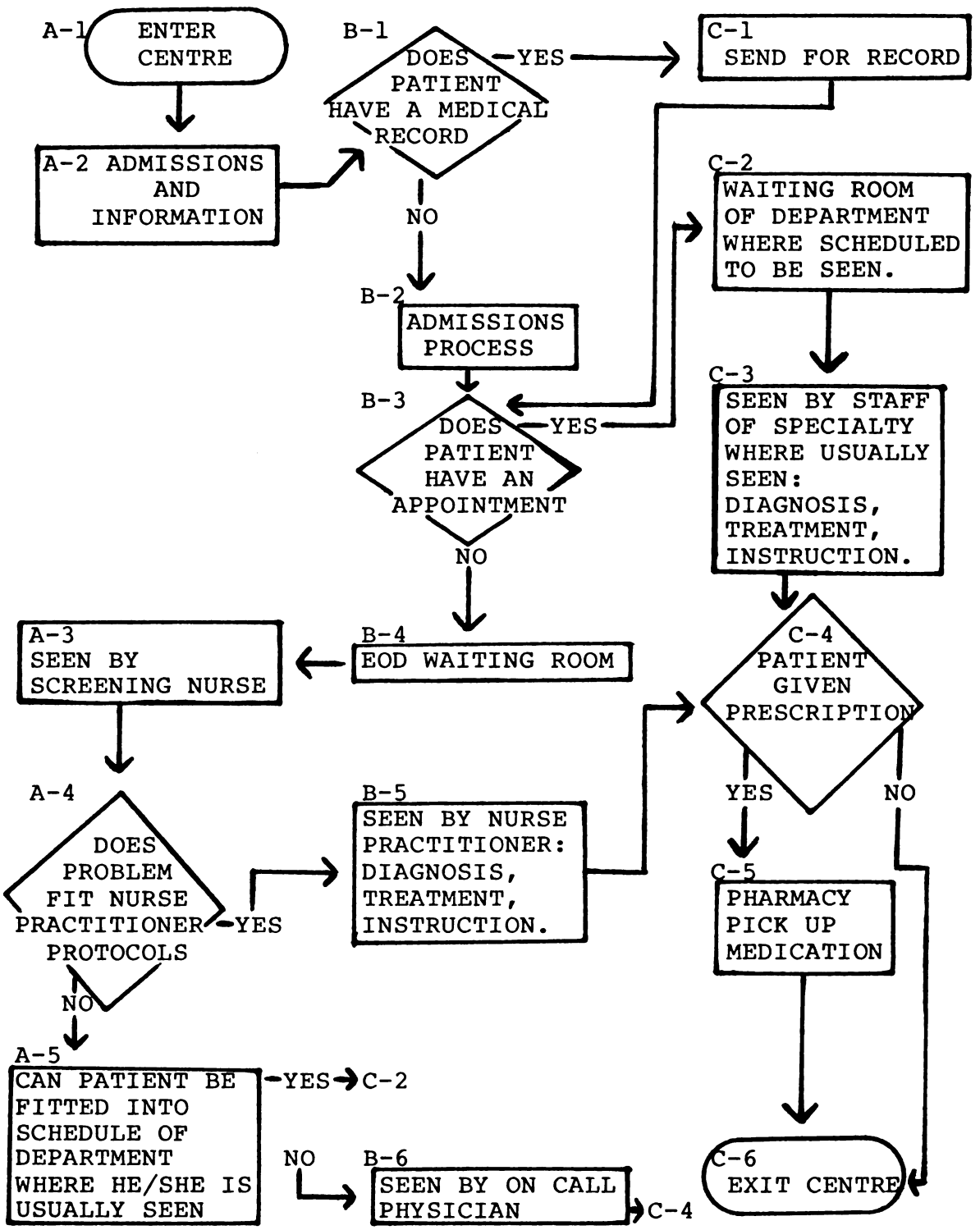


Figure 2. Patient's path through the system when the problem is not an emergency, but he/she has no appointment.



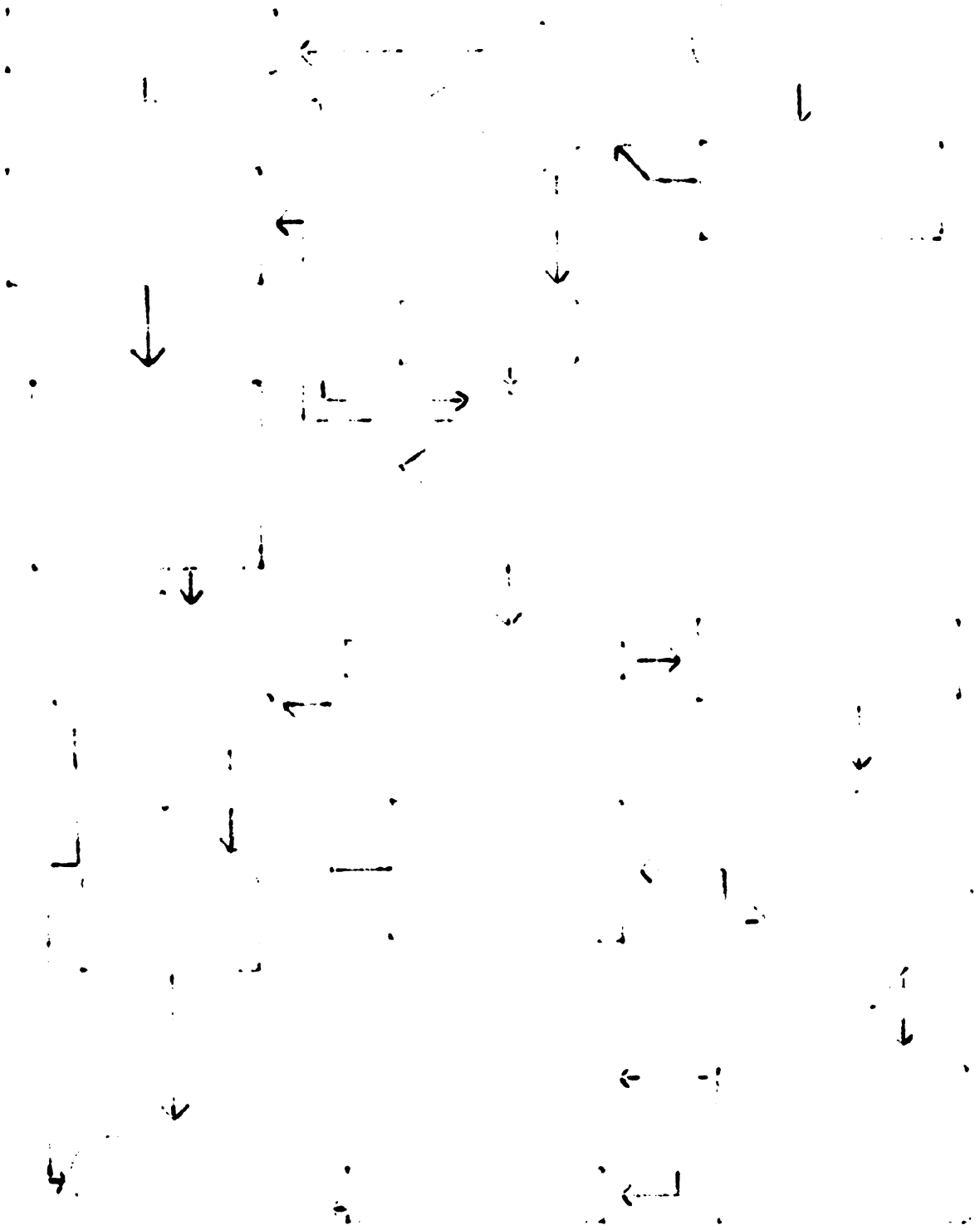
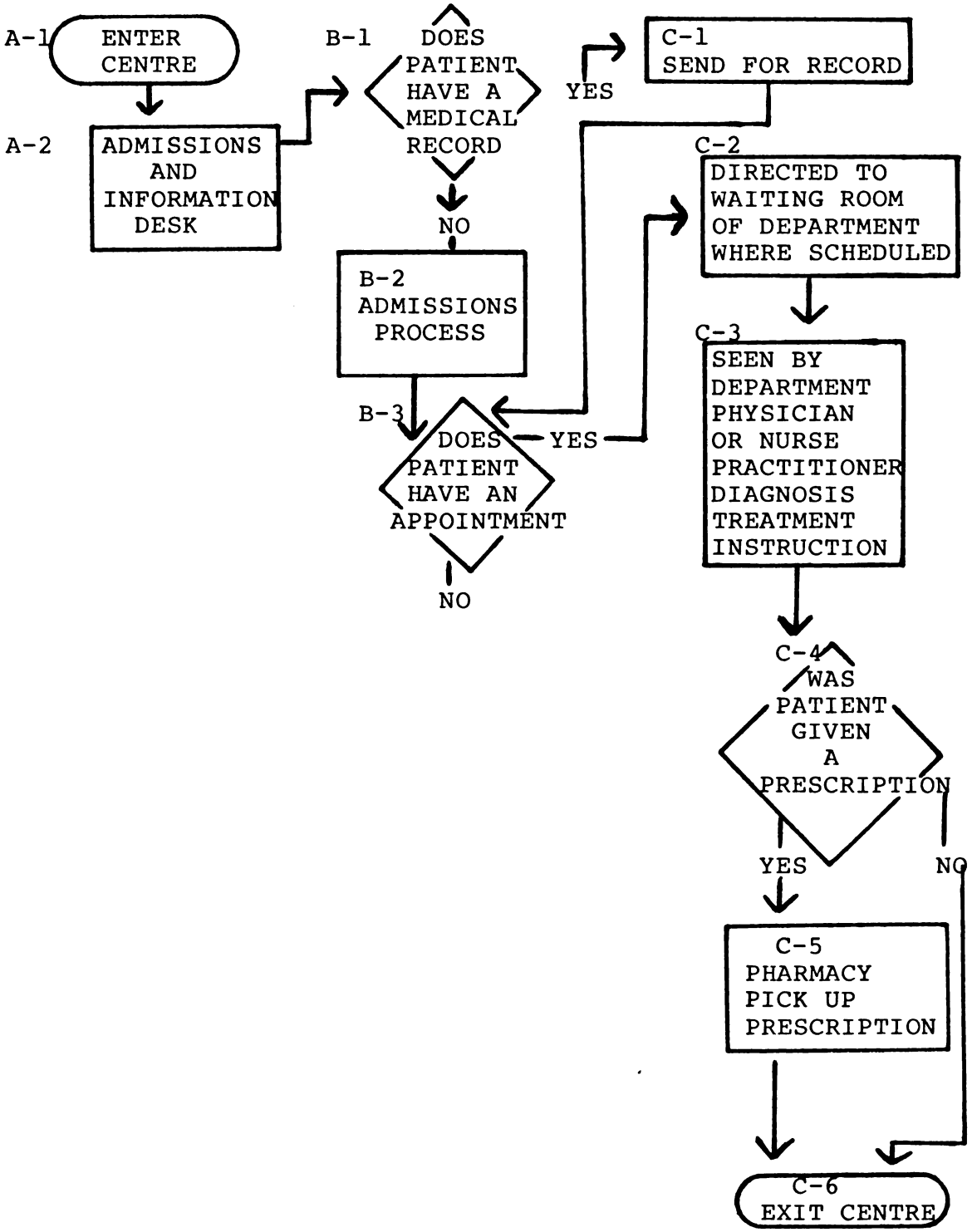


Figure 3. Path of patients through the system who have an appointment.



When the patient's problem is an emergency, as shown in Figure 1, the patient is taken or sent directly to a treatment room in the EOD and examined by the screening nurse. Any admission procedures, necessary for new patients, are carried out in the EOD at the most convenient point during or following the patient's care. When relatives accompany the patient, they may be asked to provide the information to complete the admission process with the exception of obtaining the patient's signature (see Figure 1).

The path of the patient who comes to the Centre without an appointment and a problem which is not an emergency is shown in Figure 2. The clerk first determines whether the patient has used the Centre before, and if so sends for his or her medical record. New patients must then provide the information to complete the admission process. The patient is then sent to EOD waiting room. When it is his or her turn, the screening nurse calls him or her to the screening room. She then must decide the most efficient way to meet the patient's needs. An old patient can sometimes be scheduled to be seen in the department where the patient is usually seen. If not, the screening nurse determines whether the nurse practitioner or the on-call physician should see the patient.

When the patient has arranged an appointment in advance, the admitting clerk first determines whether he or she has

previously used the Centre's services (see Figure 3). If this is the patient's first visit, the clerk carries out the admission procedures which require about twenty minutes. She then directs him or her to the department where the appointment has been scheduled.

Figures 2 and 3 do not adequately reflect the amount of time spent in the process of being admitted and waiting. Patients observed in the course of this study who came to the Centre with non-urgent problems and without an appointment rarely completed their visit to the Centre in less than two hours.

The screening nurse collects data from each patient about the reason for coming and determines which level of care provider should handle the patient's problem. Protocols exist to guide the screening nurse in deciding whether the patient should be seen by a physician or a nurse practitioner. After seeing the screening nurse, the patient usually was sent back to the EOD waiting room. The patient then had to wait his or her turn to see a physician or nurse practitioner.

Patients who remain in EOD were taken to a treatment room where a nurse practitioner introduced herself and questioned them to gather data for a health history relative to the chief concern. She then performed a physical examination which was limited to the parts of the patient's body involved in the health problem. When the examination

was completed, the nurse practitioner explained the findings to the patient and instructed him or her about treatment.

The NP treats the problem by direct means or the prescription of medication, and by teaching the patient how to care for the problem at home. Follow-up appointments were then arranged and the patient left the EOD. Patients then went to the pharmacy to obtain prescribed medication before leaving the Centre.

Patients entering the lobby of the Centre always looked very serious and were never observed smiling during any of the data collecting visits to the site. In contrast, staff members were often seen smiling and chatting as they entered or left the building. People who were new to the Centre were usually easily identified. They usually displayed signs of being disoriented and uncomfortable as they looked about the lobby.

The patients described below were observed as they entered the lobby, oriented themselves to the setting, and began the process of being admitted to obtain services at the Centre. The staff begins "seeing" patients at 9:00 A.M. with many of the staff arriving earlier than that to prepare for the day's work. The following patient was seen earlier because of the obvious urgency of his problem. He also had a communication deficit and was unable to ask many questions to resolve his own emergency or learn how to use the system. He had lost considerable hearing, and English was his second

language. Once he gained the Centre staff's attention to his emergency situation, he passively accepted what was done for him.

> (Centre lobby, 8:45 A.M.) Researcher notes an elderly man is having extreme difficulty parking his car in a fairly wide parking space. Gets out of his car, his left hand wrapped in a bloody kitchen towel (dripping). He has difficulty closing and locking his car door. He comes directly to the Information and Admissions desk. Two clerks immediately turn their attention to him. The older clerk begins to give the younger clerk instructions rapidly and then begins to speak to the man. The younger clerk following instructions is telephoning the EOD.
>
> Older Clerk: Oh! My! What's the trouble here, you must have cut yourself, eh?
>
> Patient: (Speaks in a very loud voice with a pronounced accent) I need doctor, I can't fix. (He is waving his injured hand and drops of blood seem to fly from the towel. He appears to be quite deaf).
>
> The clerk tells him she will take him directly to Emergency, but he must give her his cards. She repeats her instructions several times, each time in a louder voice as she recognizes the severity of his deafness.
>
> The screening nurse hurries from the Emergency and Outpatient Department and recognizing that he cannot hear her, points the way she wants him to go (into the Emergency and Outpatient Department).
>
> Patient: Tickets? Is you want my tickets? (He struggles to get his wallet from his coat pocket and hands it to the clerk. She takes out the appropriate cards and hands the wallet to the Screening Nurse).
>
> The Screening Nurse hurries the man into Emergency, calling back to the clerks that now that they know who he is would they please send for his chart and to please hurry. (Fieldnotes 12/13/84).

This patient is an old patient with past experience in using the Centre, but he allowed the staff to direct him

fairly completely. He was taken to the EOD where an NP sutured his lacerated hand after conferring with a physician.

A couple who are examples of people new to the setting are described in the following vignette.

> (Centre lobby, 9:00 A.M.)
> A young couple enter the lobby carrying an infant. They look around the entire lobby, read the signs on the Admissions and Information desk and walk toward the clerks. The young man tells the clerks he was a patient of the Centre as a child, but has been living in another city. He and his wife have moved back to Rapid City to live with his parents. His mother had called the Centre and arranged an appointment. While the mother holds the infant, one clerk obtains his identifying cards and fills out information forms. After all the forms are completed, the young couple is given directions to the appropriate department for services. The clerk tells them that they have to wait a bit because their appointment was "sort of squeezed in at the last moment." (Fieldnotes, 12/13/84).

The admission process took twenty-five minutes with the couple taking turns giving the clerk information and holding the infant.

Categories of Entrance Behaviors

Differences in "entering the Centre behaviors" vary according to whether the person is staff, an "old" patient or a "new" patient. Staff titles such as "doctor", "nurse practitioner", "nurse", and the term "patient" are role entities with hierachical status position within the Centre's social interaction structure. The two status positions in this system for people in the patient role are old and new. "Entering the Centre" behaviors easily

differentiate staff and other people (mostly patients).

1. Staff members: Most walk rapidly through the lobby ignoring the setting or anyone else in the lobby. Some carry an identifying lab coat. Some call out a greeting to people at either of the two service desks.

2. Other people (old and new) coming to the Centre for services: all walk more slowly and carefully scan the entire lobby upon entering the building.

Old patients: these are people who have previous experience in this setting. They look over the lobby and the people in it. They rarely refer to any of the directional signs. Some go to the Admissions and Appointments desk to confer with the staff member there. Others walk through the lobby apparently heading directly for the place where they will receive service.

Old patients form at least temporary relationships with other people, both staff and other patients, especially in the unit they customarily visit. They introduce one another to other patient acquaintances:

"This is M__ ____, she is seeing Dr. _____." They inquire about one another's health and discuss their families, jobs, movies, and television programs.

New patients to this setting: these people scan the whole lobby and other people in the lobby. They display anxious facial expressions and are the only people entering the building who read the more prominent signs (walking up very close to the sign to read them). If they arrive in pairs or trios, they often confer about the instructions displayed on the signs. Usually one person assumes a leadership role and leads the others over to the receptionist at the Appointments and Admissions desk. Some new patients never lose their newness status.

Self Disclosure

The admitting staff asked new patients many questions in order to record identifying data in medical records and determine sources of payment for the patients' care. When

the patient was seen by the care provider (physician or nurse) many more questions were asked in order to determine the nature of the problem.

Considerable data about the symptoms of the current health problem, previous health problems (as they may be related to the current problem), and ancestral health were required to synthesize diagnoses. The health care provider needs to ask a considerable number of questions to get at these data which are called the health history or the history of the chief complaint.

Few patients seemed to anticipate so many questions, many of a very personal nature about their finances (questions from the admitting clerk) and personal habits and everyday life (questions from the physician or nurse). Most patients seemed reticent to discuss these personal questions coming from the staff who are strangers to them.

The admissions clerk asked her questions in the lobby where there was little privacy. This seemed to create additional stress. Little threat seemed to arise from simply informing a clerk that one had an appointment with Dr. _____ in most cases. However, if Dr. _____ was a well-known psychiatrist or was known to treat diseases which have some negative social connotation, sharing such information publicly might be difficult.

Waiting

Almost every patient spends considerable time waiting. The process seems unavoidable because of the many people to be served and despite the staff's attempts to organize daily events to limit waiting as much as possible. The staff is aware that waiting is frustrating and stress-producing for patients. The process erodes more of the patients' independence because they are dependent on the staff to end the waiting.

Incongruence in Time Perception

There is some difference between the nurses' and patients' perception of the time spent waiting. In the patients' perception "nothing is happening" during "waiting". They experience a type of time dilation or expansion from lack of experiential events to break up the long time interval.

> Patient: There is nothing to do till they call you but worry. (Fieldnotes, 12/4/84).
>
> Patient: Waiting? Well, when nothing's happening I know it's not good for my blood pressure. (Fieldnotes, 1/3/85).
>
> Patient: Knowing that they're busy doesn't make the time go faster when nothing's happening. (Fieldnotes, 1/10/85).

From the staff's perception many things are happening at the same time. Time passes very quickly for the nurse because of the number of events the nurse experiences,

almost simultaneously, and from the number of details to which she must attend. A sort of time contraction is experienced by the nurse in contrast to the time expansion experienced by the patient.

> Screening nurse: We better go to lunch now. I don't know where the morning's gone. (Fieldnotes, 12/6/84).
>
> NP: Even on the worst day, it's five (o'clock) and the day's done before you know it. (Fieldnotes, (12/6/84).

The significance of time dilation may be greatest in its effects, much later, during last-minute teaching as the nurse-patient encounter comes to a close. The frustration of waiting may culminate in the patient having such a strong desire to "escape" that he or she cannot give full attention to essential tasks of learning self care. This was reflected by statements and questions by patients directed to the researcher after the encounter:

> When did she tell me that? (In response to a question in reference to understanding instructions). (Fieldnotes, 12/4/84).
>
> I don't remember how often she said to give it (medication) to him, but it'll be on the bottle, won't it, eh? (Fieldnotes, 2/5/85).
>
> She said next time I'm to see Dr. _____, I don't know what for. (Followed lengthy explanation by screening nurse about why patient was to see a certain physician on her next visit). (Fieldnotes, 3/7/85).

Nurses seem to have a reluctance to "let the patient go" until they feel comfortable that the patient understands

instructions. Thus, the last minutes seem precious to the nurse for emphasis and restatement of instructions. Waiting seems to have destroyed much of the value of the "last minutes" as a teachable moment.

The longest interval of waiting seemed to occur when patients were sent from the admissions desk to the department where they were to be seen. They were instructed to place their encounter form, which is a five- by eight-and-one-half inch card, in a marked wall-mounted holder in the department where they are to be seen.

Nurses periodically reviewed the accumulated cards in each department and called patients to the examining room in order of the time of their appointment. Exceptions based on urgency were made in the order of being called.

"Waiting" seems to be learned using the behavior of other patients as models for role forming. The need to maintain one's personal space and social distance while waiting seems fairly intense. This is most apparent in the consistent way in which patients seat themselves when arriving at a waiting room, and their behavior as the waiting room fills up or becomes crowded.

If the patient finds the waiting room contains few people and ample vacant seating, he or she takes a seat which leaves an empty chair between himself or herself and anyone else. The rare exceptions to this were observed to occur only when old patients encountered one another and

were well acquainted. Women sometimes pile the things they carry such as coats, purses, and shopping bags on an empty seat. Few men carried anything other than a coat which they either continued to wear or folded and placed across their knees.

As the empty seats were filled, an arriving patient usually performed an apologetic ritual before claiming an empty seat immediately next to a waiting patient.

Arriving patient: Is this seat (or chair) taken (or belong to someone)?

Seated patient: No, I don't think so.

The arriving patient then seated himself or herself, having performed the polite ritual.

Patients appeared more relaxed and were more liable to initiate brief conversations in a waiting room that was less crowded. In a waiting room in which more than half the seats were filled, people talked to one another less. Family groups seemed more restrained and tended to make more of an effort to keep children quiet.

The prohibition about intruding on the personal space of others also seems to include some taboo about looking at one another. In every waiting room most of these collections of strangers were observed sitting with their gaze at the wall in somewhat fixed fashion. This "fixedness" of gaze is only broken briefly to inspect newcomers, or to listen to a nurse entering the room to call the next patient.

Patients detest waiting but appear to accept it as unavoidable. It complicates the organization of meaning for them and for the health care provider. During interviews following their encounters with nurse practitioners, ten patients told the researcher that they had just remembered information that they felt they should have reported to the nurse practitioner. The researcher felt that the information remembered by three of these patients, during the follow-up interviews, was sufficiently important to recommend that the patients return to the EOD and report it.

These patients blamed the fatigue produced by waiting for disorganizing their thoughts and causing them to forget. Fatigue seemed more evident following appointments which occurred late in the morning or late afternoon.

> Post treatment interviews: 10:00 A.M.
> Mother of patient: I forgot to tell her (the nurse practitioner) that he (her son) did have a rash like this (pause) maybe two or three years ago. I guess I ought to write things down. We waited almost an hour, I think that's what makes people forget.
> (Fieldnotes, 12/4/84).
>
> 4:00 P.M.
> Patient: I forgot to tell her I had a headache before I vomited. (Fieldnotes, 12/4/84).
>
> 1:00 P.M.
> Patient: You know I forgot till now, I took that kind before (birth control pill). It didn't work (prevent breakthrough bleeding during cycle). I think I ought to tell her to change it, don't you?
> (Fieldnotes, 12/13/84).

Patient's Experience in EOD

Waiting ends in the EOD waiting room when the nurse or registered nursing assistant retrieves the patient's card from a wall-mounted holder and calls the patient's name. The patient is usually taken to the screening room.

The daily staffing of the EOD during the period of data gathering consisted of one to two nurse practitioners, a screening nurse, and a Registered Nursing Assistant (RNA). While the on-call physician was considered a member of the unit, he or she was rarely physically present in the unit and was not treated as being an actual member of the EOD by the nurses or the RNA.

Most patients sent to this unit from admissions were "walk-ins" (without appointments) though some patients came for appointments specifically arranged for them to be seen in the EOD. Their problems were seldom of immediate life threat, but were usually of sufficient urgency to need attention that day.

Most of the patients using the unit had acute self-limiting problems. Some physicians scheduled patients to see the NPs (nurse practitioners) in the EOD when they knew they themselves would be away from the Centre. A few patients were scheduled to a treatment room in the unit for monitoring of the progress of previously diagnosed conditions (e.g., a patient with hypertension might be seen in the EOD to have his or her blood pressure taken, heart

and breath sounds checked, and to be examined for edema). Changes in blood pressure, heart sounds, and breath sounds, or the appearance of edema often mean that the hypertension condition has deteriorated into some degree of congestive heart failure.

Four patients reported that they had asked to be seen in the EOD because diagnosis and treatment were sometimes speedier than in other departments. Two had learned about the unit from other patients, while two others reported they learned about EOD services as walk-ins on an earlier visit to the Centre.

The following vignette describes an example of a walk-in patient who appeared to be suffering from a serious problem. The patient was a young man in his late teens and had been waiting about thirty minutes when the screening nurse called his name. He had appeared restless, frequently moving about in his chair and rolling and unrolling a magazine with his hands throughout the wait. The screening nurse led him into the screening room.

Screening nurse: Danny, I've seen you before, haven't I? What's the trouble today?

Patient: I was here about this burnin' in my stomach. A lady upstairs gave me some white stuff to take. I got this burnin' again.

Nurse: Didn't she give you a prescription besides the sample of that white stuff?

Patient: Well, yeh!, But I got better when I took the stuff and I lost it.

Nurse: Lost it, the prescription you mean?

Patient: Yeh, lost it some 'eres in the house. But I didn't need it till I got the burnin' back.

Nurse: Are you having any burning in your stomach right now?

Patient: No! But it hurt some this morning.

Observer note: At this point, the RNA (Registered Nursing Assistant) knocked at the door and handed the nurse Danny's chart. The Nurse excused herself to read over the chart.

Nurse: Danny, I read here you were to come back two weeks ago to see Dr._____ and have some tests?

Danny: A X-ray of my stomach, I guess, but I was better after that.
(Fieldnotes, 2/2/85).

The nurse began to take a careful history of the location, severity, timing, and other factors associated with a burning pain in the upper abdomen. A considerable portion of the time was used by the nurse to develop a clear understanding of the quality, quantity, and timing of the discomfort to support or disconfirm a tentative medical diagnosis. Though an old patient, Danny had not learned how to share information in a way useful to the nurse and himself working as a team on his health problem.

One of the most important functions of the nurse-patient encounter is the clarification of verbal symbols so that the two participants understand what meaning each gives to a particular word. The nurses and NPs in the unit seemed fairly skilled, most of the time, in getting patients to clarify what they meant.

Nurse: You call it a burning feeling?-- (pauses as if to encourage Danny to clarify the word "burning").

Nurse: Danny, you said the pain woke you up, about what time of the night was that, eh?

Nurse: Danny, how soon after breakfast did the pain come back?
(Fieldnotes, 2/2/85).

The nurse then took the patient's blood pressure.

The nurse excused herself and left the room. The researcher followed her. She expressed a concern to the researcher and an NP in the nursing station that she felt that Danny's symptoms were serious. She said she would prefer to have X-rays done of his stomach today, but that he had not had proper preparation for such a test. She said that she was concerned that Danny is seeking only immediate relief and would put off any tests or further treatment unless his symptoms returned to bother him again. His condition might become dangerous.

The nurse phoned the Internal Medicine Department and described her patient's problem to a nurse there. The nurses both felt that Danny had a probable peptic ulcer with active bleeding. The Internal Medicine Department nurse told the EOD nurse that she would get one of the physicians from Internal Medicine to call or visit EOD right away.

An Internal Medicine Department physician phoned the screening room and the nurse reported data from the history of the patient, from the chart, and the symptoms Danny had reported that morning. Danny was sitting on the examining

room table during this phone conversation and appeared to be listening intently. He appeared very restless and a little frightened. During one pause in the phone conversation he told the nurse he could come back another day. He did not think his "stomach trouble was any big problem."

The decision of the physician and nurse was to get some tests done that day and have Danny return the next day to complete them. The Nurse was to send Danny to Internal Medicine to be seen immediately by the physician. Danny told the researcher, "I ain't got time for all this."

The nurse and physician seemed very concerned that Danny would not return for the treatment he needed. In fact, they were afraid that they would not see him again until the problem bothered him again. They planned together to exert as much persuasion upon Danny as possible to get him to return for the full series of X-rays and full treatment.

Nurse: Danny, the doctor and I have been talking.

Danny: Well, do I have to really take the tests today, I'm real busy? a-a-ah...

Nurse: (Interrupting) Danny, this just doesn't seem like a little problem, eh? The Doctor thinks this could be a bleeding ulcer. It's just too dangerous to go around with, eh?

Danny: Yeh? Well, they said that before. (His expression is angry).

Observer note: Danny appeared very uncomfortable at this point. He appeared to want just to get some medication and get away from the Centre.

Throughout the duration of the encounter, Danny acted as if the nurse's valuing immediate treatment was correct, but still that he would have preferred to put off having anything more done. He made excuses (e.g., "being very busy") instead of stating his own desires, expressing his fears, or expressing his own health beliefs about the urgency of the problem. The physician and the nurse had developed meaning from Danny's data that Danny's problem was serious and that Danny quite possibly did not understand the danger or was psychologically denying the danger.

The researcher saw Danny later waiting in the hallway outside of the crowded waiting room of Internal Medicine. He said that he had had some blood drawn, and was waiting for the Doctor to talk to him about the results of the tests. He looked tense and a little angry.

> Danny: Once you (nurses) get hold of a guy you don't let him get away. I figured on about half an hour, no more, in 'is place.

The patient's comments clearly associated the researcher with the staff. He appeared to accept reluctantly the attempt by the care-providing staff to control his behavior. He did not leave the Centre, though no one could have stopped him if he had chosen to do so.

There appears to be a strong valuing of control over the patient among members of the health care professions. Society seems to accept overt control of the patient by the health care professional within the boundaries of the health

care facility. This probably evolved out of the necessity to achieve a good outcome for patients whose fears or conflicting health beliefs would interfere with the achievement of the desired outcomes.

An example of the staff acting on its concerns by attempting to control the patient's behavior is demonstrated in the following vignette. The patient, a middle-aged man, had been told by his physician to have his blood pressure checked in the EOD while the physician was away at a conference.

> The nurse addressed the patient by his first name, demonstrating that they knew one another.
>
> Nurse: J___, what's the problem today, or did you just come over to keep me company?
>
> Patient: Dr. _____ wants me to get my BP checked. He's off at that conference, eh?
>
> Nurse: Sit up there on the table, J___. What medicine are you taking?
>
> Patient: I'm taking _____ and _____ (names of antihypertensive medications), the doctor reduced the dose of the one.
>
> Nurse: (While fitting the blood pressure cuff on his arm) How high has it been running?
>
> Patient: Well, up and down, I guess.
>
> Nurse: It's 160 over 100 now, has it been that high?
>
> Patient: I don't think it was that high last time, but the time before I think maybe it was.
>
> (Fieldnotes, 1/4/85).

The nurse excused herself and went out of the room to the nursing station to find the patient's chart. She expressed

concern to the researcher that this patient's physician was out of town and she felt uneasy about his problem going unattended over the weekend. She said, "His Doc really gets upset if I have him seen by another doctor."

She conferred with one of the NPs about what to do for the man. She and the NP then stepped into the next unit to talk to the most senior member of the medical staff who seemed more comfortable about working with nurse practitioners than some physicians. Physicians were very careful about interfering with another physician's case. He listened to their data and concerns and suggested a best way to proceed. The screening nurse then returned to the patient and instructed him how to take his medication over the weekend. She also insisted that he come in to see the on-call NP during the weekend to get his blood pressure rechecked. She told him, "Call me at home if you have any problems. I gave my phone number to you before, didn't I?"

The nurse expressed concern about the man as she continued with other patients. A little later she commented to the researcher, "He lives near my house - I may just drop by and see how he's doing, eh?" (Possibly asking the researcher for assurance that she had done everything possible).

This patient had sat quietly throughout the examination and subsequent instructions. He appeared mildly concerned in the examining room but told the researcher afterward that

he was very worried about his blood pressure and had not been feeling well before his last visit to his physician. He stated that he was thankful that the staff seemed to care. "The're good people, eh! to worry about me." The referring physician, screening nurse, and patient seemed to have come to the same conclusion that the patient's blood pressure was not well controlled and might indicate some danger. Individually, they had constructed meanings from his reported experience and the objective data which were in agreement about the danger.

On another occasion, the same nurse was heard talking to a patient she later described as an elderly woman who lived alone. She promised the patient she would stop by and see her that evening. The nurses in the EOD seemed to assume more personal responsibility for the patient, such as arranging to make a personal home visit or making follow-up phone calls to patients than other staff nurses. Staff are not paid to make home visits except under certain conditions (physician's prescription).

Staff nurses and NPs in the unit were very concerned about their patients and seemed to spend considerable time discussing ways to extend their protection of the patient outside of the Centre. Home visiting was one way to achieve this. Some old patients find such concern helpful. Others, knowing that the nurses in the unit would attempt to extend their protective control into their lives outside the

Centre, gave verbal responses in such a way to head off such interference. When a patient was worried about an injury or out-of-control blood pressure, he or she welcomed the nurse's personal interest.

Since patients also identified the researcher as a nurse, they probably shaped their responses to the researcher's questions following service in the EOD according to their feelings about the EOD nurses efforts to be protective.

Some experienced patients request services in EOD in order to expedite getting treatment without waiting to see a physician. A working mother with three sick children and her sister (who was their babysitter) attempted to use the unit in this way one morning. The Screening Nurse tried to help her in this expediting process, but ran into the problem that the children's pediatrician refused to have any of his patients seen by an NP.

The nurse called the family into the screening room and the mother immediately lifted the oldest child up on the exam table without waiting to be told. She then sat down in one of the chairs holding the youngest child. The middle child stood at her side.

Nurse: Mrs._____, what seems to be the trouble today?

Mother: We've the Strep again, I think. We had it when we moved last time and now it's back. (Pointing to child sitting on the exam table) He's the worse. Ran a fever last night and vomited his supper and breakfast.

You know the nurse practitioner is seeing my sister down the hall. She's their babysitter and she's got it too.

Nurse: Who is your regular Doctor, Mrs._____?

Mother: Dr. _____ sees the kids. (Fieldnotes, 2/6/85).

The nurse put thermometers in the two older children's mouths and explained that she would take the temperature of the youngest later. She collected some further health history data and then read the thermometers. The temperatures of both children were elevated. She then excused herself to go out to the nurse's station. The nurse told the researcher:

> This case fits the Nurse Practitioner's protocols. But, that doc won't let them (the NPs) see his patients. The trouble is, he doesn't trust many of the other docs, either. I am afraid the doc on-call won't see Doctor _____'s patients. With him gone today, and the place going crazy like this, I don't know who I'll get to see these kids.

She consulted one of the nurse practitioners explaining her problem. The NP was sympathetic, but said she could not touch Doctor_____'s cases. The nurse contacted the on-call physician by telephone to explain the problem. He apparently was also uncomfortable about seeing the children, but finally agreed that it was the only solution.

When the mother was told she was to take the children to the on-call physician's office, she said to the researcher in a very resigned way, "Well, here goes my

morning and another day of work." When asked if there were any other advantages to seeing the nurse practitioner, she said:

> Well yes, they are very thorough and they explain everything really well, eh? When the doctors explain things they aren't so careful to see I understand. I'm no dummy, but some of this is not simple. You need to ask more questions about what they tell you, but most of the doctors don't have time, somehow. The nurse practitioners take the time, eh?

The Nurse Practitioner came into the hallway at that time. "Mrs._____, I feel really badly about not being able to help, but well--" she said, and was interrupted by the mother, "That's O.K. He's such a good doctor, but I just don't understand why he won't let us see you people (nurse practitioners). He has to be gone away so much, eh?" Other physicians "share" a patient with NPs or nurses much more readily. The unit is a convenient place for the second stage of treatments of some conditions initiated in the physician's office or a hospital emergency room.

One morning, the Screening Nurse entered the waiting room to call her next patient and found a young man with his foot resting on the coffee table. He had propped a pair of crutches against the wall. She asked, "Are you Mr. _____?" When he nodded, she asked him to follow her.

He stood up, recovered his crutches and limped to the screening room with apparent discomfort. She explained my presence and the proper "permissions to observe" procedures were performed.

Nurse: What seems to be the trouble today?

Patient: I've broken my foot, and I'm supposed to meet Dr.____ here today to have a cast put on it.

Nurse: Oh, how did you do that, eh?

Patient: I dropped a boat motor on it.

Nurse: My, when did this happen, it looks quite swollen?

Patient: It happened Tuesday (three days previously). (Fieldnotes, 3/1/85).

The nurse helped the patient place his foot in a more comfortable position and gently palpated the degree of swelling.

Injuries of this type swell so rapidly immediately after the trauma that they are usually treated conservatively (i.e., aggressive intervention such as a cast or surgery is avoided at this time) to reduce the swelling (cold applications, pain medication, and elevation of the part) for a few days before any attempt is made to apply a cast. A cast, applied too soon, would seriously impair blood circulation in the foot.

This was the first experience this patient had with the Centre. He asked how he should arrange to pay for his care and the nurse spent considerable time explaining how the centre arranged financing through a combination of the provincial health plan and some contribution from him. Nurses are not usually expected to explain health financing to patients except in the home nursing services. Patients,

however, frequently request this kind of information from nurses in many kinds of settings. Patients often give precedence to establishing how and to whom services will be billed. Obtaining treatment is assigned second priority.

The nurse then telephoned the doctor's department and discussed the condition of the patient's foot with an NP who normally worked with patient's physician. The amount of the swelling remaining in the patient's foot seemed excessive for the application of a cast and she relayed this data to the NP on the telephone. She led the patient to one of the treatment rooms and asked one of the NPs to look at it.

The EOD Patient in the Treatment Room

More telephone conversations followed the NP's examination concluding with the decision to delay casting the foot until the next week.

NP: I'm sorry we're holding you up so long this morning. I'm sure you thought you'd be farther along with it than this.

Patient: That's OK. I wondered myself how a cast was going to feel with it swelled up like that.

The NP then asked him if he had noticed that some of the swelling had gone down in the short time he had been resting on the examining table with the foot in a more elevated position. He agreed that the swelling was less and the foot was more comfortable. The NP then spent about 20 minutes discussing what makes tissue swell.

This seemed to be a very effective teaching method. She guided the patient in using his own experience and observations in learning how to get the swelling reduced and keeping it down. They spent considerable time discussing what physical activities he planned to undertake between this visit and his next appointment. She then told him how these activities were most likely to affect the swelling in his foot and how he could manage the swelling and improve his own comfort.

A second example of how the nurse practitioners in the EOD collected data and processed it into meaning is demonstrated in the following vignette. The patient was a child accompanied by his mother. His chief complaint was a rash. The nurse practitioner introduced herself and explained her role before beginning to question the mother about the boy's symptoms or to examine him. The nurse in the screening room had already explained who the nurse practitioner was to the mother.

The differential diagnosis of skin lesions is generally conceded to be one of the most difficult diagnoses for any health care provider. The NP worked through her "seven variables", carefully asking and restating her questions on two points repeatedly: possible allergies and the effects of the ointment. She carefully reviewed the boy's history for any evidence of allergies. The second question was

about an ointment the mother had used which she said, "made it better, but didn't 'cure' it."

NP: You are sure he doesn't have any allergies?

Mother: No, he isn't allergic that I know of.

NP: You say he has never broken out in a rash from any medicine or food, that you know of, eh?

Mother: No, he never has had anything like that, just the usual stuff.

NP: But, I think you said he had had a rash before?

Mother Yes, he did break out in a rash, from something, I think.

NP: Has he ever been given Penicillin?

Mother: Oh!, you know I think he's allergic to Penicillin. Dr._____'s nurse, downtown, could tell you about that.

Patients often forgot very significant events in their health history and the NPs and nurses were very careful in questioning about such things as a history of allergic response to avoid precipitating a possibly fatal reaction from a new prescription. Questions concerning allergies were asked by each care provider in contact with the patient They repeated and restated questions about allergies several times to avoid overlooking clues to a forgotten incident involving allergies.

NP: His chart doesn't show any history of allergies. Has he never had the hives or hay fever, eh?

Mother: No, he's never had a thing like that.

NP: Anyone else in the family have allergies?

Mother: No - - well, his father may have something like hay fever.

The nurse practitioner turned to the researcher and said:

I don't usually pick at a thing like this, but I try to be very careful about allergies. And somehow rashes make me feel I ought to be extra careful, eh?

NP: This is an antibiotic ointment (looking at a tube of ointment brought by the mother). You say this 'made it better', eh?

Mother: Oh!, a lot better, but it didn't go away.

NP: The rash? (looking at mother expectantly).

Mother: What?

NP: You said this ointment makes the rash better, but the rash didn't go away, yes?

Mother: Well, it looked better, all the dried scaly stuff fell off.
(Fieldnotes, 1/17/85).

The NP had finally identified what the mother meant by the rash looking better.

She explained to the mother that the greasy base in the medication, not the antibiotic in the ointment, had softened the scales formed by the rash in such a way that the scales fell off. She explained that the ointment really was of no effect in healing the rash, and explained further the steps she planned to take to identify the cause of the rash. The nurse practitioner was fairly certain that the rash was a combination of causative factors. An allergic

response often occurs in combination with fungus infections which confuses diagnosis. This latter proved to be the case.

Another example of the exchanging and processing of information is demonstrated by the following case. This patient was a child of about five years of age suffering from a rash on the face. Mother and child were taken from the EOD waiting room to the examining room by the RNA (registered nursing assistant). The nurse practitioner entered the examining room, followed by the researcher. The NP made introductions, quickly began looking over the child's facial lesions while she simultaneously questioned the mother:

NP: (Addressing mother) What have we here, a pretty bad rash, eh? How long has he had this?

Mother: It must be about two weeks. It started with just one spot.

NP: Looks like an infection, that's pus (indicates some lesions with obvious pustules). (Fieldnotes, 12/13/84).

The NP asked several questions to develop a history and, using a sterile swab, collected samples of pus. She then excused herself and left the room followed by the researcher. The screening nurse and RNA were sitting at the station. The RNA was charting, while the nurse had just completed a telephone conversation.

Nurse: (Speaking to NP) Is that impetigo on that child's face?

NP: Can't be anything else. He's even got it up in his nose.

The NP conferred with a physician by phone about the child's rash, describing the lesions and the history of the rash related by the mother. The physician apparently gave her several medical orders by phone. She then returned to the examining room.

NP: I've talked to Dr._____, about Tommy's rash, eh? We are going to have to give him an antibiotic to take and some ointment to put on it.

Mother: Is this impetigo?

NP: Yes it is. Impetigo is pretty serious. If we don't clear it up right away it can lead to some pretty serious problems.

Mother: I thought at first it was chicken pox, but my Mum says it was impetigo.

The NP questioned the mother again for any individual or family history of allergy. She then explained the cause of impetigo and instructed the mother how to give the antibiotic and care for the rash using the prescribed ointment. She also explained that untreated or inadequately treated impetigo can lead to an internal infection which damages vital organs. The mother seemed to accept the seriousness of the problem. She told the NP:

Mother: I didn't know impetigo was that bad, I thought people worried about it just because it's supposed to be contagious, eh?

The NP then arranged follow-up visits to monitor the child's recovery. She told the researcher:

> I am always surprised to hear these mums say they don't know impetigo is dangerous. I keep thinking that they'd have read or heard about it before they get here.

The following example also demonstrates the exchange and processing of information. The patient was a man, aged thirty-five, who had become ill at work. He complained of pain in his upper abdomen. He told the NP he had experienced similar pain several times, but that it was more severe during this incident.

NP: Are you in pain now?

Patient: No, I drank some milk, it made it better, but then I threw up. It's just a sore feeling down there now.

NP: Was there blood in what you vomited up?

Patient: Maybe. I don't really know, I don't think I looked. I think I would have noticed if there was, eh?
(Fieldnotes, 1/10/85).

The NP questioned the patient carefully about previous incidents of the pain. She explained to the patient that she suspected some form of ulcer of his stomach. In response to her questions, the patient told her he had been under considerable pressure on his job. He also told her he was Italian and loved spicy Italian food which he ate everyday. He also said he made his own wine.

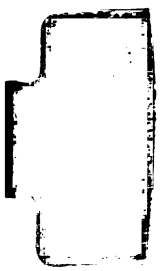
The NP arranged an immediate series of X-rays of the patient's gastrointestinal tract and laboratory blood tests. Once the patient was on his way to X-ray, she notified the

on-call physician and reported the data she had collected as well as the action she had taken. The physician told her to let him know the results of the X-rays and blood tests as soon as possible. The data from these procedures would determine whether the patient would need to be admitted to hospital, or could care for himself at home. The patient told the researcher he was worried. Interviewed briefly while waiting for X-rays, he told the researcher:

> The first few times I had the pain I was really worried. I didn't know---could be my heart, eh? I kept hoping it wouldn't come back. When it did and got worse, I tried cutting down on spicy foods. That's death to an Italian. My mother was really upset. I never get drunk, but we have homemade wine everyday. I cut down on that too. Anyways, I figure they can cure an ulcer. It couldn't be a cancer, could it?
>
> The researcher replied that the commonest cause of such symptoms was an ulcer, but that the possibility of cancer should also be ruled out. The tests he was to have would help explain the nature of his problem.

The patient was found to be suffering from extensive duodenal ulcer. The physician decided to treat the patient at home with medication, diet, and rest. Follow-up visits were scheduled in such a way that the patient could be monitored closely.

The effect of conflicting health beliefs on the process and outcomes of the nurse practitioner's care is demonstrated by the following case. A mother brought her ten-year-old daughter to the Centre at the recommendation of the child's teacher. The child had apparently made frequent



requests to go to the bathroom and when questioned she had told the teacher that "making water" burned (a burning sensation accompanied the process of urination).

NP: (addressing the mother) How long has she been having this problem Mrs._____?

Mother: I don't know. (Turns to the child and addresses her) How long has it hurt to go pee pee?

Child ducked her head and hid her face in her mother's lap. The mother urged her to tell the nurse.

Child: I don't know.

NP: Did going pee pee hurt you today?

Child: I guess so.

The NP tried clarifying the length of time the problem had existed and the severity without result. She instructed the mother in obtaining a urine specimen from the child to be examined for signs of infection and led the mother and daughter to the EOD restroom.

Later the same day, the researcher encountered the mother and child in the EOD waiting room. The mother said they were waiting for prescriptions. She told the researcher that the nurses kept telling her how important it was to return for follow-up appointments. She said, "Don't they trust me, eh? I know how to take care of her (her daughter)!"

Later the researcher encountered the mother and daughter again on their way out of the building.

Researcher: Is everything OK now?

Mother: Yes, we have to come back in a week.

Researcher: Did you get your prescriptions filled yet?

Mother: Well no, I couldn't find the drugstore, you know?

Researcher: I think those medications are pretty important. Let me show you where the pharmacy is here in the building, O.K.?

The researcher escorted the mother and daughter to the Centre's pharmacy. The mother told the researcher that she had not thought there was any hurry to get the medication. She said, "Kids get these things. They just go away, don't they?" Her question raised the ethical problem of the researcher being unable to ignore the urgency of this mother being warned not to ignore a serious health problem. The researcher essentially repeated the same information the mother had just received in the EOD. This participation by the researcher could not be avoided for legal and ethical reasons.

Later when the researcher had informed the NP in EOD about the incident with the mother in the Centre pharmacy, she said, "It really scares me to think she doesn't take this seriously. I am afraid she won't bring her daughter back either." Her assumptions proved to be correct in reference to this illness. Several months later (while this study was still in progress) the mother did return with

her daughter. The child was suffering a recurrence of the symptoms and was diagnosed as still suffering from the previous infection.

This incident clearly demonstrates a conflict in health beliefs. The mother's perception of the danger was certainly less than that of the nurse. The danger had actually increased because recurrence of the symptoms adds to the possibility of extension of the infection from the bladder to other organs. The nurses were visibly upset by the failure of their teaching. The nurse practitioner referred the mother and daughter to a physician for the second incident of infection as required by their protocols.

By the time patients seek professional help for their signs and symptoms they have already tried to diagnose their own problem. Sometimes they try home remedies or medications sold over the counter. If the medication provides relief they assume that their self diagnosis has been correct. If the medication does not relieve the problem, or the relief is only temporary, they either try some other remedy or seek professional help.

Patient informants thus demonstrated attempts to make sense out of the experience of illness in this process of self diagnosis. The use of self-selected remedies provided the crude means of testing their diagnosis.

> Patient's parent: I thought it (a rash) must be some kind of infection she got at school, but

the antibiotic ointment I tried on her isn't working. So I guess it's not an infection. (Fieldnotes, 2/5/85).

Patient: I tried douches but it still burns when I go. So I think maybe something's wrong with my kidneys? (Fieldnotes 12/7/84).

Patient: I tried _____ (a brand of antacid sold over the counter) but it only works a while. Do you have something stronger you can give me? (Fieldnotes, 2/1/85).

Some patients told the researcher that they thought through what and how to tell the nurse when she called them into the screening or treatment room. However, one patient told the researcher:

Patient: Ever since I became a Mom I know they are going to ask lots of questions, eh? And I always forget to ask something important.

Researcher: How about writing some of your questions down, then you'd not forget.

Patient: Tried that too, it didn't work.

Researcher: What went wrong?

Patient: The doctor and nurse never gave me time and I was so tired when they were done I just wanted to get out of there and get home. So I just went home and let it go.

Researcher: I believe you said that you visit several departments in this Centre?

Patient: Well, I take the kids to Dr._____ and I go to Dr._____, he delivered the kids. When I'm in a hurry I try to get us seen in here (EOD).

Researcher: Is one department any better at answering your questions than another?

Patient: Well Dr._____ tells you everything but doesn't explain it. With the kids' allergies things get pretty technical. S_____ (uses first name of the screening nurse) is real good, but there's so much to learn.

> Dr._____ (pediatrician) gets so mad, he blames me if the kids get sick.
> These people forget how technical all this is with kids that are allergic.
> You know my dad, my uncles, my brothers, all work the hearths (steel furnaces). There's a lot to know about those hearths. But you'd have a time eh? All those technical words. Well, it's the same for me when I come here, eh? (Fieldnotes, 3/1/85).

Patients complained that physicians, nurses, and other staff often did not explain what was meant by certain technical language. More urgently, the patient needs to create a personal meaning out of what the Centre staff is saying and doing in order to understand what is happening to his or her personal health. In addition, the patient often expressed fears about what the present health problem meant to his or her future health. Patients also said that there was too much to remember, though many said they were given pamphlets or written instructions which were helpful.

One mother said:

> Now I really know about ears. The nurse practitioner explained ears, Dr._____ explained ears, and best of all the NP gave me a booklet. But what I can't get yet is shots. They tell me and tell me, but I can't get the right of it. And neither one of the booklets on that helped.

Another mother listening to the above interview added:

> Or allergies, I have read everything they give me, everything in the library and we still have got problems. (Fieldnotes 3/7/84).

Several patients said pamphlets were helpful. Another said she got the most help understanding her high blood pressure

from an article in Chatelaine magazine (a popular Canadian publication for women).

The patient informants often asked the researcher, "What did she mean by that?" following their sessions with the nurse. The researcher responded to such requests by having the patients restate what they thought they had heard the nurse say, and answered questions as briefly as possible. Three times it was necessary to send patients back for clarification of information from the NPs in EOD.

Patients' unresolved questions were of benefit to this research because those patients with such questions seemed more motivated to give follow-up interviews. The researcher limited participation as much as possible.

The patients' problems were one of conforming to the expectations (customs) of the Centre with insufficient previous life experiences from which learning could be transferred. New patients were forced to divide their attention between the health problem bringing them to seek help at the Centre and the need to listen and observe closely to learn what they were expected to do. Also, many patients seemed to need to hide their newness in the Centre system. They seemed to have a strong need to be able to conform and to avoid looking as if they did not know what to do or appearing out of place. Patients frequently apologized for being new and not understanding how to carry

out an instruction such as how to void in a cup in a specific way to provide a "clean catch urine specimen".

The patient's complex problem was composed of several factors:

1. Visits to health care facilities are not a customary normal daily activity for the average person.
2. The person's primary concern was focused on an alteration or threat to his or her health which aroused some fears.
3. The patient seemed to want to appear as if he or she knew what to do and was not new.
4. The patient was moved firmly and politely, but expeditiously through the system by being told rather than taught what to do.
5. During the admission or appointment making process, the patient surrendered considerable personal control of his or her body and behaviors to another person (usually a stranger).
6. A teaching plan is lacking to teach the patient how to function in the setting. Patients were often told more than they could remember at one time.
7. Nurses attempted to assist patients in learning biomedical <u>meanings</u> in terms of current and future health implications of the the illness they

experienced. Prevention of complications was stressed.

At the point in the process when they met the staff of the Emergency and Outpatient Department, new patients had learned to function in the system by following directions or using old patients as role models. When the nurse, usually the screening nurse, summoned them to the treatment room used for screening they received their first real orientation. She described the sequence of events they would experience during examination, diagnostic tests and treatments.

The screening nurse's actions during encounters fell into distinct categories:

1. introducing self and allaying anxiety
2. describing her role and function in determining the best way to approach their specific problem
3. eliciting a history of the chief complaint, some background information about the problem, and a partial physical assessment directly related to the chief complaint

New patients said they felt very comfortable with the screening nurse. They said she was the first person they had encountered in the Centre who made them feel more at home and that she allayed many of their anxieties. Old patients frequently compared the screening nurse and the

nurse practitioners to other nurses with whom they had experience at the Centre or elsewhere.

> Other nurses don't seem to listen to a patient very much. (Fieldnotes, 3/14/85).
>
> With a lot of the other nurses I never know how much they know about what's wrong with me. (Fieldnotes, 3/14/85).
>
> Other nurses just go about what they have to do. They talk to you, or tell you what to do, but leave the important stuff to the doctor. (Fieldnotes, 12/6/84).
>
> My doctor's nurse is real nice, but you always feel you are taking up her time and the doctor's time. I know when I've been with my doctor too long because she starts watching her watch. (Fieldnotes, 1/19/85).

Most of the new patients reported that they had never had any experience with a nurse practitioner prior to the encounter just preceding the interview with the researcher. The screening nurse questioned some of the new patients concerning previous experience with nurse practitioners. She then oriented them to what they could expect of a nurse in this rather new role. Others were sent to be seen by a nurse practitioner without any such anticipatory preparation.

Most new patients said they did not experience any anxiety about being treated by a nurse practitioner rather than a physician. Three reported, however, that their first reaction was one of frustration. They "went along" with the idea because it would "get me out faster." These three patients felt that their being sent to a nurse practitioner

rather that a physician might indicate that the screening nurse considered their symptoms somewhat less urgent or important.

All three,however, reported favorably about the experience with the NP:

> She was very good (said the first informant). She listened to me, and asked me questions. I always feel so stupid talking to my doctor. I always have trouble answering his questions, and he turns away from me halfway through my answer. (Fieldnotes, 12/6/84).

> Well, I just figured, what the hell, eh?. I didn't want to be here all day and she (the screening nurse) said I'd be in and out faster this way. Yeh, I figured this was kind a second-class treatment. But, that nurse practitioner was real thorough, and I figure now that it was as good as I'd get from my doc, for sure. Like I told you before, my doctor's sick and his office nurse suggested I try here. (Her family physician does not have an office in the Centre). (Fieldnotes, 12/6/84).

> I didn't much like the idea of my kid just being seen by a nurse if she turned out like other nurses we've been to. But, I figured that the screening nurse was sure different, so maybe her advice about seeing a nurse practitioner was going to turn out OK. (Fieldnotes, date unrecorded).

The structure of the conversational encounter between the screening nurse and the patient was controlled by the nurse. She controlled subject content and turn taking. She exerted few limitations on the length of patient responses, however. The screening nurse was never observed interrupting the patient's response verbally or through her body language.

Interruptions were always from someone who was external to the encounter. The telephone interrupted many interviews.

Nurses always gave patients the opportunity to continue their part of the conversation after the interruptions. When an intrusion became necessary the intruding staff member would first apologize to the patient, and then deliver the message causing the interruption.

> RNA enters after tapping on Screening Room door.
>
> I am sorry (addressing patient and then turning to face screening nurse) but the nurse from _____Health Unit (local health department) is on the phone about that problem you wanted to talk with them about. She really insists on speaking to you at once, eh?
>
> RNA: (to the patient) I'm sorry but _____ (NP) has a bad problem in Room 3. She needs help right now!

On several occasions the nurses were observed going through a small stack of messages about telephone calls they had received while they were with a patient. NPs and the screening nurse told the researcher that they usually did not intrude on their team member when they were with a patient. Exceptions were made when the message was urgent or the recipient had warned co-workers of an expected call and left special instructions about it.

Control of turn-taking in the interaction was signaled by the screening nurse through

1. completion of a question statement, stopping speech, looking directly at the patient and waiting for the patient to respond.

> (Speaking to a parent in reference to her four-year-old child) When was the last time he had this same kind of ear infection? (Pauses and waits for response). (Fieldnotes, 12/6/84).

2. repeating significant words in the patient's response and ending the statement with a tone of inquiry. This invited the patient to confirm or expand on their previous statement.

> Patient: He stopped my prescription for Premarin (Estrogen supplement) and I started having hot flashes again worse than before. I get nerves. I'm crying before I know it. I'm upset all the time now.
>
> Screening nurse: You get upset and cry more often now? (Stops speaking, looks directly at patient, and waits expectantly). (Fieldnotes, 3/7/85).

3. signaling the patient that he or she could continue or expand the information just given in a statement, by simple responses such as:

> (pause) And? (pauses again and waits).
>
> or
>
> When the patient finished speaking, the nurse simply waited, looked expectantly, as if to invite the patient to continue what he or she was saying.

The screening nurse concluded her interactions with patients in one of three ways:

1. implementing a specific nursing treatment such as an injection, applying a dressing, and explaining about follow-up appointments;
2. sending or conducting the patient to a treatment room in the unit, or to the office of the on-call physician;

3. sending the patient to another department with which she had arranged to have the patient "worked in."

During follow-up interviews several informants compared the nurse's turn-taking control techniques with those used by their physicians. They said their physicians did not allow them to talk nearly as much, and often did not wait for them to tell the whole story but interrupted before the patient completed a statement. Their comments supported the conclusions of Erickson and Rittenberg (1985) in their study of topic management by foreign medical school graduates. They found that the professionals in their study interrupted frequently and continually reasserted their control of the conversations. Such behaviors by the professionals teach the patients the professionals' valuing of time. The patients appear to learn that the professionals' time is more valued than the urgency of gathering all the data from what the patients have to say, or answering the patients' questions.

Conservation of time is an important factor directly affecting the conversation structure of the patient-service encounters. A large number of people have subscribed to the Centre's services, and the daily flow of patients is fairly heavy. In arranging appointments, the staff usually expects each staff member to spend about thirty minutes in actual face-to-face conversation with a

patient. Thus, both the number of patients waiting to be seen and the amount of time available directly affect both the quantity and quality of nurse-patient interactions. Complex cases require more time to resolve and result in more waiting by other patients.

The screening nurse, as can be expected, has a much higher encounter rate than either physicians or nurse practitioners. Normally, her encounters are shorter in duration. The screening nurse averaged from six to eight patients in an hour, and she spent from six to twenty minutes with each patient. There were three sixty-minute encounters, all involving fairly complex problems of a more urgent nature than usual.

Longer encounters with the screening nurse were always broken into segments of shorter duration as the screening nurse temporarily interrupted an encounter to phone for consultation, send patients to obtain specimens, have tests performed in other departments, or wait for a response from another department about "working in" an appointment for a patient with a specific need.

Sometimes, during these longer encounters, the patient was instructed to return to the waiting room. The screening nurse saw other patients during the time she was waiting for new data or for an appointment with the department to whom she was making the referral. Long

encounters often were broken into two, three, or more segments and appeared to create increased patient anxiety.

> Patient: I came in about my headaches, you know. Sometimes they mean my blood pressure is up. Well, it's high---she got a real high one today. So she called my doctor, and he was busy so I was sent back here (EOD waiting room) to wait. When he called back, he ordered some tests. So she sent me to have my blood taken. Then I had to wait on them to call back about the tests and now I'm waiting to see what the doctor wants to do about it. I feel awful.
>
> Researcher: Is your headache worse now?
>
> Patient: No, not really, I just feel nervous-- I think it's worrying about what they found out, eh? (Fieldnotes, 12/8/84).

Interactions with Nurse Practitioners

Nurse practitioners also controlled both the structure and content of conversational encounters. The NP's statements to the patient served the purposes of:

1. introducing herself and explaining the nurse practitioner role and functions
2. eliciting an introduction from the patient to herself
3. eliciting a history of the chief complaint
4. eliciting personal, family, and health histories
5. eliciting the patient's understanding and health beliefs relative to the chief complaint
6. explaining physical examination procedures and giving and explaining instructions
7. giving information

8. eliciting patient's understanding of instructions and information

9. giving opinions

After introducing themselves, the nurse practitioners always followed with an explanation of variable length about the role and functional activities of a nurse practitioner. The content and length of this explanation varied with the individual nurse practitioner. It was given in each of the encounters observed even when the patient was not new. NPs were unable to explain to the researcher why they re-explained the role of the nurse practitioner to old patients, but asked me if the researcher thought it was a "good thing to do." The researcher agreed that it was, and they offered additional comments that:

> As long as it puts them (the patients) more at ease, it seems like a good idea and not worth worrying about. (Fieldnotes, 12/6/84).

The re-explanation is probably related to the relative newness of the nurse practitioner role as an experience in health care by patients. It may also be symptomatic of some anxiety about the acceptance of the nurse practitioner's role and the desire to achieve the patient's comfort and confidence.

The NP's explanation of her role usually seemed to begin with a question. Occasionally, this question required the patient to provide information about his or her experience with nurses in this expanded role.

> Have you had any experience with a nurse practitioner before? (Fieldnotes, 12/6/84).
>
> Mrs. _____, I am a nurse practitioner, have you been cared for by someone called a nurse practitioner before? (Fieldnotes, 1/10/85).

Each nurse practitioner displayed a slight degree of anxiety when inquiring about patient experience receiving care from nurse practitioners, although all of the nurse practitioners at the Centre had at least five years of practice in this role.

One hundred and twenty-six nurse-patient encounters were observed. The nurse initiated the verbal interaction in 90% of the encounters. Old patients, familiar with the staff and routines of the Centre, occasionally initiated conversations. When the patient initiated the conversation, it always occurred in the hallway, rather than in the examining room.

Turn-taking control by nurse practitioners was accomplished essentially through the same techniques as those used by the screening nurse. Nurse practitioners, however, spent considerable time out of each encounter returning conversational control temporarily to the patient to clarify statements about symptoms or home treatment methods the patient had used.

When the on-call physician was asked to come to the unit and see the patient with the nurse practitioner, a hierarchy of the control of turn taking developed. Once the physician entered the examining/treatment room, control was

deferred to the physician by the nurse practitioner. The on-call physician was asked to help with complex differential diagnoses or to make a medical decision not covered by the Centre's nurse practitioner protocols on four occasions. On each occasion, the nurse practitioner introduced the patient to the physician, thus acknowledging the higher status of the physician's social position in the system. She then briefly related the essential history and physical findings for his benefit.

In two of these encounters the physician simply gave an opinion and recommendations for clinical management and left the room. On the other two occasions, he directed a few health history questions pertinent to the chief complaint and briefly read portions of the patient's medical record. He then gave his recommendations and left the room. In each case when the physician made comments in the form of recommendations, both the nurse practitioners and the patient acted as if these were actually commands rather than recommendations.

Physician: I think we want to up the dose on that.
And, maybe have your blood pressure checked in a week or so.
(Leaves room)

NP: OK, he wants you to have more diuretic, eh?
So let's take the tablet twice a day, eh?
Then we'll see what happens.

Patient: Two instead of one, right?
And he wants you to check my blood pressure next week, eh?

NP: Yes, I think that's about what he wants. (Fieldnotes, 2/14/85).

Content of Nurse-Patient Interaction

Nurses and patients very consistently maintained the focus of their conversations on the problem. Instances of small talk referring to weather conditions or polite questions such as "How is the family? Got your Christmas shopping done, eh?" were frequent comments, but of short duration. The use of small talk seems to reflect both nurses' and patients' attempts to reduce anxiety.

One half of the content of the encounter was concerned with the collection of assessment data through history taking and physical examination. Usually an equal amount of time was spent teaching the findings and conclusions, and then explaining the medical management of the problem, or teaching the patient self care.

Several patient informants said they noticed that both the screening nurse and nurse practitioner talked through the "best" way to go about resolving the patient's problem. The screening nurse frequently seemed to be "thinking out loud" the process of how to get the patient seen and cared for most rapidly. The patient was usually invited to concur with the screening nurse's choice of solution.

Screening nurse: I think we can see if the nurse practitioner will see you, that will get you taken care of sooner, eh? (Fieldnotes 12/4/84).

> Screening nurse: I think your doctor will want to see this. I better see if he can see you today, or I should get you an appointment as early as he can see you. (Fieldnotes, 3/7/85).
>
> NP: (Examining separate lesions of a rash) The margins are a bit irregular and there are a lot of scales, eh? I think we have a fungus here-- doesn't quite fit an allergy by itself and its not bacterial, eh? (turning to researcher with expression of inquiry). (Fieldnotes, 2/14/85).

Synthesis of meaning in terms of determining a diagnosis seemed to proceed through mental comparisons with the criteria for making a specific diagnosis through a process of elimination, e.g., "Doesn't quite fit an allergy . . ."

Patient informants were asked by the researcher whether they had observed their physician "thinking out loud" in this way. The following informants said that their physicians did not share their thoughts.

> No. I know he has to think things out. But, I think he does that when he leaves the room and comes back after, eh? (Fieldnotes, 12/20/84).
>
> My doctor just kind of stares at the wall for awhile. The nurse (office nurse) and I just wait till he turns his attention back to us. I had one doctor who thought so long, the nurse and I just talked about something else, till he was ready again (to continue the conversation). (Fieldnotes, 1/3/85).

An elderly patient informant said:

> My doctor just seems to know what I need. She starts telling me what changes she'll make in my medicine or whatever else she wants me to do. When she's done she asked me, "You understand all that, eh?" But, she never stays in the room to hear whether I understand or not. (Fieldnotes, 1/3/85).

One patient informant, however, said that her pediatrician did verbalize his thinking as he mentally worked through the diagnostic process.

> My pediatrician does that. Thinks out loud like that, but he's the best doctor for explaining things too. (Fieldnotes, 1/3/85).

Health Beliefs

The health beliefs of the participants were not an explicit part of any of the discussions in any of the observed encounters. The health beliefs of health care providers and patients were demonstrated implicitly during each encounter and were a specific point of inquiry in each of the researcher's interviews with nurses and patients.

Implicit agreement in beliefs that the staff of the Centre can be helpful in restoring or improving health is demonstrated by the patient's seeking help at the Centre and by the staff member's choice of life's work. Implicit disagreement in beliefs between nurses and patients is demonstrated by the manner in which patients comply in carrying out the instructions they have been given to remedy their health problems.

Beliefs about Medications

People have complex and conflicting beliefs about medications. Patients frequently looked perplexed when the nurse practitioner did not prescribe a medication for an

infection. Even after being given explanations that antibiotics are beneficial in treatment of infections due to specific kinds of infection organisms, patients appeared dissatisfied when not given a prescription for an antibiotic.

A segment of each of the observed nurse-patient encounters included teaching concerning the specific medication being prescribed. Nurse practitioners frequently expressed their dissatisfaction with the outcomes of this teaching effort. The following excerpts from the fieldnotes cite examples of the problems the staff describe in teaching patients:

> Nurse practitioner: They really don't expect to have to listen how we are going try to make them well. (Fieldnotes, 12/4/84).
>
> Physician: Most patients are not going to listen to instructions, but they do hear most "orders" and since that's what works, that's what they should get. (Fieldnotes, 12/4/84).
>
> Physician: They (patients) really expect the magic pill every time. They don't want to hear that there's no sure cure, or that they cure themselves by doing as we instruct them. (Fieldnotes, 12/6/84).
>
> Nurse practitioner: So often they tell me that when they, or the child they bring me, became sick they started using an antibiotic from an old prescription. We all tell them to take the prescription till it's all gone. I don't think half of them do that. Too many patients tell me they have some at home in the medicine cabinet. (Fieldnotes, 12/4/84).
>
> Nurse practitioner: We get so many telephone calls from mothers asking if it's all right to start their kid on the medicine from an old

> prescription. They say they don't have time to bring the kid to be seen.
> (Fieldnotes, 12/4/84).

Patient informants interviewed were often reluctant to answer the researcher's questions about how closely they followed the instructions given them by physicians and nurses. Of eighty-eight patients interviewed, only four said they followed instructions exactly. Sixty said that it was impossible to take medications precisely the way "doctors and nurses want me to" (Fieldnotes, 12/4/84 and 12/7/84). The following segment of a conversation between the researcher and a patient being treated for hypertension is an example of the way many patients described their medication-taking behavior.

Researcher: Do you take the medicine the way they told you to?

Patient: No, I just take it as I need it. (Researcher waited for her to continue spontaneously).

Patient: Well, I know they get upset about that, but I just take it when I know I need it, eh!

Researcher: How do you know when you need it?

Patient: Well mostly when my fingers or feet swell. But, sometimes I get a headache, or just a funny feeling and I know it's time I started the medication again, eh?

Researcher: Are you afraid of this medicine?

Patient: (Her head nods yes once, but she makes a statement to the opposite) No, I just

don't feel right when I take it all the time.

Researcher: You don't feel right when you take it?

Patient: Well, I'm not sure you have to take it all the time. (Underlined words were emphasized).

Researcher: Is the medication expensive?

Patient: No, its free on my plan. (Gathers up her purse and gloves indicating to researcher that the interview is ended). (Fieldnotes, 2/14/85).

A mother talking to the researcher said that she had called the screening nurse to ask if she could give her son some of the antibiotic left from an illness of hers. She said that she makes the children take their prescriptions until the medicine is gone, but for their own illnesses neither she nor her husband ever used the whole prescription. She complained about it going to waste. She changed the subject and gave signs of needing to leave when asked why she insisted her children take all their prescription, but she and her husband did not. The researcher seemed to have pursued the subject too aggressively and may have offended the patient.

One elderly patient interviewed said she and her husband take their medication exactly as the physician prescribed it. She said that they did not take them regularly until her husband had a mild stroke.

> Patient: That really scared me. I talked to S____ [the screening nurse] and she explained things to me. Since then we've been pretty good about taking the medicine. (Fieldnotes, 3/8/85).

Deficiency in knowledge alone does not explain why patients do not always comply with their health care provider's instructions. Their comments to the Nurse Practitioners and to the researcher/interviewer demonstrated that they had concerns about:

1. The adequacy of research into the effects of medications:

   > Patient's mother: They (health professions including pharmacists) don't know it all, eh? After you take or eat something for years that they say is all right, they come out with that it causes cancer or something. (Fieldnotes, 2/14/85).

   > A middle-aged male patient: Gosh, you know you have to be careful, some of these medicines can even affect your kids, when you have them years after you took the stuff, eh!

2. Patients have a value that opposes "taking" or "being" on a medicine all the time.

   > Patient: They say <u>they</u> can't cure it (hypertension). They say I've got to take my medicine and watch my salt. And, they want me to walk. It seems like they could take care of this kind of trouble without so much fuss. They'd work a body to death to stay well. It can't be right to be taking something every hour of the day. It ain't right, eh? (Fieldnotes, 1/3/84).

3. The beliefs (and possibly values) of patients and health care providers conflict over curability. Patients, as in the interview cited above, do not accept health care provider explanations that

certain chronic alterations in their health are conditions they can control by modifying their lifestyle.

> Patient: She said it's a virus, and they can't give me a antibiotic for a virus. Well, why did I need to come here to hear that, eh? (Fieldnotes, 3/14/85).
>
> Patient: I know I need antibiotics or something for this (upper respiratory infection), but she won't give me one. One doctor is the same way, but Doctor _____, now he'd give me an antibiotic if he wasn't away, eh! He knows I know what I need. (Fieldnotes, 2/21/85).

4. Some patients blame health care providers for the lack of a cure for a chronic alteration in health. Fifty-two patients in encounters with nurse practitioners or screening nurse, or in interviews with the researcher used the expressions:

> They ought to find a way . . .
>
> They are looking at the wrong things, they would have found (a cure) out something by now.
>
> Somehow, it isn't right to pay these people to only be told so many things I have to do for myself.

Differences in health beliefs (and possibly health-related value systems) were most often implied rather than explicitly expressed. Patients seemed to be trying to avoid prolonging the encounter. They seemed to recognize that the nurse was not likely or unable to change her health beliefs for congruency with the patients'. In the interviews,

patients apparently identified the researcher as holding beliefs similar to the nurses. This seemed to cause some to be reluctant to disclose some of their beliefs related to health.

This reluctance about self-disclosure was not consistent in all areas. Apparently there are neutral areas of cultural differences which patients felt comfortable in discussing. During the holiday season of late December, many enjoyed describing their family's traditional holiday customs. In the same interview, some avoided describing how they were going to modify the nurse's instructions about their care when they returned home. Others were more open in saying that they were not sure they intended to follow the instructions to the letter.

Nurses seemed aware that patients held tenaciously to certain health beliefs and would have difficulty accepting teaching which was not congruent with their beliefs. For example, bleeding and fever caused concern to both nurses and patients. Patients seemed alarmed by any bleeding or fever, e.g., signs of vaginal bleeding outside of the expected menstrual cycle, or a few tenths of a degree of elevation above the expected norm of body temperature. Nurses, however, did not become alarmed unless the bleeding between menstrual cycles reported by the patient became a constant flow, or fever reported by a patient exceeded 38.9 degrees C. (102 degrees F).

In the following example, the patient complained of vaginal bleeding between her periods. She complained that the bleeding had started when her birth control pill had been changed to a "lo-dose" type. The "lo-dose" oral contraceptives contain smaller doses of synthetic hormones which produce estrogen and progesterone like effects. The "lo-dose" types are associated with a lower incidence of many of the side effects of stronger oral contraceptives and are less likely to induce changes in cells which might later lead to malignancy.

After determining that the patient was having a very small amount of bleeding (called "spotting"), the screening nurse explained that the doctors felt that a little bleeding was not harmful to healthy women. She also explained that "lo-dose" types were believed to be safer because they were associated with fewer other side effects than pills of the higher dosage type.

> Screening nurse: You see, they now believe the lower dose B.C. (birth control) pills are safer. Not so many side effects, eh?
>
> Patient: But, when I bleed between my periods I don't feel right. It's a mess to have this going on. Monthly is enough. Can't I take one that's at least strong enough to stop this?
>
> Screening nurse: Yes, I can give you a different one to try, O.K?
> (Fieldnotes, 12/20/84).

After the patient left the screening room, the nurse said to the researcher:

Screening nurse: They really get upset when they have breakthrough bleeding. I have to be careful how much to say about it not hurting them so I usually just change the pills for them. I've learned you can't argue with them.

Researcher: Would nurses get uptight if they had bleeding that went on for very long?

Screening nurse: Well there's that too. But, I think I'd put up with that rather than the other side effects. (Fieldnotes, 12/20/84).

In the following example, the mother of a four-year-old had been told by the nurse practitioner that a temperature taken rectally of 38.1 degrees centigrade (approximately 100 degrees Fahrenheit) represented insufficient fever to worry about. The mother had brought her child to the Centre because the child complained of an earache and had some fever.

Mother: She vomited up her breakfast so I couldn't get her to take her aspirin for the fever.

NP: You said you took her temperature rectally and it was only 38.1 (degrees centigrade), I wouldn't worry about that little fever. The earache is more significant. You did the right thing by bringing her in when she complained of earache.

Mother: But, I couldn't do anything about her fever when she wouldn't take her aspirin, eh?

NP: We'd rather parents didn't use aspirin for their children these days. You've heard about Reyes Syndrome, eh? If she has a temperature of --oh, say about 38.9 (approximately 102 degrees) I'd say give her some Tylenol. But she doesn't need anything till it gets up that high, OK? But, it's important to get fluids down her. (Fieldnotes, 1/4/85).

Later, when the NP left the room for a few minutes, the mother told the researcher that doctors and nurses did not seem to take fevers very seriously.

Within the content and structure of each encounter, there appears to be both overt and covert evidence of conflict between the health beliefs of patients and the person delivering the health care service. This conflict in beliefs modifies each participant's perspective of the events within the encounter. The differences in beliefs seem to result in the synthesis of different meanings by each participant from the same events. Each participant hears what the other participant is saying. The meaning each hears differs with personal beliefs and values.

Sources of Health Information Used by Patients

The patient informants in this study listed the sources of health information they used most as:

1. my doctor (45%)
2. magazines (35%)
3. television (20%)

Patients cited such magazines as Chateleine and Family Circle as useful because they feature health related articles which were short and easy to understand.

Television serials about hospitals and doctors were cited as sources, though patients said that they were not

always certain about the accuracy of the information. Nurses and nurse practitioners were not mentioned as a source. One patient mentioned that she thought watching "soap dramas" helped her learn how to use the Centre more effectively, but had not taught her anything new about her health.

Nurse practitioners on different occasions commented that some of the information they had to teach patients "they should have learned from their grandmothers." "They ought to know what to do when they have a cold." (Preliminary visit to the setting, 10/2/84). The nurse practitioners said:

> They ought to know to drink more fluids! They ought to know they need more rest! They ought to know to stay home to keep from spreading their infections! (Fieldnotes, preliminary visit to setting, 10/2/84).
>
> They ought to know how to balance their diet! She knows better than to eat foods like that with diabetes! (Fieldnotes, 1/5/85).
>
> You'd think they'd know to keep a cut clean, eh?" (Fieldnotes, 3/5/85).

Summary of the Analysis of Data

Patients coming to the Centre for services are assigned to one of three paths through the system. The choice of path depends upon the urgency of the problem and whether an appointment has been arranged in advance. A visit to the Centre involves a considerable amount of waiting which

patients find frustrating and fatiguing. Fatigue from waiting seems to affect the ability of patients to retain learning. Further research seems indicated to study the effects of waiting on learning learning retention.

Patients appear to learn how to function in the system by either following directions or using role modeling based on the behavior of other patients who seem to know what to do. Patients learn to identify people in the setting by being introduced and from uniforms the staff wear. They also identify staff members' roles through associating the person with the particular room where they meet them (e.g., the examining room) and from symbolic objects such as medical instruments they see the staff person using.

Patients frequently misidentified people when they associated a uniform with a specific role. Women in white uniforms were assumed to be nurses which was frequently not true. Nursing assistants, physical therapists, laboratory technicians, and others who are not nurses wear white uniforms. Nurse practitioners who are nurses wear laboratory coats over street clothing. Most physicians simply wore street clothing and patients assumed any male they met in an examining room was probably a physician. Thus, the clothing worn by staff people often provides misleading information.

Nurses and patients differ in their perceptions of health and illness. They also differ in their perceptions

of how medications should be used. Physicians and nurses believe patients want immediate cures which are not possible. The professional staff also believes that though life style modification supported by medication as the appropriate type of care, patients resist modifying the way they live.

Patients appear to make compromises between what they think is realistic and practical for them, and what nurses teach them to do. Thus, the outcomes of a visit do not always meet either the nurses' or the patients' expectations. Physicians and nurses sometimes compromise by giving orders to patients when they think that patients will ignore teaching. Patients probably ignore orders as often as they ignore teaching, but further research is needed to clarify this. Physicians and nurse practitioners sometimes also compromise by changing medications at the patients' request in order to gain the patients' cooperation.

CHAPTER SIX

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

The findings of this enthnographic study describe the interaction of nurses and patients in the emergency and outpatient department (EOD) of a Canadian health service organization. The research was focused on the identification of the processes through which nurses and patients synthesize meaning from the experience of their health service encounters.

Health care service encounters between nurses and patients are viewed in this study as bringing about a transcultural interface of the value and belief systems of the nursing subculture and the culture of patients. This interface is viewed as a set of phenomena which are culturally and experientially related. Culture and experience shape the meaning or sense people make of a new experience by guiding the way they perceive events. The experience consists of what happens to them, what they tell one another, and what they observe about each other. The findings should be useful to health care providers and teachers of health care providers in attempting to improve communication between the people who give and receive care.

Patients seem to have difficulty understanding or creating meaning out of the combination of:

1. experience of symptoms.
2. previous experience of illness.
3. events in the health care setting.
4. health beliefs of their culture.
5. teaching and counseling by health care providers.

It would seem possible to assist patients in the processing of information into meaning. Yet, there is no assurance that helping people understand one another's meaning will alter their values or beliefs. A clear understanding of what the health care provider means would help the patient make more fully informed choices.

The Researcher's Preparation for the Process of Inquiry

The first step in this work was to explore relevant literature to determine the extent of support for the contention that nursing is a subculture. Arguments were found which both support and disagree with the assertion. The contention was supported in the writings of Leininger (1970, 1978, 1985), Brink (1982), and Hutchinson (1984). These writers demonstrate that health professions such as nursing are subcultural entities in that specific values, beliefs, and attitudes are learned, shared, and transmitted down through generations of health care providers, and integrated into cultural patterns which govern the

individual professional's behavior.

Linton (1945), however, wrote that occupations and professions were extensions of the belief systems of the society of which they were a part. Though differentiated by knowledge and skill, he wrote that it did not follow that they represented distinct cultural entities. Kottak (1982), Levi-Strauss (1963/1967), and Saunders (1954) wrote that subcultures are distinguishable from the greater culture by demonstrating distinct differences in beliefs.

Culture was described in this literature as the folkways of a people. Folkways are defined as the values, beliefs, attitudes, and overt customs and behaviors which identify a group of people as culturally distinct. A subculture was defined as a group which possesses folkways consistently and distinctively varying from, but within, the folkways of their larger culture. To qualify as a subculture, a group must consistently vary sufficiently in their folkways to be defined as different. These differences must not be of a degree to constitute a separate and distinctly different culture.

To determine the influence of a transcultural interface between nursing and the people who use the services of nurses, it was first necessary to be able to demonstrate emic and etic differences in the organization of meaning from the encounter between nurses and their patients.

Nurses constructed meanings in terms of diagnostic statements from what patients told them and what was observed. Patients constructed meanings related to becoming free of the illness experience and often believed that achievement of their goal did not require full compliance with nurses' teachings.

Methodology

An ethnographic approach seemed most appropriate for an inquiry focused on emic and etic differences. Non-participant observation, limited participant observation, and interview techniques were used to gather data from one hundred and twenty-six nurse-patient encounters, eighty-eight patient interviews, and many interview discussions with nurses, nurse practitioners, nursing administrators, and some physicians in the setting. The ethnosemantic semiotic approach was used in the analysis of the data to explore the synthesis of meaning in the domains of role, health and health care, and transcultural interactions.

Findings

The Centre is very different than other settings in which people normally perform the activities of daily living. It is a culturally foreign environment to patients because the settings of ordinary daily living do not provide sufficient learning which the patient can transfer to guide

independent function in the Centre. The new patient requires instruction or direction to function in the setting from the Centre staff.

Admissions personnel and other staff were always friendly, courteous, and patient. They tended to direct patients rather than to teach them how to conform to the staff's expectations. Health care personnel generally seemed to believe that limitations imposed on them by time and the demand for their services, made directing patients more efficient than teaching patients how to function in the setting. The duration of each health service encounter is limited. Nurses place the highest priority on direct services (hands-on care) and patient teaching.

Patients thus had to orient themselves and learn to function in this setting by following directions very carefully. They also used other patients as role models.

The findings concerning the nature of the transcultural interface demonstrate that the areas of agreement and conflict in which nurses and patients differ are likely to influence the effectiveness of health teaching. Nurses and patients differ in biomedical beliefs, particularly those concerning the use of medications, and the effectiveness of lifestyle modification.

The health care provider and the patient seem to perceive each other as members of distinct groups which is demonstrated by the terms of reference members of each group use to describe the other group. Each refers to the other group as they or them. Physicians and nurses used the term "they" for patients in talking about patients as people who think they should always be given "something to take" (a prescription) before leaving the encounter. Patients used the term "they" in talking about physicians and nurses as people who often want patients to do things which to them (the patients) do not make sense.

Most patients differed from nurses in how disease or alterations in health were perceived. Patients described their health problem as something that nurses and physicians should be able to cure or eliminate in a definable time period. Nurses perceived alterations in the patients' health as a condition to be controlled by altering the patients' lifestyle with the support of biomedical treatment or medication.

Ninety per cent of the patient informants interviewed gave a description of medication-taking behaviors which differed from the instructions they had been given. Many patients appeared to feel that taking medications over any long period of time might be harmful to them.

The two groups seem to differ in whether they perceive the greatest danger to be from the disease or from

the taking of medication. The health care providers perceive more danger to children from the disease pertussis (whooping cough) than from the vaccine used to prevent it. Many parents perceive that the danger of fatal reaction to the vaccine is greater than the disease.

The two groups seem to agree that biomedical health care providers do not know all the possible dangers of the substances they prescribe. Patients, however, seem to disregard (or not to understand) the statistical evidence upon which health care providers base their actions.

Many patients did not understand why certain medications were withheld by the health care provider. Some patients felt that an antibiotic medication would resolve their health problem such as a cold or the "flu" despite explanations that the medication was inappropriate. Nurses were heard instructing several patients that antibiotics were not appropriate in the treatment of viral infections. Many patients apparently did not believe such instructions because they repeated requests for antibiotics after this teaching.

Many patients, however, stated that they only took medications until they felt better, or when they felt they needed it. This suggests that

1. patients do not understand or believe that medication is still necessary when they are not experiencing the symptoms of illness.

2. patients have fears about taking medication, which results in avoidance of medication when no symptoms are being experienced.

Patients also said they felt the nurse practitioner should be able to resolve their (the patients') problems without requiring patients to do or learn so much for themselves. Patients also sometimes complained that they felt some of the very explicit instructions given them were in conflict with the way they think and feel about their own health.

Conclusions

The Domain of Role

In everyday life when a person approaches a stranger, the person making the approach usually opens the conversation by stating his or her purpose. Health care facilities and school rooms may be two of the few places where the person approached opens the encounter by making the first statement. Patients entering the setting in this study immediately perceived the admitting and information clerk as functioning in the role of gatekeeper. They synthesized this meaning from their perception of the setting and objects in her immediate environment. The lobby and the objects in it function as symbols which

communicate the legitimization of the staff person's role as well as the functions of that role.

Parsons (1951) described the encounter as consisting of actors and objects. The setting and the objects (acting as communications symbols) in the setting influenced the patients as actors. Patients accepted direction, examination, and treatment from people who were strangers because inanimate symbols legitimized the behaviors.

Uniforms, however, were found to communicate confusing information. Physicians usually wore no identifying uniform. Apparently the fact that the encounter occurred in the examining room legitimized the physicians' behaviors without the need of uniforms.

Patients, however, assumed most women in white uniforms were nurses, when in fact about one third were laboratory technicians, physical therapists, or nursing assistants. Uniforms, then, were misleading as communication or legitimizing symbols.

The examining room and its instruments also functioned to legitimize the role and functions of nurses, the screening nurse, and the nurse practitioners. When the patient was sent or taken to the examining room, the women who entered performed the functions of their role legitimized by the place in which the encounter occurred. This function of objects as symbols to mark legitimacy seems significant.

People within most cultures are probably socialized to accept the authority of health care providers to direct and instruct them. They have to have some way to identify who possesses such authority.

Role ambiguity occurred in two contrasting forms. Nurse practitioners were sufficiently concerned about patients' acceptance of their role that they explained the role and its functions to each patient. Patients experienced role ambiguity in that while illness is associated traditionally with dependency, physicians and nurses often requested that the patient learn self care of his or her own illness.

Patients seemed to accept, without visible qualm, the nurse practitioner's right to perform health care functions. Nurse practitioners, however, seemed to experience role ambiguity as evidenced by their behavior of explaining their role to each patient. Role ambiguity also seemed to stem from the fact that some physicians did not permit their patients to be seen by nurse practitioners.

Nurse practitioners do receive considerable support in their role. The Centre administrative staff is supportive and clear protocols have been developed to guide the nurse functioning in this role. Nurse practitioners stated that most physicians seemed comfortable working with nurse practitioners once they had been oriented to the role and its place (status?) in the Centre. Physicians, observed

during consultations requested by the nurse practitioner, behaved collaboratively rather than directing the nurses in their actions. The nurse practitioner and patient, however, usually followed suggestions given by a physician as if the suggestions were orders.

The dependent behaviors which are apparently normal for patients in the illness role would be categorized as role insufficiency under other conditions. Meleis (1975) wrote that supplementation should be implemented to remedy role insufficiency. This may occur naturally as the patients depart the setting and recover the direction of their own lifeways. This raises the question of whether some non-compliance with health teaching may be due to a need to overcome feelings of role insufficiency which are a residue of the Centre experience.

Non-compliance may also be due in part to role conflict. If dependence is understood by patients to be a traditional part of their role, conflict may arise when they are instructed to assume independent self care.

Lambert and Lambert (1981) state that a person who understands how the health care system works is less likely to feel powerless and will experience less role insufficiency. In this study, patients with experience appeared more comfortable once they knew how to function in the system, but did not appear to be any more compliant than newly admitted patients. Precise data about what patients

do after leaving the Centre is lacking. The screening nurse reported that patients seemed more likely to comply during a crisis.

Social Status

Roles are always performed in some relationship to other people performing other roles (Bennett and Tumin, 1948). These relationships include the assignment of authority, responsibility, and prerogatives. High status of a role in any social system is associated with more authority, responsibility, and prerogatives (Bernard and Thompson, 1970). Outside of the Centre, the patient has the authority, responsibility, and prerogatives for maintaining his or her own health. Upon entering the Centre and asking for its help, the patient passes these powers to the health care staff. The patient appears to have the lowest status in most health care facilities, including the Centre.

In reality, patients do have prerogatives. In most cases they choose the physician they prefer, except when referred from one physician to another. They can refuse to be referred and they can change physician at almost any time. They can complain to the physician or the administration of the Centre. They also have the power of noncompliance, which essentially affects only themselves.

The second rung of that social hierarchy of roles involved with patient care appears to be occupied by the registered nursing assistant. Educational preparation

and the legal limits of practice are similar to the licensed practical nurse in the United States. Some Canadian Provinces are considering changing to the American title to facilitate RNAs obtaining American licensure. The RNA reports to nurses and occasionally directly to physicians. RNAs instruct and direct patients with approval of the nurse. Registered nurses give orders to the RNAs and patients. RNAs implementation of the orders from nurses is regulated by legal limits on the practice of both and by the Centre's job description for RNAs.

Nurses have higher status than RNAs and patients, and slightly lower status than nurse practitioners. Their status is considerably lower than physicians. Nursing education teaches that nurses have the preparation, authority, and accountability to make nursing diagnoses, teach about health, and counsel patients. In the limited interviews outside of the EOD, the gestalt feeling developed by the researcher was that most nurses believed that they should not do or say anything (relative to health or illness) to a patient without a physician's written order. Some of the nurses, however, stated they knew they could refuse to carry out physician's orders which:

1. do not agree with the Centre's job description of their position.
2. are in conflict with the medical policies of the Centre.

3. conflict with any part of the Nursing Competency Act of the province.

The screening nurse occupies a unique position in the hierarchy. She has no special certificate but has taken courses in health appraisal and nursing diagnosis. She gives orders to other nurses in the form of suggestions which seem to be accepted. In addition, she has considerable nursing experience. Thus, her status is both achieved and ascribed. Some of her status is based on her generally sound judgment and exercise of responsibility. She has the authority through her status and role to determine the type of care provider according to the patient's problem under the guidance of protocols. She has some latitude to order tests and treat without physicians' orders.

The nurse practitioners have more education than nurses and can give orders to nurses, RNAs, and patients. They were not observed giving any orders to the screening nurse, but offered suggestions (usually acted upon) and on two occasions reversed her decision. When an NP reversed a decision of the screening nurse, the NP immediately explained her reasoning. The screening nurse always accepted the NP's reasoning.

NPs phone or write orders for medication within the limits of Centre policy and NP protocols. They make suggestions to physicians which in the observed situations

were accepted. Nurse practitioners said that physicians accepted the accuracy of their observation almost all the time and suggestions about three-forths of the time.

The administrative structure of the Centre was not observed except for some discussion with the nursing administrator. She has achieved status through seniority, experience, and the direct support of the most senior physician. The senior physician initiated the original plan to open the centre with the help of the nursing administrator. She was the Centre's first staff nurse.

Nurses' Professionalism

All of the nurses seem to place a high value on having the status of professionals. Most of the nurses, however, did not seem to meet Kelly's criteria of professionalism (see pages 32-33) in those areas of the criteria for which data were available.

1. All of the nurses seem to be providing services which are vital to human welfare.
2. Little evidence surfaced in the data to support a conclusion that the nurses were using knowledge which distinctly belongs to nursing. Nor was their evidence that the nurses were attempting to expand the body of nursing knowledge.
3. Much of the performance of nurses' roles seemed to require intellectual operations, but with the

exception of the EOD nurses and a few others, "large individual responsibility" (p. 158) was not exercised. This conclusion is based on the fact that except for a few nurses, the larger responsibility for decision making was the prerogative of physicians.

4. Most of the nurses were not prepared in schools of higher learning and did not participate in setting or negotiating policy for their practice.
5. That they consider nursing their life's work seemed to be evidenced in part by the way in which nurses met patients' needs. However, patterns of employment should also be considered in determining the degree to which nurses consider their work a "life's work". The data about employment history were in confidential personnel files and were not accessible except by direct approach to all Centre nurses. This was outside the scope and focus of the study.

Domain of Transcultural Relationships

Culture consists of the distinctive lifeways (customs), values, beliefs, and attitudes of a group. The basic conflicts at work in the one hundred twenty-six observed nurse-patient encounters and eighty-eight interviews seemed to fit into distinct categories centered on differences in values and beliefs.

1. Patients seemed to believe that the chief complaint was a disease which was considered a time-limited event controllable by the health care provider. Nurses seemed to believe that the patients' health problems were conditions of altered health which may be chronic. They believed the best solution to these problems was lifestyle modification supported by treatment or medication prescribed by the health care provider.

2. Patients believed that health care providers may lack individual or collective knowledge of the potential dangers of certain forms of biomedical intervention.

-taking medications over a prolonged time might be hazardous (e.g., taking antibiotics as prescribed for ten days, or taking anti-hypertension medication daily when no symptoms are present).

3. The biomedical health provider bases choice of action on statistically demonstrated probability.

-e.g., the danger of complications of polio vaccine is statistically lower than the danger of, and susceptibility to, the disease.

- dangerous side effects of Pertussis (whooping cough) vaccine are less frequent in occurrence than the frequency of complications occurring following pertussis infections.

Some mothers argued that they had been told, or had learned from the media, that the dangers of taking certain vaccines were more serious than the disease, and that chance of their child catching that specific infection was small.

4. Patients often felt that the discomfort involved in undertaking change would be greater than the comforts to be gained (e.g., weight reduction, implementation of exercise programs, or cessation of smoking). Nurses believed that comfort from the proposed change would be greater than the discomfort experienced from disease.

-none of the nurse practitioners and few of the other nurses smoke (most said they were former smokers).

-many nurses said they were involved in regularly scheduled exercise.

-most of the nurses, according to the screening nurse, maintain adequate immunization status.

These findings agree with the health belief model (Becker & Rosenstock, 1974). Redman (1980), in writing about the health belief model, states that people are not likely to comply with a suggested health program:

> . . . unless they believe that the threat to them from taking the action is not as great as the threat of the disease itself. (p. 30)

Rosenstock (1974) recommended changing the delivery system to achieve desired change rather than attempting to change people's beliefs.

The staff seemed to believe that events occurring in its staff-patient encounters were congruent with the generally accepted model in use by most biomedical health service providers. Congruent with that model they expected encounters to proceed as follows:

1. Patient arrived with knowledge deficit, perspective of the chief complaint, and health beliefs.
2. Patient was assessed and a diagnosis was formulated.
3. Health education was given.
4. Patient health knowledge deficit, and supposedly his or her health beliefs, were to be altered to agree with the health care provider's beliefs.
5. Patient's behavior was to be altered.
6. Control of the patient's altered health condition was to be achieved. The patient was then to be discharged to self care or intermittent monitoring and adjustment of regime.

The projected sequence of events predicted by this model did not occur in the encounters which the researcher observed. Patients were observed to appear to learn what they were taught, but acceptance of instruction and being able to repeat segments of the instruction are not sufficient evidence of altered health beliefs. People often

learned a segment of knowledge without believing it was true.

The actual model which was seen at work looked more like the following:

1. Patient arrived with a level of knowledge about health, his or her own health beliefs, and some personal conclusions about the chief concern.
2. Patient was assessed and a diagnosis was formulated.
3. Illness treatment and health education were given.
4. Patient gained some health knowledge, but health beliefs were altered very little or not at all.
5. Patient's behaviors were altered to a degree, but not to the degree sought by the health care provider.
6. Improvement of the patient's altered health condition was achieved partially or wholly, but a potential for recurrence of the same problem remained.

This model illustrates the researcher's perspective of the nurse-patient encounters. An application of the Goffman model (1976) of frame analysis demonstrates that staff members, patients, and the researcher constructed different interpretations of the same events as illustrated in Table 2.

Table 2

Comparison of Patient, Staff, and Researcher Perspectives of the Events of Nurse-Patient Encounters: Application of the Goffman Model of Frame Analysis.

Patient Perspective	Staff Perspective	Researcher Perspective
Learning where to go.	Greeting patient. (admitting clerk)	Patient enters setting and is greeted by staff.
Being interrupted in finding out where to go.	Determining: -urgency of problem -old or new patient -appointment status.	Patient encounter with admission clerk.
Waiting.	Admitting or in-take process.	In-take process with minimal explanation of why.
Being told how to get where I'll be taken care of.	Directing the patient to the the department where he/she is to be seen.	Directing the patient where to go.
Arriving at another place to wait.	(Departmental nurse) a new patient arriving to wait his/her turn.	Patient learns there is more waiting to be experienced.
Waiting.	Serving each patient in his/her turn.	Participants demonstrate different perceptions of the passage of time.
Being seen in the treatment room. Trying to describe the changes I feel from my illness.	History taking.	Participants construct a congruent description of the patient's experience of the illness.

Table 2 (continued).

Being examined.	Physical examination of the patient.	Physical assessment.
Learning what is wrong with me.	Medical and Nursing diagnosis.	Analysis of data and sharing findings with the patient.
Being treated.	Treatment.	Interaction between nurse and patient involving touch.
Being told what what to do to get well.	Patient teaching.	Lecturing, listening, some formative evaluation of patient perception of instructions.
Getting my prescription.	Prescribing medication.	Giving the patient prescriptions with instructions.
Learning when to come back.	Arranging follow-up.	Arranging future appointments for the patient.
Leaving the Centre.	Discharging the patient.	Patient exits Centre.

The events of each step of the encounter appear very ordinary. However, three different perspectives of reality are constructed by the participants. The patient's perspective reflects the combined stress of coping with illness, the need to adapt to the strange environment of the health care facility, and fatigue. This combination of factors would be expected to interfere with the learning

process.

The patient constructs a meaningful compromise between his or her beliefs and what they understand of the biomedical beliefs of the health care professional. The patient's management of his or her chief complaint at home, free of the health care provider's supervision, was then the product of a value compromise between what he or she considered reasonable and sensible, and what he or she had been told or taught at the Centre. It seems that in each of these conflicts in values the patient maintained his or her previously held convictions and modified the biomedically prescribed regime.

The focus of this study was on process rather than outcomes. Thus, data concerning how many patients failed to have their prescriptions filled are lacking. Three patients who were advised to walk more to modify their blood pressure and weight, told the researcher that they had not done so. They offered a number of reasons why they had not (usually related to time commitments).

Some patients, however, demonstrated compliance with what they had been taught. The patient who had dropped a boat motor on his foot did use the techniques of positioning the injured part as he had been taught to reduce the swelling in his foot. Patients did take at least some of the prescribed medication.

Conflicting Values Involving Fear

Patients demonstrated conflicts within their own health belief systems. They also demonstrated conflicts between their own health belief systems and the biomedical belief systems of the nurse. Some patients said they expected an antibiotic to remedy their chief concern but demonstrated that when given antibiotic prescriptions, the medication was not taken as instructed. When instructed to take the medication for ten days, some took the medication for less than half that period.

Nurse informants base their biomedical beliefs upon acceptance of the findings and recommendations of medical research. Acceptance of such findings is based on acceptance of statistical evidence as truth. Patients have little knowledge of, and very little faith in, calculus and statistical procedure. They probably are not likely to change their beliefs through exposure to something which to them is suspect.

Patient informants said they received most of their knowledge about health from their physicians. They also cited magazine and television articles, especially when discussing medications which had been discovered to have serious side effects.

Their body language sometimes seemed to express tension and possible suspicion of the ability of physicians and nurse practitioners in making some decisions. In their

speech and acts they made statements that they believed the nurses should resolve the patients' health problems.

They also held beliefs about the use of medications, the knowledge possessed by health care professions, and the home care of sick people which were at odds with their expectations of the health care professional. Several times patients made statements that the nurse practitioner or physician should listen more to patients' ideas about likely solutions to health problems.

Patient informants also differ from the nurses in the degree of significant danger they perceive in certain symptoms such as fever. Nurses often explained to parents that some degree of fever was not harmful to children. Most parents of patients appeared to accept this information but frequently asked about the dosage of anti-febrile medication (such as aspirin) before leaving the encounter.

Patients taking prescribed anti-hypertension medication had learned about the early warning signs of stroke from physicians and nurses, periodicals, or television. They had also been told that when they first began to take anti-hypertensive medications, they might experience some weakness and dizziness.

Patients had difficulty understanding why weakness and dizziness were described as both the early warning signs of a stroke but also were the symptoms of side effects of the medication. They thought the two pieces of information were

ambiguous and found that frightening. Patient informants cited experience with the side effects of these medications as the most common reason for taking the medication "as I need it" rather than as prescribed.

Major limitations on health care service encounters in producing change seem to be related to:

1. Time: The time available for each one-time health service encounter is inadequate to bring about major alteration in health values and beliefs, but is sufficient for minimal change in knowledge deficits. The scope of this study does not answer the question whether longer encounters would actually bring about more change.
2. Teaching plans: Nurses appeared not to have developed long-range teaching plans for patients who could be expected to return for multiple visits. Teaching was geared to the moment with indefinite plans for re-enforcement.
3. Compromise: Patients make compromises between their own values and beliefs and those of the nurses. Nurses make compromises to obtain improved cooperation from patients. Potentially useful compromises are not reached when the holder of specific health beliefs perceives considerable danger by other than strict adherence to that belief.

4. Belief systems: Lack of acknowledgement of patients' belief systems.
   Assumptions by health care providers that health teaching will alter health beliefs.
5. Conflicting information: frequently the media presents health information which conflicts with accepted findings in current research.
   Information from media often conflicts with the teaching by nurses.
   Patients become confused about which information to believe.
6. Fears: Patients need to be encouraged to express their fears about their symptoms and the effects of medications.

Perhaps the essential problem is one of whether health education or teaching can be given. The Lewin model of change (1947) stresses the full involvement of participants in change in the earliest stages of planning.

When nurse practitioners worked through the diagnostic process audibly, patients appeared more comfortable and became involved in the process. They also appeared more comfortable when they felt they were taking an active part in planning treatments. Frequently, patients took advantage of such a time to ask questions and to compare their own thinking with that of the nurse.

Knowles (1984) states that adult learners gain more from instruction which is congruent with their own identified needs and which is planned to actively involve the learner. Perhaps "thinking out loud" is a good way to increase patients participation in their own care and improve learning. Knowles (1984) wrote:

> When we have arrived at that point, we develop a deep psychological need to be perceived by others, and treated by others, as capable of taking responsibility for ourselves. (p. 9)

He further contended that when the adult learner enters an educational setting to which he was conditioned as a child to behave dependently, he demands to be taught which demonstrates a return of childlike dependence. This seemed to be quite similar to what happened in health care facilities.

Knowles also wrote in describing readiness of adult learners to learn, that they are motivated to learn when they perceive a need and can be involved in the:

> . . . diagnostic experiences in which they assess the gaps between where they are now and where they want and need to be. (p. 11)

The Transcultural Interface

Orque's Intercultural Communication Model (1981/1983) displayed her conception of the interface between the nursing subculture and that of the patient. She illustrates the communication system as two overlapping circles. One circle

represents the nursing subculture; the second, the culture of the patient. The overlap of the circles represents the area of intercultural communication which is conceptualized in this study as the transcultural interface. The results of this study indicate that the overlap of the circles in Orque's model represent areas of congruence and conflict between culturally distinct health values and beliefs occurring within the service encounter.

Shared Components of the Encounter

Nurses and patients hold many health values and beliefs in common. They value trying to eliminate or control ill health. They believe, to different degrees, in the utility of biomedical therapy to alter or control events in a person's health.

Nurse's Side of the Interface

The nurse brings to the encounter a complex blend in which the socialization of nursing education overlays that into which he or she was enculturated from birth to entry into the profession. In addition, there is a separate subcultural component from advanced nursing practice which is distinct from the greater profession. The values the nurse brings into the encounter are largely based on biomedical research findings and traditional health care provider beliefs.

These values include a generalized perception of patients as people with a questionable knowledge of the science of health. Nurses interviewed in the study said several times that they thought that many of the health promoting behaviors they had to teach patients should have been common knowledge. As cited in Chapter Five, they felt that patients' common knowledge should include such information as:

> They ought to know to drink more fluids!
>
> They ought to know they need more rest!
>
> They ought to know to stay home to keep from spreading their infections!
>
> They ought to know how to balance their diet!
>
> She knows better than to eat foods like that with diabetes!
>
> You'd think they'd know to keep a cut clean, eh?"

Nurse practitioners bring into the encounter the special problem of explaining their rather new role. The nurse practitioners also brings into the encounter feelings which have evolved from the negotiation of acceptance of their new role by physicians and other nurses.

The Patient's Side of the Interface

Patients enter the encounter setting with individual and culturally based values and beliefs about their personal independence and the control of their lives. They appeared to have been socialized to accept the necessity of

surrendering a certain amount of their personal independence to the health care provider. They demonstrate a valuing of biomedical intervention by coming to the Centre for assistance in managing their health.

They entered the setting with preconceptions of the roles and functions of nurses and physicians, but were able to accept and adapt to the new concept of a nurse in the nurse practitioner role. Some had difficulty accepting more responsibility for their own recovery.

Individual patients seemed to vary more than the nurses in expressing the values, beliefs, and feelings they brought to the interface. Their feelings, especially fears, were influenced by doubts raised by news media describing mistakes by health professionals. New information about health sometimes reverses previous "truths" taught to patients.

One patient expressed his frustration in attempting to make sense of the many news media releases about health.

> A few years ago it was eat more protein and starch; now they say eat less meat, and more grain which is starch. How is a person supposed to keep up with it all, eh? How is a person really supposed to know what to do today? (Fieldnotes, 3/7/85).

Hutchinson (1984) found in her study in a neonatal intensive care unit that nurses organized meaning technically, intellectually, and emotionally. The findings in this study seem to agree with Hutchinson's in reference to nurses

constructing meaning technically and intellectually. There was insufficient data to demonstrate emotional input into the organization of meaning. This does not exclude the possibility that there was such input which may have been covert or overlooked by the researcher.

Recommendations

The recommendations developed from the findings in this study have been sorted into two categories. One category consists of recommendations for the improvement of services within the Rapid City Health Centre. The second category consists of recommendations for further research.

Recommendations for Nursing Practice.

1. Patients became more actively involved in the care process during encounters in which nurses verbalized the work of thinking through the diagnosis and management processes. This sharing of the problem solving processes permitted the patients to participate in decisions. Patient involvement of this kind should be explored using an experimental evaluative design.

2. In this setting, better communication and teaching methods need to be developed to achieve the maximum help for patients from one-time encounters. The heavy case-loads of the EOD impose limitations on time available to teach individual patients during each encounter. It might be helpful to approach one-time encounters as part of a

sequence in continuing care. Though one-time encounters usually involve episodic health problems, most patients have more than one such episode of illness in a lifetime. Anticipatory educational planning should gradually alter health beliefs of patients toward a valuing of preventive care.

The management of episodic illnesses related to chronic health problems should benefit from the development of individualized curricula aimed at meeting each patient's long range health needs. This teaching plan would need to be coordinated with the teaching carried out by the department where the patient is seen on a regular basis. Each patient's teaching plan should made be a regular component of each patient's medical record. Teaching plan formats should be developed which make the best use of the time available and provide planned follow-up.

Each encounter should include the opportunity to review information and instruction with the patient. Protocols for nurse practitioner management of specific kinds of health problems should be expanded to include carefully defined follow-up inquiry, teaching, and/or modification of the prescribed regime.

1. Follow-up could be accomplished by telephone or home visits by staff or by referral to home care agencies. This should achieve:

- better compliance with the prescribed regime.

- disclosure of other health problems of the patient (undisclosed by the first encounter),
- the course of recovery and/or changes in the patient's condition, and precisely how the patient is following or varying from the prescribed regime.
- better information about why patients vary from prescribed regimes and the effects of such variance.
- increase patients' opportunities to ask questions.
- reinforcement of previous teaching.
- evaluation of nurse practitioner protocols.
- provide feedback about how people perceive the Centre, its staff, procedures, and the quality of care.

3. Staff should explore ways to reduce the stress of waiting. The effects of stress (such as fatigue) must also be considered when the staff begins health teaching and counseling.

4. Ways should be sought to reduce the sense of "foreignness" of this setting to patients. A reorientation of administration and staff using simulations in which the staff person is required to act out the role of a new patient might be useful to aid personnel in developing more humanistic admissions, waiting, and treatment policies.

Such reorientation should be designed according to established guidelines for inservice curriculum and include well prepared evaluation procedures.

5. The Admissions and Information services should be separated physically to provide privacy for patients.

- information services should continue relatively unchanged until further studies indicate need.
- the admissions area should be separated from the information area with seating for the patient, and improved communication by removal of the desk as a physical barrier between the clerk and the patient. Clerk and patient might sit side-by-side in a conversational arrangement with any necessary information handling equipment such as the typewriter or computer terminal conveniently placed. When the patient is able to see what the clerk is doing, anxiety might be reduced.

6. The staff should explore ways to increase patients' use of the information they are given. This would require close study of patient opinions about the information they receive at the Centre and about the services provided at the Centre. Little time is wasted in these nurse-patient encounters. From the first moment, during which the informants introduce

one another, they become immediately involved in the sharing and processing of information. The exchange of information, however, is not the same as the sharing of the same meanings. Both nurses and patients seem aware of the danger that information is not always perceived as meaning the same thing to both participants in the encounter. Nurse practitioners and nurses were observed verbally reviewing what the patient said to clarify exactly what patients meant. Despite these efforts, many encounters ended with doubt expressed by nurse and patient informants that they fully understood one another. The significance of improving mutual understanding in such an important life event is sufficient reason for further study.

Recommendations for Further Research

Improvement in patient care should result from a better understanding of the transcultural interface in health care service encounters. Patients and nurses interpret what they experience during the interface from the perspective of their own cultural or subcultural education. Further research needs to be undertaken to identify how the interface varies in different settings, between patients, and between other types of health care service personnel.

Cross cultural research should be helpful in clarifying the characteristics of the interface. Erickson and Wittenberg (1985) reported that they are exploring such phenomena as they

occur in encounters between foreign medical school graduates and their patients.

A comparison study of the synthesis of meaning in cross cultural encounters such as those occurring in UNESCO's GOBI (UNICEF, 1986) projects might provide findings which are more generalizable than those of this research. GOBI is an acronym for the four components of a program initiated in the third world to decrease the death rate of children. It consists of:

Growth monitoring.

Oral rehydration therapy.

Breast feeding information.

Immunization.

Family spacing is also included. The project is transcultural in that many of the UNESCO personnel are foreign to the people with whom they work. Cross cultural comparisons are available between GOBI projects in such countries as Bangladesh, Ethiopia, and Haiti.

1. Other health care facilities (American as well as Canadian) should be studied to:

-provide information about the generalizability of the findings in this study to other settings.

-support or disconfirm the findings of this study.

-clarify the need of change in curricula preparing health care providers.
-guide studies for improved utilization and marketing of health care services.

2. The findings in this study seem to show that there is a relationship between waiting, or the stress and fatigue of waiting, and the retention of learning. Research seems indicated to determine the degree of disablement of learning from these factors. Studies are needed to determine:

-how much information is learned.
-how long is learning retained.
-what factors promote/impair learning retention.
-accuracy of retained information.

Perception (the meaning) of the reality of any life situation varies with cultural background, individual experience, and the amount and kind of stressors the individual experiences in specific situations such as illness. The nurse and patient differ in the meaning each constructs from the patient's description of the illness experience. Congruence of the meanings constructed by the nurse and patient is important for good outcomes of care. Nursing care methods must be found which promote the mutual understanding by the patient and the nurse of one another's meanings.

APPENDICES

APPENDIX A

A TROUBLED PATH TO DEVELOPING ETHNOGRAPHIC SKILLS

An intellectual autobiography of the ethnographic researcher provides readers with background information for the interpretation and evaluation of findings. Such information is essential to the reader of such research because the ethnographer is the only data collecting instrument.

I entered professional nursing practice via the traditional preparation of nurses in the 1950's through graduation from a hospital diploma nursing program. My first working experiences were as a general duty nurse on pediatric and general surgical wards. In 1952, I left my hometown to work in a large teaching hospital in Chicago and was assigned to the neurosurgical ward. Neurosurgical nursing became my primary interest. I found few textbooks and almost no current nursing literature at that time dealing with this specialty.

Over the next several years I worked principally with neurosurgical patients and became by self-preperation and experience, a neurosurgical clinical nursing specialist.

In 1964, I entered undergraduate study at the University of Michigan while continuing to work in neurosurgical nursing at University Hospital in Ann Arbor. It was at this time that I was introduced to ethnography as the primary research method of anthropologists. At the time, I would have done almost anything to find a way to continue my work as a nurse and simultaneously conduct this kind of research. Looking back on those days I now recognize many opportunities I missed because of lack of training. I knew something about ethnography. I simply did not know how to go about it.

My undergraduate courses did provide me with some healthy doubts about the ways in which I and my colleagues went about our work. I began to see the places in which we care for patients as organized to meet the convenience of physicians and nurses, and less human centered than I would have liked.

I continued to work as a neurosurgical nursing clinical specialist until 1972 when I entered graduate study in nursing at Wayne State University. During the course of graduate studies I made a major change in the direction of my professional career. I became interested in the community and family aspects of nursing care as opposed to the delivery of care in the hospital setting and became a Family Nurse Practitioner.

Upon completion of my master' degree in nursing, my husband (a school psychologist) and I moved to Michigan's Upper Peninsula. I accepted two half-time positions, one as a public health nurse for the northwestern third of Chippewa County, and the second as a nursing instructor at Lake Superior State College.

As a public health nurse I provided home health services and introduced the idea of family health clinics in the remote rural townships to reduce travel for my clients. In these clinics, I combined women's health care, immunization for children, and free professional nursing consultation to families. I also became involved in consultations with Native Americans (Chippewa Tribe) helping to identify specific tribal health needs. I helped the Bay Mills and Leelanau Peninsula tribes develop health plans and needed services. I also organized an interdisciplinary study group to look at young teenage pregnancies and taught emergency medical technicians for the county's voluntary ambulance crews.

In my other half-time position as a nursing instructor at Lake Superior State College, the head of the department and I developed a completion baccalaureate program for non-degree registered nurses. I then taught these courses.

In July of 1975, I was appointed head of the department of nursing at Lake Superior State College and continued to teach full time. I resigned from the Health Department, but

continued my work with Native Americans and the ambulance corps. At this time, I also became an adjunct Wayne State University faculty member to assist that University in bringing an outreach Master's degree program in nursing to the Upper Peninsula. This outreach program was developed to meet a serious shortage of graduate prepared nursing faculty in northern Michigan and southwestern Ontario. I taught neurophysiology, some components of public health nursing, and health assessment for this outreach program as well as serving as a clinical preceptor.

In 1978, I left my college teaching position to open a rural health center in western Chippewa County. I served the clinic as director and family health practitioner. I returned to teaching in the Department of Nursing at Lake Superior State College in 1981.

In response to a need expressed by many Upper Peninsula educators, Dr. Charles Blackman of the Michigan State University College of Education came to the Upper Peninsula in 1981 to plan a series of courses at the doctoral level. The first courses were a series of three in ethnographic research taught by Dr. James L. Buschman. I began to think that at this stage of my career development, the nursing profession's beginning acceptance of qualitative research, and my undergraduate itch to do ethnography had finally meshed.

The initial survey of the Centre as a research setting raised the immediate concern about how I would ever record everything that was happening in the setting. I was also concerned about how I could remain objective. In preparation I practiced recording fieldnotes which I then evaluated critically for completeness and informant perspective. I found that feedback from the informants was very important to verify the observations recorded in the fieldnotes. It also became evident that for complete and accurate fieldnotes, it would be necessary to record as many of the stimuli seen, heard, or smelled as possible.

As a first step, I reviewed the available literature on the mechanics of ethnographic method beginning with texts suggested suggested by Dr. Buschman for the three courses in ethnographic research offered in the Upper Peninsula by Michigan State University.

Bogdan and Biklen's Qualitative Research for Education: An Introduction to Theory and Methods; and George Spindler's Doing the Ethnography of Schooling: Educational Anthropology in Action; and Raymond Gorden's Interviewing: Strategy, Techniques, and Tactics were very helpful.

Other useful guidance was found in found James Spradley's Participant Observation; and Schatzman and Strauss's Field Research helpful. I read or re-read many

ethnographies of different kinds relating to education and health care.

The books of Madeleine Leininger bridge the gap between the ethnography being done in education and the ethnographic research which has only begun to be applied to nursing. Leininger's special interest is the phenomena of caring and the wide range of the meaning of caring across many diverse cultures.

I read or re-read many other articles by nurses in anthropology such as Tripp-Reimer, Brink, Orque, Bloch, and Hutchinson. I needed no persuasion that ethnographic studies of patient care needed doing. The holes in nursing knowledge are quite painfully visible to most researchers in nursing. The value of field research to nursing is not well accepted.

Then, at last, I began to explore potential settings for the study. I approached several facilities in the area with the proposal for this research and in the beginning, their response was favorable, even to some degree eager. In the second stage of negotiations, however, the requirements of the University Committee on Research Involving Human Subjects caused the administrative personnel of all but one of the facilities began to foresee some problems. Most stated they felt that completion of permission forms in addition to those already in use in each facility would cause considerable patient anxiety. Some of the personnel

who would eventually become involved in the observations showed signs of concern about being observed.

The nursing administrator of a Canadian Health Service Organization was very supportive and with some modification, the proposal was implemented in that one setting. This nursing administrator presented the proposal to the Centre's medical staff administration and assisted me in obtaining their agreement to the implementation of the research. It was rather apparent from their poorly concealed amusement that they did not take the project very seriously. One physician in passing me in the hallway asked, "Well, how are we interacting, eh?", which certainly did little for my confidence.

The negotiation of relationships in the Emergency and Outpatient Department was my responsibility. This observer/observed relationship was crucial for the validity and reliability of the findings. I soon discovered that the screening nurse functioned as a coordinator in an informal capacity. She was the one who oriented me to the operations of the EOD. She also took me with her for the first coffee breaks and introduced me to nurses from other departments.

The nurse practitioners were a little more reserved at first. They asked me several question about NP practices and quality of performance in other health facilities. Following my first observations of the NP-patient encounters, they wanted to know how they compared with other

NPs. It took several visits to convince them that the research was not intended to evaluate the quality of their performance. I did assure them (truthfully) that I believed they were delivering as high a quality of care as I had observed in other places. We talked about ways primary nursing services could be improved and the experience of orienting other professionals and patients to the new NP role.

Though the focus of this study was on process rather than outcome, one outcome of my visits to the Centre should be mentioned. The overall quality of care impressed me. At the end of my visits I could quite honestly say to the staff that they gave a very high quality of care in comparison to other health care facilities with which I am familiar. My findings, however, have not changed my feelings that considerable improvement in patient care is needed.

Getting to know the patients was very difficult because, with few exceptions, I could only observe and talk to them for short intervals on the one day they visited the EOD. A few returned during the course of the study and I was able to get to these patients a little better. I struggled to "feel like a patient" when I was with them. It was almost a year later in reviewing my fieldnotes that I realized how much they identified me as a nurse. I see this as a major weakness of the study, but unavoidable at the time. Subterfuge was and is unacceptable to me.

It turned out that recording everything that went on was difficult. Often I felt that I was trying to watch all three rings of a circus simultaneously. I began to make a practice of jotting quick notes in the margins to remind me to watch for a particular incident to re-occur. I felt this would enable me to re-examine some activities of the nurses and patients more closely. I remember looking with envy at a sample of Fred Erickson's notes from a visit to a classroom in China and thinking to myself: how did he get it all in his fieldnotes?

I filled in details as I rewrote my notes. Use of a tape recorder as I traveled home from the Centre helped. I used it to review the happenings of the period I had just spent in the setting. When I compared these recordings to my raw fieldnotes I always found additional observations to help flesh out my rough fieldnotes. As the experience progressed, I began to see fieldwork affecting me in the same way that learning to paint increases my perception of color. As a hobbyist oil painter I have found that learning to paint caused me to develop perspectives of form and color I had never noticed. Fieldwork began to have the same effect as I listened and watched people coming and going through the EOD and subsequently passing through my fieldnotes. I saw things I had never noticed about patients or nurses.

In the future, I would like to explore several facets of this setting in greater depth. If money were available,

I believe a non-nurse interviewer of the participants might help clarify, confirm, or disconfirm some of my impressions of the informants experience and perception of the setting.

I am struck by a passage in Patricia Chapman Pulliam's dissertation where she comments that even after finishing and submitting her report, she wonders what lies still undisclosed in her fieldnotes. I echo her feelings, completely.

A major ethical concern related to my research troubles me. Recently studies of patient care have led to a closer look at how some people use health services. In some cases expensive care, which patients could not afford, was denied them. The rationale for denial was that their lifestyle might negate any the good effect of the treatment.

Sixty Minutes, the television news program of April 20, 1986, reviewed cases of children born with spina bifida who were denied expensive surgery because the child's parents could not provide the homelife which could insure the child's survival despite surgical treatment. I have problems dealing with such possible outcomes of research. I have always believed that the discovery and sharing of truth was beneficial. Today, I am not so certain. Our society has not given the health professions any clear mandate on how we should proceed.

APPENDIX B

Informal Schedules For Questions

A guide for questions to be used to open discussions and to serve as a check list was prepared for interviews with each type of informant. These were revised four times in the opening weeks of data gathering.

Schedule for Nurses

1. Can you tell me in general what kinds of things are part of your job in your department?
2. Who do you report to?
3. Who reports to you? What do they report about?
4. Who are the patients you see?
5. What is your usual day like? What do you do first? Then what happens?
6. Would you describe your part in a typical patient's appointment in your department?
7. What kinds of services can you do for a patient without a physician's order?
8. What do you like best about your work with patients here?
9. What do you find the most frustrating about your work?

10. What do patients do that bothers you the most?
11. Is there one department you prefer to work in? Why do you prefer that department?
12. How easy are patients to get along with?
13. Do they follow your (the physician's) instructions?
14. How well do they follow instructions?
15. Why do you think they don't follow instructions?
16. If you could change one service for patients here, what would it be? Why? How would you do it?

Schedule for nurse practitioners and screening nurse

These questions were asked in addition to those asked of all nurses.

1. How do you think patients feel about nurse practitioners?
2. How well do the physicians accept nurse practitioners here? How well do you get along with physicians?
3. What do you like most about working as an NP?
4. What do you like least?
5. Have many of your patients been cared for by a nurse practitioner before?

Schedule for Patients

1. How did you find your way here (waiting or examining room)?
2. Is there a problem learning to find your way around here?

3. How long have you been coming to the Centre?
4. How long do you usually have to spend waiting when you come here? What do you do while you are waiting?
5. Why do you use the Centre (or EOD) rather than other places you could go for service?
6. Which departments of this Centre does you family usually use?
7. What do you like most about the services here? (Centre or EOD)
8. Do you always follow the instructions they give you?
9. Do you feel you usually understand:
   -their questions?
   -their instructions?
10. Where (or from whom) do (did) you get your information about health (or that problem)?
11. Did I hear you say you had been sick for (time period described during examination)? What did you think was wrong? How did you figure that out? Did you try anything to help you get better?
12. What do you do with any medicine that gets left over? (To learn whether patients take all of the medication they were given).
13. What worries you about taking medication? (Used where appropriate).
14. How do you feel about the services in the EOD? Do the nurses in EOD seem different from other nurses?

Have you been (examined, treated, taught) by nurses like the (nurse practitioner or screening nurse) before?

15. What do you think they should have done? (When patient expresses disagreement with opinions of nurses).

16. If you could change one thing about services here, what would it be?

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