JUGGLING A WAY OF BEING: A GROUNDED THEORY OF
HOW ONE GROUP OF NURSES NAVIGATES TENSION AMONG PERSONAL
AND PROFESSIONAL VALUES 'IN THE MOMENT'

by

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TABLE OF CONTENTS

i

LIST OF FIGURES

ABSTRACT

Despite nursing's espoused professional values of caring and social justice, some patients are stigmatized and receive discriminatory nursing care. There is a gap in existing literature about how nurses deal with the tension they experience when personal and professional values collide. The purpose of this study was to generate a substantive theory of the process that nurses use when faced with values tension in clinical practice and how this affects their behaviour. Using constructivist grounded theory methodology informed by symbolic interactionism and critical social theory, the theory of *Juggling a Way of Being* was co-constructed with data obtained through interviews with registered nurses (n=8) who provide frontline care in an emergency department in Atlantic Canada. The study's findings revealed a process fraught with tension as nurse participants assimilated internal and external stressors, adjusted the patient-centered/nurse-centered lens according to their interpretation of the situation, and achieved a point of action or inaction. Implications for nursing practice and administration, education and research are discussed.

LIST OF ABBREVIATIONS USED

HIV	Human Immunodeficiency Virus
AIDS	Acquired Immunodeficiency Syndrome
CNA	Canadian Nurses Association
NANB	Nurses Association of New Brunswick
ED	Emergency Department
COREQ	The Consolidated Criteria for Reporting Qualitative Research Checklist
RN	Registered Nurse
SBAR	Situation, Background, Assessment, Recommendations
IV	Intravenous

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CHAPTER I: INTRODUCTION

Despite nursing's espoused professional values of caring and social justice, some patients are stigmatized and receive discriminatory nursing care. The problem of stigmatized patient care is well documented within marginalized populations. Evidence demonstrates that stigma results in poor care for those who are homosexual (Aguinaldo, 2008; Hancock, 2008; Katz, 2009; Sinding, Barnoff, & Grassau, 2004; Stewart, 1999), obese (Rogge, Greenwald, & Golden, 2004), deliberately self-harm (Law, Rostill-Brookes, & Goodman, 2009; McCann, Clark, McConnachie, & Harvey, 2007), have human immunodeficiency virus (HIV) (Andrewin & Chien, 2008; Chan, 2009; Kagan, Ovadia, & Kaneti, 2009; Li, et al., 2007; Rintamaki, Scott, Kosenko, & Jensen, 2007; Siminoff, Erlen, & Lidz, 1991; Smith, Rossetto, & Peterson, 2008; Stewart; West, Leasure, Allen, & LaGrow, 1996), hepatitis C (Butt, Paterson, & McGuinness, 2008), a drug and/or alcohol dependency (Lovi & Barr, 2009), the homeless (Zyrinyi & Balogh, 2004), are undergoing abortion and reproductive decision-making (Gesteira, Diniz, & Oliveira, 2008; Hancock), have a mental illness (Bjorkman, Angelman, & Jonsson, 2008; Chambers, et al., 2010; Kukulu, & Ergun, 2007; Lauber, Nordt, Braunschweig, & Rossler, 2006; Ross & Goldner, 2009; Schafer, Wood, & Williams, 2011), are older (Campbell, 1971; Chan & Chan, 2009; D'A Slevin, 1991; Higgins, Van der Riet, Slater, & Peek, 2007), have disability (Matziou, et al., 2009), are gypsy travelers (Francis, 2011), and those who are of non-Eurocentric ethnicity (e.g., Aboriginal women; Browne, 2007; Van Herk, Smith, & Andrew, 2011; South Asian immigrant women; Johnson, Bottorff, Hilton, Browne, & Grewell, 2002).

Goffman (1963) argues that stigmatized characteristics include racial and religious identities (*tribal stigma*), physical disability and disfigurement (*abominations of the body*); and addictions, mental illness and homosexuality (*blemishes of individual character*). Further, most literature suggests that within the context of healthcare, stigma is directed toward these three types of "others". In fact, research findings have demonstrated the impact of health care professionals' stigmatized personal values in terms of their unwillingness to help vulnerable patients, oppressive behaviours toward stigmatized others, and on patient outcomes including quality of life, access to care, and psychological well-being. In turn, people who have received discriminatory health care describe it in varying ways such as being treated differently than other patients (Butt, et al., 2008; Zukoski & Thorburn, 2009) or being refused or withdrawn from services (Butt, et al.; Rintamaki, et al., 2007; Zukoski & Thorburn). Patients have reported being addressed with a negative demeanor including fear (Rintamaki, et al.; Zukoski & Thorburn), lack of eye contact, distancing, angry tone, and open blaming (Rintamaki, et al.). Stigmatized patients describe being objectified by their illness and losing personal identity (Gaillard, Shattell, & Thomas, 2009) as well as being the recipients of paternalistic care (Gaillard, et al.; Van Herk, et al., 2011).

Background and Significance

In my own experience, I have struggled to understand how and why nurses, as caring professionals, feel justified in failing to engage in caring behavior with some patients. I have observed "care" that is task-driven and distant in the context of patients with certain illness experiences such as HIV/AIDS, smokers with lung cancer, Hepatitis C, those who engaged in harmful use of drugs and practiced sex-work, people with

extreme (or simply different) religious and cultural beliefs, and even those who live in geographical areas deemed to be "less than". I have wondered how nurses reconcile their personal and professional values in situations like these. I have asked myself, "Have nurses not entrenched the professional values that guide our practice; and if not, why? Do nurses compartmentalize professional values such that some do not apply to "those" patients?" I do not believe that nurses are "bad" people. I recognize that nursing is an inherently ethical profession and that there are many factors at play when personal attitudes interfere with the development of nurse-patient relationships and the provision of care. This thesis work was driven by my desire to better understand those factors; to understand what is going on when a nurse's personal and professional values collide and stigmatizing behaviour is the outcome.

Stigma reduction has become a worldwide priority for research, advocacy, and health policy (Ragarum, Raghu, Vounatsou, & Weis, 2004; Weiss, Jadhav, Raguram, Vounatsou, & Littlewood, 2001). The ultimate goal is to develop programs and policies aimed at reducing human suffering (Parker & Aggleton, 2003). For example, in 2009, the Mental Health Commission of Canada launched a 10-year anti-stigma/anti-discrimination initiative. The elimination of stigma and the reduction of discrimination were identified as priorities to be addressed as part of a federal framework for mental health. Up to the present, most anti-stigma initiatives have attempted to modify individuals' opinions and attitudes through education aimed at increasing empathy (Stuber, Meyer, & Link, 2008). While interventions targeted at the individual level may have some usefulness, they cannot be considered sufficient to have large-scale effect at a macro-level. To have far-reaching efficacious outcomes, anti-stigma initiatives must

begin by looking at the deeper social, economic, political, and cultural causes of stigma (Corrigan, Markowitz, & Watson, 2004; Parker & Aggleton). Current anti-stigma interventions are decontextualized from the environment in which stigma occurs; understanding the context of stigma should be the first priority in efforts to combat stigma (Kleinman & Hall-Clifford, 2009; Stephenson, 2009). The importance of understanding stigma in the context of the environment where it occurs cannot be ignored.

Substantial bodies of research exist that examine issues of stigma, including its cultural, individual, and environmental influences; situations in which stigma is perpetuated; nursing's professional values; personal values; and ethics. Far less research has been conducted to enhance understanding of what happens when personal and professional values are incongruent. Significantly, there is a gap in the literature in regards to the internal tension that nurses experience when faced with conflicting personal and professional values.

Purpose of Study

The purpose of this grounded theory study was to generate a substantive theory of nurse behaviour when inequalities arise in the course of providing patient care. It was important to gain increased understanding of the interactional processes underlying the phenomenon of interest: how nurses, despite being socialized to professional ethics of caring and social justice can provide inequitable care. To this end, constructivist grounded theory methodology (Charmaz, 2006) was used in this inquiry.

4

Research Question

What is going on *within the nurse* when personal and professional values collide while providing care, or observing the care of other nurses, and how does this affect nurse behaviour?

CHAPTER II : LITERATURE REVIEW

There is debate around the early review of literature in grounded theory. Followers of the classic Glaserian approach to grounded theory argue that a preliminary literature review should be avoided to prevent entering the study with predetermined ideas (Wuest, 2007). Others believe that an early literature review is important to justify the need for the study and to enhance theoretical sensitivity (Heath & Cowley, 2004). Constructivist grounded theorists support the later view (Charmaz, 2006). In keeping with the constructivist approach to grounded theory that was used in this study, an initial literature review was conducted and discussed below.

Stigma

In his seminal writing on stigma, Erving Goffman (1963) described this phenomenon as "the situation of the individual who is disqualified from full social acceptance" (p. 3) and that the stigmatized person is "reduced in our minds from a whole and usual person to a tainted, discounted one" (p. 3). Goffman's work inspired a profusion of research on stigma, its sources and consequences. Since the publication of *Stigma: Notes on the Management of Spoiled Identity* (1963), the concept of stigma has been refined and expanded by researchers and theorists from across disciplines (Link & Phelan, 2001).

Goffman (1963) observed that stigma can be seen as a relationship between an attribute and a stereotype. This idea around locating the meaning of stigma has been explored and refined in the literature. For example, attribution theory has been used as a stigma framework in that it describes "causal beliefs as determinants of emotional, attitudinal, and behavioural responses to stigmatized individuals and groups" (Hegarty &

Golden, 2008, p. 1023). The use of Goffman's term 'attribute' has been debated among authors as it locates the cause of stigma within the stigmatized individual. Because human differences are socially determined, Link and Phelan (2001) argue that the word "label" rather than "attribute", "mark", or "condition" is more appropriate as it describes something that is affixed. That is, an attribute implies that the stigmatized characteristic has validity and is permanent whereas a label is not necessarily permanent and leaves the validity of the stigma open to question.

Link and Phelan (2001) conceptualize stigma as a process that unfolds when five inter-related concepts co-exist: *labeling, stereotyping, separation, status loss and discrimination, and power imbalance* (Figure 1). Their work is important in that it demonstrates the evolution of the stigma concept from one "grounded in the individual to one rooted in social space" (Yang, et al., 2007, p. 1524-1525). Link and Phelan describe the first component of stigma as distinguishing and labeling differences. Many human differences, such as the colour of one's eyes, are overlooked and socially irrelevant. Other differences, however, are highly salient in North America at this time such as one's skin colour or sexual orientation. "The point is that there is a social selection of human differences when it comes to identifying differences that will matter socially" (p. 367). Attributes deemed socially relevant are dependent on time and place. Once socially constructed differences are distinguished and labeled, they are usually taken for granted as "just the way things are". The second component of stigma occurs when labeled differences are linked to undesirable characteristics that form a stereotype. The taken-for-grantedness of socially salient human differences results in stereotypes that are often reflexive. This linking of labels to stereotypes leads to the third component of the stigma

7

Figure 1. Conceptualization of the Process of Stigma using Link and Phelan's (2001)
Five Inter-Related Components of Stigma
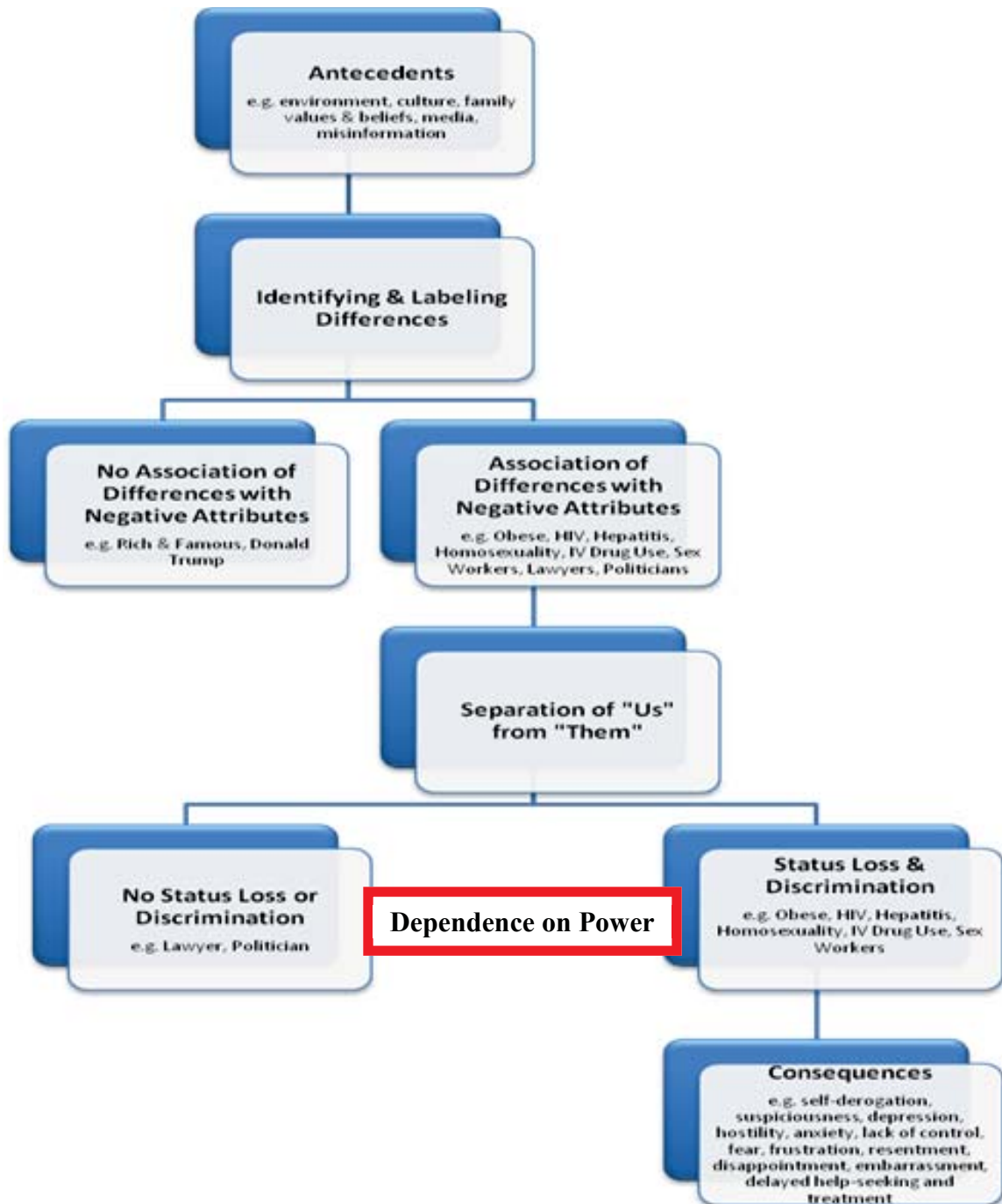
process: separating "us" from "them". The labeled person is seen as fundamentally different from those who do not carry the label; "the linking of labels to undesirable attributes becomes the rationale for believing that negatively labeled persons are fundamentally different from those who don't share the label" (p. 370). The fourth component of stigma is status loss and discrimination. "[W]hen people are labeled, set apart and linked to undesirable characteristics, a rationale is constructed for devaluing, rejecting, and excluding them" (p. 370-371). Stigmatized individuals and groups, then, experience reduced life chances such as income, housing, education, emotional well-being, and health. Finally, the fifth component of stigma is its dependence on power. Link and Phelan argue that stigma is completely dependent on power, whether social, economic, or political. The fourth and fifth components of Link and Phelan's conceptualization of stigma set it apart from the writing of others such as Goffman (1963), Stafford and Scott (1986); Crocker, Major and Steele (1998); and Jones et al. (1984). Their incorporation of power, status loss and discrimination allows their definition of stigma to "cohere with current understandings of what a stigmatized group is" (p. 377). They give a convincing example of how lawyers and politicians are often labeled, stereotyped, and separated as others but do not experience the status loss and discrimination that is experienced by a less powerful group. In this type of situation, while the cognitive aspects of stigma may be in place, people who are relatively less powerful do not possess the "social, cultural, economic, and political [influence] to imbue their cognitions…with serious discriminatory consequences" (p. 376). For stigma to exist, a power imbalance must in place.

The idea that stigma is socially constructed is well supported in the literature. Goffman (1963) wrote that stigma occurs as a discrepancy between "'virtual social identity' (how a person is characterized by society) and 'actual social identity' (the attributes really possessed by a person)" (p. 2). Jones et al. (1984) describe the stigmatizing process as one in which society defines what is aberrant and provides the context in which devaluing attitudes are expressed. Stigma is "driven by particular socio-cultural arrangements…socio-cultural value systems and beliefs can shape the content stigmatizing attitudes will assume" (Rao, Horton, Tsang, Shi, & Corrigan, 2010, p. 351). Building on this idea of stigma as a socio-cultural process, the literature also presents stigma as a "fundamentally moral issue in which stigmatized conditions threaten what really matters for sufferers" (Yang et al., 2007, p. 1528).

Stigma: Cultural Contexts

Stigma is seen as a universal phenomenon but its definition, expression, and outcomes vary across cultures (Pescosolido, Martin, Lang, & Olafsdottir, 2008; Rao, Angell, Lam, & Corrigan, 2008; Yang et al., 2007). Culture gives a framework for interpreting and giving meaning to experience and the rules, values, morals, and beliefs held by a culture shape the dynamics of stigma (Gilbert, Gilbert, & Sanghera, 2004; Gilbert, et al., 2007; Rao et al., 2008). Link and Phelan (2001), in their discussion of the first component of the stigma process, distinguishing and labeling differences, spoke to the enculturation of values that make certain differences socially relevant. They wrote that differences considered socially important differ dramatically according to time and place and across cultures. It is important to understand how culturally created stigmas arise and how they are sustained and to understand the "social, economic and cultural

forces that maintain the focus on a particular human difference" (p. 368).

An important dimension of culture that impacts on psychological processes is individualism/collectivism (Crandall, et al., 2001). The intensity of cultural investments in social connectedness and group membership can be noted in cultural differences of the meaning, expression and outcomes of stigma (Rao et al., 2010). In individualist cultures, such as in North America, Western Europe, and Australia (Crandall et al., 2001; Rao et al., 2010; Triandis, Bontempo, & Villareal, 1988; Weiss, et al., 2001), emotions such as pride and shame relate to the self (Gilbert et al., 2004) and self-reliance is valued (Rao et al.). Judgments of personal responsibility/causal attributions are more prominent in individualist cultures (Hegarty & Golden, 2008). Conversely, collectivism is defined as "a social pattern consisting of closely linked individuals who see themselves as part of one or more collectives…; are primarily motivated by the norms of, and duties imposed by, these collectives; are willing to give priority to the goals of these collectives over their own personal goals; and emphasize their connectedness to members of these collectives" (Triandis, 1994, p. 2). Collectivist cultures, such as in Asia, Africa, Latin America, and Micronesia (Chew-Graham, Bashir, Chantler, Burman, & Batsleer, 2002; Crandall et al., 2001; Gilbert et al., 2004; Gilbert et al., 2007; Lam, et al., 2010; Rao et al., 2008; Rao et al., 2010; Triandis et al., 1988; Weiss et al., 2001; Yang et al., 2007; Zhou, 2007), commonly have relationships with unequal power (Triandis et al., 1988), and value interdependence and family integrity (Rao et al.). Understanding stigma in the context of culturally determined beliefs necessitates consideration of how "stigma is intertwined with cultural and social forces and enacted in daily life" (Lam et al., p. 35).

The tension that occurs when collectivist and individualist values are in competition has been documented in the healthcare literature. For example, Yan (2008), in a study that explored cultural tensions within the profession of social work, found that participants from minority cultures experienced tensions between their own values and those of the dominant society, their workplace organizations, and their clients. Practitioners from collectivist cultures that emphasize inter-dependence were noted to have difficulty with the individualist values and duties of their profession involving, for example, the institutionalization of the elderly.

Stigma has been described as a process that results in a person or group being reduced to less than human. People who are stigmatized within relationships experience separation and status loss because of power imbalances. Sadly, patients in healthcare encounters are inherently vulnerable to the more powerful healthcare professional (Peternelj-Taylor & Yonge, 2003). The asymmetry in professional relationships is often not recognized and some nurses fail to strive to "ensure that it does not take the form of abuse – creating or maintaining helplessness in the other" (Myhrvold, 2006, p. 133). Clearly, some nurses fail to notice the potential for stigma to negatively impact the development of trusting relationships with patients and to result in discriminatory care.

There appears to be at least three distinct types of factors that contribute to stigmatizing behaviour: professional, personal, and environmental factors.

Professional Values

The nursing profession socializes its members to embrace core concepts that underlie the scientific and humanistic aspects of nursing practice. Caring; interpersonal relationships (Koldjeski, 1990; Woodward, 1999); and ethical principles of providing

safe, compassionate, comprehensive, and ethical care; promoting health and well-being; promoting and respecting informed decision-making; preserving dignity; maintaining privacy and confidentiality; promoting justice; and being accountable (Canadian Nurses Association (CNA, 2008) are inherent professional values. Given these values, it is perplexing how nurses could in turn engage in stigmatizing behaviours.

Caring

Nursing embraces the concept of caring as a professional underpinning and necessary in ethical practice (Olsen, 1997). Watson (1985) identified nursing as "the science of caring" (p. 1). Caring has been described as the essence of the domain of nursing and the hallmark of nursing practice (Kapborg & Bertero, 2003; Leininger, 1988). Caring has also been described as the meaning of, the reason for (Kuhse, 1997), and the ethic of nursing (Tschudin, 2003).

Watson (1985) theorized that caring exists when the nurse and patient share the human experience and, through empathy, attempt to understand each other's circumstances. Swanson (1991) defined caring as "a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility" (p. 165). Caring is a commitment on the part of the nurse to become involved with another (Kapborg & Bertero, 1997). It involves a giving of the self; therefore it is a humanistic act (Rink, 2000). Caring can be described as activities that assist others, an emotional presence, and an experience of human concern. It involves a quality of interaction that requires the nurse's being (presence), knowing (competence), and doing (action) (Kapborg & Bertero; Swanson). "Caring entails taking care of the entire human being…physically, emotionally and intellectually" (Kapborg & Bertero, p. 191). It

13

involves the ability "to be with a patient in a way that acknowledges your shared humanity" (Benner & Wrubel, 1989, p. 13). A caring presence facilitates the development of trusting, therapeutic nurse-client relationships. Why, then, do nurses engage in discriminatory care?

Therapeutic Nurse-Client Relationship

The nurse-client relationship is "therapeutic in nature, is established to meet the needs of clients and is based on trust and respect" (Nurses Association of New Brunswick (NANB), 2000, p. 24). Nursing is an "interpersonal process" (Peplau, 1952, p. xiii) that is hinged on a nurse's therapeutic use of self. A therapeutic nurse-client relationship facilitates client well-being (NANB), empowerment (Forchuk & Reynolds, 2001), dignity, and autonomy (Berg & Danielson, 2007).

The components of the nurse-client relationship include power, trust, and respect (NANB, 2000). The relationship between nurse and client is "asymmetric" (Berg & Danielson, 2007, p. 507) as there is an imbalance of power in favour of the health care professional. The client is inherently vulnerable due to the need for nursing care (NANB; Berg & Danielson). Because of this vulnerability, trust is essential in a caring relationship. Travelbee (1963) instructed nurses to demonstrate "a belief in the worth, dignity and irreplaceability" (p. 71) of each client with whom she interacts. Respect for a person's dignity, worth, sexual orientation, religious beliefs and lifestyle is fundamental in the therapeutic nurse-client relationship (NANB). How is it that nurses who practice therapeutic relationships engage in discriminatory care?

14

Ethical Nursing Care

The Code of Ethics for Registered Nurses (CNA, 2008) is a "statement of the ethical values of nurses and of nurses' commitments to persons with health care needs and persons receiving care" (p. 1). The Code provides guidance for ethical nursing practice by identifying key professional values and the need to address inequities in health care. Nurses are instructed to reflect on their professional actions and interactions and to "recognize that they are moral agents in providing care" (p. 5).

The Code of Ethics for Registered Nurses (CNA, 2008) outlines seven primary values that articulate the "core responsibilities central to ethical nursing practice" (p. 3). The first value, *Providing Safe, Compassionate, Competent, and Ethical Care,* directs nurses to care for clients holistically, understanding that compassionate actions and communication are necessary in a caring relationship. The second value, *Promoting Health and Well-Being*, instructs nurses to ensure that all nursing actions are client-centered recognizing the influence of the social determinants of health and client health beliefs and values. The third value, *Promoting and Respecting Informed Decision Making,* encourages practice that facilitates client autonomy and recognizes power differentials in the nurse-client relationship. The fourth value, *Preserving Dignity,* supports nursing practice that is respectful, supportive and maintains client integrity. Nursing care is given with the intent to relieve pain and suffering, whether physical or emotional. The fifth value, *Maintaining Privacy and Confidentiality,* recognizes the vulnerability of clients. Nurses uphold client trust by keeping health information in confidence and speaking about clients with respect in interprofessional discussions. The sixth value, *Promoting Justice,* incites nurses to "refrain from judging, labelling,

15

demeaning, stigmatizing and humiliating behaviour toward persons receiving care"

(CNA, p. 17). The seventh value, *Being Accountable,* refers to a nurse's responsibility to

adhere to professional standards of care and practice according to the Code of Ethics

(Oberle & Raffin-Bouchal, 2009).

The Code reminds nurses of their individual and collective duty to take action

against social inequities that influence health and well-being. Nurses are instructed, for

example, to understand the importance of efforts to enhance access to health care for

vulnerable groups (CNA, 2008).

Philosopher John Rawls' (1971) theory of justice as fairness describes justice as a

set of principles that are used to determine how benefits are divided among citizens. All

societies inevitably will have inequalities in their basic structure and he instructs that it is

to these inequalities that the principles of justice apply. The theory of justice instructs

that disadvantage to few is not made right by the greater good. Indeed, "injustice is only

tolerable when it is necessary to avoid even greater injustice" (Rawls, 1971, p. 4).

Rawls' theory of justice is based on the principles that each person has an equal right to

basic rights and freedoms and when inequalities arise they must be "to the greatest

benefit to the least advantaged members of society" (Rawls, 1985, p. 227). In justice as

fairness, persons self-interested in advancing their own interests will do so from the

initial position of these principles (Rawls, 1971). Rawls describes justice as a complex

moral issue in that all humans are required to make decisions in everyday life about the

judgments they make. One's judgments are not static but may change with self-

reflection, a process that Rawls calls *reflective equilibrium* (Rawls, 1971). "Rawls'

conception of society is defined by fairness; social institutions are to be fair to all

cooperating members of society, regardless of their race, gender, class of origin, reasonable conception of the good life, and so on" (Stanford Encyclopedia of Philosophy, 2008). Rawls acknowledges the influence that the environment, culture, history, and social institutions have on decisions about justice. He describes a theoretical *veil of ignorance* that should be used to uphold the principles of justice and prevent these inevitable factors from unfairly influencing judgments of equality (Rawls, 1985).

Social justice, at the macro level, focuses on "the relative position of one social group in relationship to others in society as well as on the root causes of disparities and what can be done to eliminate them (CNA, 2006, p. 7). Social justice in health care can also be considered in the context of individual persons receiving care. Nurses must work to "prevent oppressive practices such as discrimination against individuals on the basis of gender, sexual orientation, age or any other social factor that might affect health and well-being" (CNA, 2009, p. 2). Social injustice occurs when the quality of care a person receives is negatively impacted, for example, by discriminatory preconceptions by a health care professional (CNA, 2009). Life chances such as opportunities for education, health, housing, and psychological well-being can be limited by enacted discrimination (Link & Phelan, 2001). Nurses practice "at the intersection of public policy and personal lives" (Falk-Rafael, 2005, p. 222). They are, therefore, ideally situated to advocate for social justice at a socio-political level as well as in their daily interactions with individual patients (CNA).

Nurses are professionally socialized to the ideals of caring, presence, the therapeutic nurse-client relationship, social justice, and nursing ethics. Nurse scholars such as Watson (1985), Leninger (1988), Peplau (1952), Parse (1981), Swanson (1991),

and Travelbee (1971) have provided nurses with theoretical direction for caring practice. Professional standards of practice and the Canadian Nurses Association's (CNA) (2008) Code of Ethics for Registered Nurses define the ethical responsibilities of nurses. With these professional values in mind, each nurse-patient encounter should be one of trust and caring connectedness. Why, then, do nurses who practice ethical nursing care engage in discriminatory care?

Tension Within and Between Professional Values

In the complexity of healthcare situations, tension may arise within and between professional values. There are often situations in which two or more ethical principles are in competition. This requires the nurse to determine their relative weight in a particular context (Purtilo, 2005; Wilmot, Legg, & Barratt, 2002). Rodney et al. (2002) described this as working 'in between' competing values.

When nurses are expected to follow physicians' orders that go against patients' wishes, tension occurs between benevolence, autonomy, and dignity versus non-maleficence and risks for personal harm such as loss of job or license (Lutzen & Nordin, 1993). When families override patients' known wishes not to be resuscitated, nurses experience conflict between autonomy and fidelity versus the legal rights of next-of-kin (Cooper, 1991). In complex issues such as selective abortion (Cignacco, 2002) and insertion of feeding tubes at end-of-life (Wilmot et al., 2002), balancing professional values of beneficence, non-maleficence, autonomy, dignity, and respect, for example, becomes "a complex, uncertain, emotionally-laden process of moral struggle" (Cooper, p. 25). Issues of distributive justice versus equitability may become challenging for nurses: Do all patients really deserve equal treatment? Should those who engage in risky

behaviours receive the same benefit as others? Nurses have described tension between values of autonomy and beneficent guidance when patients refuse recommended care (Woodward, 1998). These examples indicate that tension within and between professional values can potentially be a source of stigma and discriminatory behaviour.

While nurses are subject to the profound influence of professional forces on the development of a moral identity (Varcoe et al., 2004), they are also strongly influenced by their own socially-constructed values and beliefs.

<div align="center">**Personal Values**</div>

Human beings are socialized to the cultural values of the context in which they live. Liaschenko (1999) describes values as having both cognitive and affective facets that "help to build a moral vocabulary by which we evaluate ourselves and others as praiseworthy or blameworthy" (p. 36). One's preconceptions are influencing factors in how a situation is evaluated and thus have the potential to produce negative as well as positive outcomes (Kundrik-Leh, 2007).

Every nurse, as a socialized human being, has personal values, morals, attitudes, and beliefs that can influence nurse-patient interactions (Macdonald, 2003). Partiality, although intrinsically human, can interfere with a nurse's ability to give morally sensitive care (Woodward, 1999). Discriminatory behaviour has been shown to be significantly related ($p<0.001$) to prejudicial attitudes (Li, et al., 2007), and nurses must recognize the impact of their preconceptions on practice (NANB, 2005). Personal factors that have been noted to influence attitudes and discriminatory behaviour include ethnicity and cultural differences in the way people perceive and respond to "others" (Gesteira, et al.,

2008; Li, et al., 2007; Schafer, et al., 2011), a person's degree of religiousness, and how one gauges 'right' from 'wrong' (Andrewin & Chien, 2008; Gesteira, et al.).

Deep-rooted personal biases, preconceptions, and attitudes are difficult to change (Seccombe, 2006) and can result in enacted stigma, whether blatant and deliberate or subtle and unintentional. Blatant discriminatory practice is discussed by Hancock (2008) who described an 'ethic of conformity' amongst a group of social work students. These students expressed that upholding Christian hetero-normative values is necessary and just to maintain decency in society. These students' personal values allowed them to rationalize oppressive behaviour toward subordinate sexual groups. In another study that looked at discriminatory behaviour in the context of HIV, 29% of participants (nurses and physicians) reported giving intentionally differential treatment to patients (blame, judgment, breach of confidentiality, avoidance and failure to obtain consent for procedures) based on their sero-status (Andrewin & Chien, 2008).

Unintentional forms of discriminatory behaviour are reported in research findings more commonly. Rogge et al. (2004) describe the phenomenon of *civilized oppression* as containing elements of non-peer, power-laden relationships; diminishing and controlling behaviours; cumulative acts of omission and commission; and absence of malicious intent that result in harm or disadvantage to the recipient. The literature describes healthcare provider behaviour that could be viewed as civilized oppression as including, for instance, task-only care and medical treatment without regard for emotional needs (Carveth, 1995; Kukulu & Ergun, 2007), prioritizing care of other patients over that of the less desirable other (Gesteira, et al., 2008; Higgins, et al., 2007), delayed or ignored care needs (Higgins, et al; Law, et al., 2009; Zyrinyi & Balogh, 2004), derogatory

language (Higgins, et al.), anger with the endorsement of punitive/abusive behaviour (Law, et al.; Zyrinyi & Balogh), not involving patients in clinical decision-making (Zyrinyi & Balogh), social judgment and determination of worth (Johnson & Webb, 1995; Zyrinyi & Balogh), and avoidance (Kagan, et al., 2009). How do nurses deal with powerful personal attitudes, biases, and values that can lead to discriminatory care?

Stigma is socially constructed and dependent on multiple factors. In addition to professional and personal influences, the literature shows that there are a number of environmental factors that contribute to stigmatizing behaviour.

Environmental Factors

By far the largest body of research on discriminatory nursing care identifies *contextual and structural factors* that have been found to play a role in negative behaviours. In a Brazilian study that described overt oppression and disregard for patients seeking abortion, the legal context played a role in nurse attitudes and behaviours as it was a crime in that country to abort (Gesteira, et al., 2008). Results from this paper, while difficult to generalize, are important in that they clearly demonstrate the power of the state on individuals' attitudes and behaviours.

Other structural influences on healthcare providers' behaviour noted in the literature include gender socialization and professional socialization. Research findings indicate that gender is an important influence on stigma. Gender socialization may lead to stereotypical gender-related behaviours characteristic of the more dominant, aggressive male and the more passive, nurturing female (D'A Slevin, 1991; Franzini, Litrownik, & Blanchard, 1978; Hoffman, 1977; McArthur & Eisen, 1976; McEwen, 1987; Morgan & Dunn, 1988). In Andrewin and Chien's (2008) study of stigmatization of patients in

Belize (a male-dominated society) in the context of HIV/AIDS, women were found to be held to a higher moral standard and suffer greater social consequences than men for behaviour deemed to be sexually or morally deviant. Male participants in research on attitudes toward those who self-harm reported higher levels of anger, anxiety, perceived manipulation, less willingness to help, and greater support for coercive and segregatory behaviours than women (Law et al., 2009; Mackay & Barrowclough, 2005; Warm, Murray, & Fox, 2002). D'A Slevin proposed that gender socialization may result in women having 'softer' attitudes than men and influence their decision to enter a profession such as nursing. This is interesting to consider in light of research findings that indicate professional socialization can actually influence practitioners to develop more negative attitudes toward certain populations. Nurses have been noted to be less willing to care for the elderly (D'A Slevin; Treharne; 1990) and patients with HIV/AIDS (Andrewin & Chien) as their clinical exposure to these patient populations increases.

The literature suggests a number of workplace/contextual factors that influence healthcare providers' behaviour. The workplace has been described as the ethical climate in which clinical decisions are made (Johnson & Webb, 1995). This claim is supported by the findings of three studies that looked at how nurses label patients, negatively or positively, and how these labels are perpetuated by and between nurses. Carveth (1995) found that 75% of the time nurses agree on how a patient has been classified. Labels have been described as "contagious" in that they become a collective opinion based on the sharing of patient information. In fact, direct contact is not even necessary for a nurse to form a strong opinion of a patient. Indeed, Giddings (2005) and Johnson and Webb reported that nurses do not challenge patient labels in an effort to fit in and conform to

22

the accepted norm. Further, institutional norms that promote notions of "difference"

perpetuate a culture in which diversity is resisted (Harrison & Gill, 2010; Pescosolido, et

al, 2008).

Research shows that nurses are forced to navigate tensions in the workplace

which in turn shapes their ability to carry out professional values (Beagan & Ells, 2009;

Johnson & Webb, 1995; Pauly, 2008; Varcoe, et al., 2004). Hierarchical relationships in

healthcare have been identified as a key barrier to ethical nursing practice, in part, due to

the traditional privilege of medicine (Beagan & Ells; Varcoe, et al.). Nurses have

described being verbally abused, or dismissed, by physicians and how this silences them

from advocating fully for patient needs (Varcoe, et al.). In turn, some have argued that

nurses, as an oppressed group, may enact *downward oppression* as a means of survival

(Dong & Temple, 2011). This could account for Johnson and Webb's finding that nurses

work in a context in which the social judgment of patients is an important means of

managing uncertainty in relationships fraught with power and status imbalances. In

another study of healthcare professionals' attitudes toward the homeless, Pauly discussed

the tendency of emergency department staff to adopt a cultural norm of devaluing repeat

users of healthcare as a waste of time and resources. Such contextual norms can lead to

detachment and decreased quality of care (Beagan & Ells).

The dominant ideology of biomedicine in healthcare emphasizes disease, cure of

disease, technology, and quantitative measures of success (Beagan & Ells, 2009; Pauly,

2008; Varco, et al., 2004). The positivist values inherent in biomedicine have been noted

to be barriers to building trusting relationships and prioritizing patients' quality of life

(Varcoe, et al.). Pauly found the importance of the principle of *fixing* in emergency

departments as being consistent with the biomedical model. Indeed, participants in this study felt a sense of failure when unable to fix patients' physical and social issues. Similarly, Beagan & Ells found this fixing phenomenon manifested in healthcare providers when imposing the "best" course of action/treatment rather than listening to the wishes of patients or considering their social circumstances. Likewise, patients are often labeled "non-compliant" in an environment that values biomedicine dominated by the idea of fixing.

Varcoe et al. (2004) describe the shift to corporate values in healthcare with the adoption of non-nursing managers, expanded job descriptions of nurse managers, and little communication between front-line staff and managers and how this shift has led to fragmented care. Nurses described feeling a lack of support and leadership for ethical practice. Corporate approaches to healthcare reflect the current priority of the healthcare system: to provide financially responsible care. This mandate to work "lean" was found to impact nurses' ethical practice greatly. Limited funding and resources have resulted in nurses experiencing increased workload, physical and emotional exhaustion; inadequate time to provide care; and lack of time to know patients and develop relationships (Andrewin & Chien; Beagan & Ells, 2009; Grief & Elliott, 1994; Macdonald, 2007; Varcoe, et al.). Varcoe et al. found that it has become necessary for nurses to ration time and care, "sometimes according to the deservedness of certain groups" (p. 322). Pauly (2008) echoed this when she noted that some groups are deemed less deserving based on social status and at times care is rationed accordingly. In describing what it is like to work in a context laden with values that often contradict their own, nurses described a process burdened with "professional struggle and deep personal struggle as they sought to

sustain their identity as moral agents by doing what they saw as 'good' while contextual forces constrained their ability to choose and act in ways they deemed ethical" (Varcoe et al., p. 319). Clearly structural/contextual factors can be barriers to the enactment of professional values of caring, making a difference, patient-centeredness, advocacy, professional integrity, holistic care, patient empowerment (Beagan & Ells), and ethical practice or "doing the right thing" (Varcoe, et al.). How do nurses deal with environmental factors that contribute to stigmatizing behaviour?

The perpetuation of stigma has various roots. Beyond cultural dynamics that uphold this phenomenon are other social factors that enable stigma to advance.

Situations in Which Stigma is Perpetuated

Phelan, Link and Dovidio (2008) developed a typology of the three functions of stigma and prejudice: "exploitation and dominance (keeping people down); norm enforcement (keeping people in); and disease avoidance (keeping people away)" (p. 358). Policies and institutional practices that are created to address social problems can facilitate the continuance of stigma. For example, the acceptance of involuntary commitment of psychiatric patients must be considered through a stigma lens. Coercive policies such as this one exemplify "the exercise of power in placing labeled individuals in separate circumstances and treating them differently" (Link, Castille, & Stuber, 2008, p. 410). Looking to Link and Phelan's (2001) conceptualization of the process of stigma, a clear connection can be made in this example of the status loss, discrimination, and power imbalance faced by the labeled and separated "other". The link to Phelan et al.'s three functions of stigma is also evident: involuntarily committed patients are dominated

25

and kept apart from "acceptable" members of society while social norms of compliance are enforced.

Corrigan, Markowitz and Watson (2004) described the concept of structural, or institutional, discrimination as including policies that intentionally or unintentionally restrict opportunities of those who are stigmatized. Examples of intentional structural discrimination can be noted in former US laws that undermined the rights of African-Americans (Corrigan et al.) or laws that prevent individuals with mental illnesses from voting (Yang et al., 2007). Unintentional structural discrimination occurs when there is no overt effort to discriminate but opportunities for members of minority groups are nonetheless limited. Some current examples of unintentional structural discrimination include less funding allocated to mental illness research than other diseases higher on the public health agenda (Corrigan et al., Link & Phelan, 2001), limitations of access for physically disabled individuals due to architectural insufficiency, mental health treatment centers located in isolated areas or in disadvantaged urban neighborhoods where the residents do not have the power to protest (Link & Phelan), and mental health care professionals moving to private treatment centers with better financial reward and less acutely ill patients (Corrigan et al., Link & Phelan). In Canada, structural discrimination could arguably be linked to what has been called a 'two-tiered healthcare system' despite the Canada Health Act's (Minister of Justice, 1984) mandates for public administration, comprehensiveness, universality, portability, and accessibility. "What is key in structural discrimination is that the decision to stigmatize does not take place at the interpersonal level. Rather, discriminatory policies exert their adverse effects via broader, systemic forces" (Yang et al., p. 1527).

Misinformation is another means of perpetuating stigma. For example, Badahdah's (2010) study showed the power of misinformation given by the Saudi Arabian government and how it may be responsible for generating beliefs among citizens that persons infected with HIV are morally inferior and a source of shame.

Finally, research on stigma has mainly focused at the micro-level; the perceptions of stigma and consequences of stigma on individuals. "Research examining the sources and consequences of pervasive, socially shaped exclusion from social and economic life are far less common" (Link & Phelan, 2001, p. 366). Researchers have focused heavily on the meaning of stigma to individual sufferers to the detriment of understanding more fully the process of discrimination. Link and Phelan indicate that this lack of research into the ways that rejection and exclusion are produced prevent us from having a better understanding of where responsibility lies for the problem and effective strategies for action (Link & Phelan).

The problem of values tension with the potential for stigmatizing behaviour on the part of nurses is an ethical issue. Accordingly, a look to the literature from the discipline of ethics is indicated.

Ethical Perspectives

Ethics is a study of and reflection on morality that "consciously calls into question assumptions about existing components of our morality that fall into the category of habits, customs, or traditions" (Purtilo, 2005, p. 15). Underpinning the discipline of ethics is the question: "What do human dignity and respect demand?" (Purtilo, p. 15). From this foundation, ethics seeks to understand what values, behaviours, and characteristics measure up to this standard and, when conflicts arise,

which values and/or duties are most important and why. Ethical theories provide frameworks to determine the nature of right versus wrong and to identify characteristics and behaviours that are virtuous (Purtilo).

One's personal value system is a moral framework for how to think, feel and act in particular situations (Purtilo, 2005). "Personal value systems are our most fundamental source for maintaining a sense of integrity" (Purtilo, p. 128). That is, this set of values enables a person to act on their own convictions in a way that is personally meaningful (Purtilo). Purtilo discusses the potential for conflict between professional and personal values in professional life. When personal values are threatened, this may present opportunities for self-reflection and refinement of one's personal value system. Alternatively, she notes that people can also employ counterproductive coping responses when faced with values tension. A challenge to personal integrity may result in emotional detachment, ignoring or denial of the tension, or rationalization – a belief that one's own point of view is the only truth regardless if it is validated (Martin, 1986).

The caring response is the end-point of professional ethics (Purtilo, 2005). A caring response "shifts the claim on [the healthcare provider] from a patient's hope that you will offer a kind or even generous response, to making it your duty to respond to the patient's need" (p. 303). A caring response is person-centered, highly individualized and is attentive to what matters to the person. Concern for the whole person and respect for human dignity are of utmost importance in professional ethics (Purtilo).

Caring for the 'Uncareable'

"As healthcare professionals, we do have a moral obligation to care for those who come to us for help, even those we do not like" (Blackall & Green, 2012, p. 8). This

statement reflects the struggle of people in caring professions, including nurses, to maintain their personal integrity in certain healthcare encounters. Ethical perspectives such as consequentialism, deontology, feminism, ethic of care, ethic of face, virtue ethics, and ethical action principles can assist in answering the question, "How do I care for the 'uncareable'?".

The major ethical theories of consequentialism and deontology can be used as lenses when considering how to care for the 'uncareable'. Consequentialism is an ethical perspective that holds that acts are morally assessed solely by their outcomes (Stanford Encyclopedia of Philosophy, 2012). The consequentialist paradigm focuses on the consequences of choices and contends that the moral actor will increase 'the Good'; that is, "promote the greatest happiness for the greatest number" (Christie, Groarke, & Sweet, 2008, p. 54). Consequentialist reasoning, therefore, would instruct nurses to consider the consequences of enacting negative feelings toward the 'uncareable'. Using a lens of consequentialism, nurses must act in ways that promote patients' physical and psychosocial well-being. This ethical perspective instructs that discriminatory care is morally incorrect due to the detrimental outcomes to patients. Deontology is an ethical perspective that focuses on the intent of the moral actor rather than consequences of actions. This line of reasoning instructs that only those actions that are motivated by a sense of duty are morally correct. Deontological thought is duty-based and holds that the moral imperative is to 'do the right thing' (Christie et al.; Stanford Encyclopedia of Philosophy). With this in mind, the moral nurse will act in accordance with professional ethics of caring, compassion, and social justice and strive to build therapeutic relationships with all patients.

Feminism is a "worldview that values women and that confronts systematic injustices based on gender" (Chinn & Wheeler, 1985, p. 74). The feminist approach to ethics claims that the oppression women experience is "so extensive, familiar, and entrenched in our thoughts and habits that it is very easily overlooked" (Christie, 1999, p. 33). Feminism rejects the idea of one "truth" as it recognizes the influence of context on women's experiences (Hall & Stevens, 1991; Harding, 1987). One who gazes through a feminist lens values the experiences of women, seeks to understand the social structures that oppress women, recognizes women's strengths, and is committed to social change to benefit women (Hall & Stevens, 1991; McCormick & Bunting, 2002). Looking at a problem through a feminist lens allows exploration of human relationships, personal meanings, and emotions (Wuest, 1995). This study sampled women who belong to a female-dominated profession. The feminist perspective helps to situate the phenomenon of interest from the vantage point of the participants; it is a lens that accepts the subjective experiences of women (Campbell & Bunting, 1991). In seeking to understand how nurses "care for the 'uncareable'", a feminist ethic encourages looking at the factors implicit in nurses' behaviours; the contextual influences of power imbalances and gender inequalities. Feminist research can generate knowledge from women's reflections and ultimately be a point of departure for transformative social action (Kushner & Morrow, 2003; Plummer & Young, 2010).

An *ethic of care* would instruct the healthcare professional to never abandon or dismiss a vulnerable other (Myhrvold, 2006). Care ethic emphasizes the humanity of the one cared-for, respecting individuals for who they are (Nortvedt, Hem, & Skirbekk, 2011). In caring ethics, how moral agents balance competing interests is relevant. This

way of being fosters trust, mutual concern, and recognition of shared humanity (Nortvedt et al.; Purtilo, 2005). The relational ontology of care ethic with its contextual focus would support Munhall's (1993) assertion that nurses need to 'unknow' preconceptions in order to be authentically present with patients.

Levinas' (1979, 1998) *ethic of the face*, which "involves an unconditional being-for-the-other" (Woodward, 1999, p. 392) maintains that a moral person is one who can overlook personal interest and preference (Woodward). This ethical approach instructs that "we can choose to bear witness to the other's vulnerability or we can refuse to bear witness… We can respect, revere, and honour the other's humanity, or we can leave him or her deserted in total isolation, negating his or her existence as a human being, including the need for recognition and human connectedness" (Naef, 2006, p. 149).

Virtue ethics suggests that a virtuous nurse will inhabit character traits that will motivate him or her to work for the good of the patient always and to refrain from harming vulnerable people (Darr, 2006; Lutzen & Barbosa da Silva, 1996; Pelligrino, 1994; Pelligrino & Thomasma, 1988; Purtilo, 2005). "Personality traits may lead the nurse to nursing; however, these inclinations may not be sufficient when exposed to the conflicts inherent in healthcare" (Smith & Godfrey, 2002, p. 303). Virtue ethics teaches that nurses must continuously strive to acquire virtues, through experience and observation of virtuous role models so that preconceptions and negative feelings are controlled and moral behaviour is habitually enacted (Darr; Gardiner, 2003; Smith & Godfrey).

Finally, *ethical principles* are frameworks for moral behaviour. For example, patients have a reasonable expectation to be treated with respect and that nurses will

follow their professional code of conduct (fidelity). The ethical principle of justice encourages inclusiveness and equity in healthcare encounters. A just nurse would strive to consider social factors implicit in a patient's circumstances and avoid laying blame or enacting discriminatory behaviour (Purtilo, 2005).

From these examples it is clear that, from an ethical standpoint, nurses have a moral responsibility to respect the humanity and uniqueness of all patients and to be motivated to meet their needs through authentic caring presence.

Incongruence between Personal and Professional Values

Oppression and its consequences for stigmatized groups are well documented in the literature. While the evidence supports structural and contextual influences on the enactment of professional values, the relationship within and between personal/individual factors and views of professional responsibilities and ethical practice remains unclear. In terms of personal factors, little is known about the *internal tension* nurses experience when personal and professional values collide. A small body of research addresses this issue and increases understanding of the phenomenon in question: What is going on *within the nurse* when personal and professional values are in conflict?

Self-Awareness and Willingness to Resolve Values Conflict

Research findings suggest that in order for internal tension to exist, an individual must have a certain degree of self-awareness and self-reflection must occur. Nurses have described how personal and professional values blend to create a code by which they live and practice (Davis, 1991; Nathaniel, 2006; Varcoe et al., 2004). Personal values, although expanded and modified during professional socialization, are important in one's ethical orientation (Davis). Nurses and other healthcare professionals are aware of the

different voices within themselves and how each brings different perspectives of what "should" be done in a given situation (Csikai, 1999; Varcoe et al.). Study participants have described the importance of separating personal values and beliefs from professional obligations (Csikai; Davis). Nurses engage in inner dialogue when they feel torn between values (Davis; Nathaniel; Varcoe et al.). Internal tension forces nurses to make critical decisions in choosing one value or belief over another (Nathaniel; Varcoe et al.). Nathaniel described this as part of the process of *moral reckoning*: when core values are in conflict, *structural binds* occur which result in inner turmoil. Ultimately, internal tension compels movement; choices are made and responses are enacted (Nathaniel; Varcoe et al.).

Second, the inner tension that occurs when personal and professional values collide is handled differently based on one's ability or willingness to separate private moral views from professional duties (Farsides, Williams, & Alderson, 2004; Hancock, 2008). Hancock, in a study of evangelical social work students' helping attitudes toward sexual groups found that only some students are "able to achieve a clear and consistent awareness of their social location and are able to differentiate between their personal views and the needs of others" (p. 358). Similarly, Farsides et al. reported differences between *absolutists*, *tolerators* and *facilitators* in a study looking at healthcare professionals' views on antenatal screening. Absolutists are described as those who have a "moral belief about something which is fixed and non-negotiable" (p.506). Tolerators believe in the virtue of accepting others' differences but struggle, at the same time, to remain true to their own moral views. Facilitators have the ability to separate personal and professional values "to the extent that the moral limits they operate within are almost

completely externally defined" (p. 508). While both of these studies noted three distinct groups of participants with variations in their ability or willingness to help in ethically-laden situations, what allows some to "intellectually accept and digest differences as unequal and…discern ways in which dominant groups make life more difficult for members of subordinate groups" (Hancock, p.357-358) is left unclear. The literature does, however, give some insight into the opposite.

Internalization of Professional Values

Baum (2010) investigated social workers' willingness to provide service in a politically-charged situation. The findings of this study suggest that those who were unwilling to provide service had a narrower view of professional obligations than participants who were able to look past the emotions involved in the situation to the suffering of others. Baum proposed that those who were unwilling to provide service had not fully internalized the values of the social work profession. Two separate studies (Baum; Hancock, 2008) noted that some practitioners seem to have found ways to freely internalize professional values of responsibility and duty to care. These participants were able to put aside controversial aspects of situations and focus on issues of equity and social justice. Both studies identified these persons as standing out from the majority of other members of their peer groups in that they were able to "differentiate between their personal beliefs and the needs of others" (Hancock, p. 358). What enabled them to demonstrate such deep empathy and sense of equity and understanding of the obligation to not contribute to the oppression of patients was not determined. Both authors give recommendations for future research to gain understanding of the relationship between personal features and views of professional responsibility.

Justification

      In addition to the possibility of failure to internalize professional values, the literature offers other reasons why conflicting personal and professional values may be enacted in discriminatory behaviour. A recurrent theme that is noted in this body of literature is *justification.* Chan (2009) described how Thai nurses' resolved internal tension when personal and professional values were in conflict. This group of nurses justified discriminatory attitudes and behaviours based on perceptions of risk to personal safety. While aware of a mandate for non-discriminatory practice, nurses in this study implied that the ethic of non-discriminatory was inapplicable to some patients with particular risk behaviours such as intravenous drug use. This justified them in overt devaluing of this type of "other". Oppressive behaviour has been justified by evangelical social work students as "necessary for maintaining a decent, orderly society" (Hancock, 2008, p. 352). In exploring the concept of social judgment, Johnson and Webb (1995) found that nurses justified negative attitudes and behaviours toward unpopular patients based on the "realism" that it is inevitable that there are people who nurses will like and dislike. In this study, social judgment was noted to be a universal phenomenon among all participants; that is, all were aware of it and of their own inclination for doing it.

      Bolton (2001) conducted a study examining the emotion-work of nursing and the various *faces* nurses use in their everyday working lives. It is suggested that when personal and professional values are in conflict, different faces can be presented as a means of self-protection. This could be considered justification of behaviour. For example, it was noted that the *professional face* can be used as a shield to create distance and to mask feelings of anger or dislike.

Some days the ward is full of teabags. You spend all day telling them to stay on

their beds. They think this is a holiday camp. I know I should treat them the

same as everyone else, but they don't act the same. We get some lovely women

in here, going through a really hard time and they hardly mutter a word. I can feel

myself going into automatic overdrive with the teabags. I suppose I end up

looking a bit stern, but it's either that or losing my rag… (p. 92)…(the nurses use

the term 'teabag' to refer to their own stereotypical image of a certain type of

patient who they categorize as being lower working class, living in socially

deprived areas, usually smokers, and often resistant to demands made of them to

conform to the social rules of the ward (p. 98).

Bolton also described the *humorous face* that can be used to blatantly disregard

professional values. This "applied" humour is often sarcastic and inherently oppositional

and has a veiled purpose as can be noted in the following:

This woman today. She took herself so seriously. She really believed in her

status as customer and that she was doing us a favour by being here. We soon

clicked on and we played games with her all day. We called her 'madam', we

continually asked if everything was to her satisfaction, and we each took it in

turns to go and fluff up her pillows and change her water jug. She really had first-

class service – only what she was due of course! (p. 96).

Consequences of Internal Tension

Finally, the review of literature indicates that the internal tension that arises when

personal and professional values are in conflict has consequences for the individual.

Farsides et al. (2004) found that for some, the separation of personal and professional

values is a daily struggle that bears a cost. Some participants in this study dealt with internal value tension by "discounting the relevance or significance of their own moral views" (p. 508).   Similarly, Calderwood et al. (2009) described the negative emotional impact that internal tension had on social work students experiencing conflict between personal and professional values. These participants described feeling uncomfortable, isolated, and even discriminated against when professional obligations made them behave in ways that were incongruent with their personal values.

Gaps in the Literature

This review of literature helps in understanding the inner dialogue that occurs when internal tension arises in the face of conflicting values and ways in which nurses and other healthcare providers may succumb to negative personal attitudes. It also gives a glimpse into the consequences to those who are aware of and struggle with competing personal and professional values. While this literature review provides a glimmer of understanding on the topic of interest, the question of how nurses "resolve the inherent paradox between the demands of their professional ethics and personal biases" (Chan, 2009, p. 182) remains unclear. More research is needed to more fully understand what is going on when nurses' personal and professional values are in conflict and how they deal with the internal tension that arises.

Summary

Gaps remain in the literature in the area of competing personal and professional values and how this results in discriminatory behaviour by nurses. It is unclear what personal/individual forces are important in some healthcare providers being able to enact professional values in controversial situations when others cannot or will not. More

research is needed to enhance understanding of what is going on when personal and

professional values collide and discriminatory behaviour is the outcome. Little research

in the writer's geographic location, eastern Canada, has been conducted on this topic.

The literature shows that this ethical issue is a global concern and more work is required

to fully understand the process of balancing personal and professional values.

CHAPTER III : METHODOLOGY AND METHODS

This chapter will discuss the research question, design, methodology, sampling, data collection, analysis, and ethical considerations.

Research Question

This qualitative study developed a grounded theory regarding nurses' perceptions in response to the question: What is going on *within the nurse* when personal and professional values collide while providing care, or observing the care of other nurses, and how does this affect nurse behaviour?

Methodology: Constructivist Grounded Theory

This qualitative inquiry used constructivist grounded theory methodology (Charmaz, 2006). The research question focused primarily on exploring the interactional processes involved in the phenomenon of interest. Grounded theory is suited to this type of knowledge development as it aims to discover *why*, *how* and *in what context* social behaviours occur (Sheldon, 1998; Wuest, 1995). Constructivist grounded theorists "aim to discover why people do what they do and to uncover possibly hidden knowledge, symbolic meanings and rules of social life. They try to explain others' realities" (Norton, 1999, p. 38). Constructivist grounded theory is well suited to nursing inquiry in that a new understanding of behaviour can assist in improving the quality of care that patients receive and to interrupt patterns that negatively impact patient outcomes (Nathaniel & Andrews, 2007).

Grounded theory methodology was developed by sociologists Barney Glaser and Anselm Strauss (1967) who identified a need for explanatory theory about human behaviour. Glaser's primarily quantitative background and Strauss' pragmatic qualitative

experience (Roberts, 2008) combined to create a methodological approach to inquiry "founded on the premise of critical realism" (Mills, Bonner, & Francis, 2006, p. 8). The formulation of grounded theory occurred at the time when qualitative research methodologies began to appear and there was a new emphasis on the post-positivist paradigm of inquiry (Annells, 1997).

Over time, a second approach to grounded theory emerged that reflected "changing philosophical views regarding inquiry" (Annells, 1997, p. 123). Strauss and Corbin's (1990) reformulation of grounded theory rejected the notion of one "true" reality that can be found. In this tradition of grounded theory, there is a move to an epistemology of relativism where "knowledge is relative to particular circumstances – historical, temporal, cultural and subjective – and exists in multiple forms as representations of reality" (Benoliel, 1996, p. 407). Truth can never be known, only interpreted through interactive processes between researcher, participants, and data (Annells; Mills et al., 2006).

Grounded theory continued to evolve to take the methodology "around the postmodern turn" (Clarke, 2003, p. 553). Postmodernism challenges existing "truths" (Wuest, 1995). Charmaz (1995) states that affirmative postmodernists "1) wish to dispense with scientism, not science, 2) value intuitive ways of knowing…, 3) support emancipatory movements, 4) recover truths and values from premodern thought, and 5) recognize the interconnectedness of science, subjective meaning, and social order" (p. 46). These statements are reflective of the premises of the constructivist approach to grounded theory.

Constructivist grounded theory is derived from the social constructivist paradigm of inquiry. Constructivism "assumes that people create and maintain a meaningful world through dialectical processes of conferring meaning to their realities and action within them" (Charmaz, 1995, p. 62). Thus, social meanings do not exist independent of human action. It is clear that, though grounded theory has evolved from its original Glaserian approach, the underpinnings of symbolic interactionism remain in the constructivist approach. Constructivism assumes "evershifting realities" (Wuest, 1995, p. 126) and recognizes that a single explanation of the phenomenon being studied may be impossible to achieve (Appleton & King, 1997).

Epistemologically, constructivism is subjective and transactional (Appleton & King, 1997). Knowledge is defined in the reciprocal relationships between the researcher and participants (Appleton & King; Ghezeljeh & Emami, 2009; Greckhamer & Koro-Ljungberg, 2005). The researcher's voice emerges in the text as a result of intense immersion in the phenomenon. Charmaz (2004) argues that when a researcher "enters the phenomenon" (p. 981) she is able to empathically understand the meaning of an experience. The reciprocal nature of the researcher-participant relationship results in co-construction of knowledge (Mills et al., 2006).

A constructivist grounded theory approach was taken in this study as it aligns with my postmodern worldview. In the classic grounded theory writings, Glaser and Strauss described theory as emerging from data separate from the scientific observer (Charmaz, 2006). "Unlike their position, I assume that neither data nor theories are discovered. Rather, we are part of the world we study and the data we collect. We *construct* our grounded theories through our past and present involvements and

interactions with people, perspectives, and research practices...[Constructivism] assumes that any theoretical rendering offers an *interpretive* portrayal of the studied world, not an exact picture of it" (Charmaz, p. 10).

Interpretive Lenses

Symbolic interactionism and critical social theory were used as interpretive lenses in this research project. Grounded theory's foundations are rooted in symbolic interactionism, a theoretical perspective which asserts that in order to understand a social process the contextual meaning to those involved must first be understood (Joen, 2004). Both symbolic interactionism and grounded theory are influenced by pragmatism (Annells, 1997; Charmaz, 2006) which encourages flexibility and focuses on practical application of research outcomes (Creswell, 2007; McCallin, 2003). The influence of symbolic interactionism and pragmatism suggest that grounded theory is consistent with critical social theory which focuses on socially informed meanings and emancipatory action (Campbell & Bunting, 1991).

Symbolic Interaction Theory

Symbolic interactionism is a theory about human behaviour with three basic assumptions: (1) people's actions are based on the meanings they have for the people and things around them, (2) meanings are derived from social interaction, and (3) people's meanings are modified through an interpretive process used to understand and deal with the world (Blumer, 1969). Symbolic interactionists, then, describe a process that results in behaviour. Meaning is constructed by experience. The meaning ascribed to a phenomenon determines the value assigned to it by the individual. Subsequently, the behaviour toward that phenomenon is motivated by the meaning and value it has for the

42

person (Chenitz & Swanson, 1986). "With whom, with what, and how one interacts becomes a major determinant of how one perceives and defines reality" (Kendall, 1999, p. 744).

In society, people align their behaviour with those around them. Therefore, common values and beliefs are shared in a group through means of communication (Chenitz & Swanson, 1986). Such meanings become "embedded in and reflective of existing cultural and organizational contexts" (Snow, 2001, p. 371). According to symbolic interaction theory, meanings can be redefined with resultant behaviour change (Blumer, 1969; Chenitz & Swanson).

"The epistemological assumptions of grounded theory are derived from symbolic interactionism which explores the processes of interaction between people's social roles and behaviours" (McCann & Clark, 2003, p. 8). A form of interpretivism, symbolic interactionism facilitates the examination of a human behaviour and how meaning is derived in social contexts (Chenitz & Swanson, 1986; McCann & Clark). This theoretical lens is particularly useful to understand, or create a new perspective on, social problems and the influence of context on social behaviours (Chenitz & Swanson).

Critical Social Theory

Critical social theory is based on the premise that "society is structured by rules, habits, convictions and meanings to which social beings adhere" (Mooney & Nolan, 2006, p. 241). Critical theorists purport that one's perceptions are socially, historically, and symbolically constructed (Campbell & Bunting, 1991; Kincheloe & McLaren, 2005) and that critical theory brings attention to ways in which culture can sustain social inequities (Merriam & Simpson, 1995). A critical theory perspective aims to examine

how some groups "are constructed as belonging to the social fabric, whereas others are left on the margins, constructed as 'Other'" (Kirkham & Browne, 2006, p. 324). Critical theorists seek more than understanding of this process; they strive to find new possibilities for the future through critical reflection (Merriam & Simpson; Mooney & Nolan).

> [T]o be denied the status of full partner in social interaction and prevented from participating as a peer in social life as a consequence of institutionalized patterns of cultural value that constitute one as comparatively unworthy of respect or esteem comprises a situation of injustice (Kirkham & Browne, p. 325).

Critical theory research focuses on the experiences, wishes and needs of oppressed people (Fleming & Moloney, 1996). Critical theory inquiry is about more than opposition to power imbalances and knowledge development. Critical theory research generates insight into societal problems, but more importantly it has the potential to empower people "to transcend the constraints put on them" (Creswell, 2007, p. 27). The critical perspective lends itself well to nursing research which is driven by professional ethics known to be inherently emancipatory (Fleming & Moloney). Nurse researchers who gaze through the lens of critical social theory can gain insight into problems that impact client outcomes, encourage nurses to challenge the status quo, and provide direction for emancipatory nursing action.

Theoretical Triangulation

"Theories give researchers different 'lenses' through which to look at complicated problems and social issues, focusing their attention on different aspects of the data and providing a framework within which to conduct their analysis" (Reeves, Albert, Kuper, &

Hodges, 2008, p. 631). Grounded theory methodology has a classic affinity with symbolic interactionism (Kushner & Morrow, 2003). While symbolic interactionism is useful to develop understanding of processes, attention to broader social and structural issues may be overlooked (Hall, 1990; Sohier, 1993). Kushner and Morrow proposed the notion of *theoretical triangulation* as a strategy that encourages a more comprehensive view of complex social issues in healthcare research. In this study, broadening the philosophical framework to include both symbolic interactionism and critical theory allowed me to consider the interplay between both individual and structural/environmental/cultural factors that were implicit in the process being investigated (Burbank & Martins, 2009; Kushner & Morrow).

Historically, symbolic interactionism and critical theory were considered to have conflicting philosophical perspectives. Indeed, symbolic interactionism focuses at the micro level of understanding humans in their social worlds and meanings derived from interactions, while critical theory has an emphasis on macro level concepts of class, power, and social inequalities (Burbank & Martin, 2009; Kushner & Morrow, 2003). It has been argued, however, that these two traditions can be complementary and congruent. Habermas' (1973) critical theory was influenced by George Herbert Mead, who provided the foundations for symbolic interactionism (Burbank & Martins). "Habermas, in his theory of communicative action, brought critical perspective to the individual level and asserted that all the power inequalities that can be seen in society at large can be found in individual interactions between people as well" (Burbank & Martins, p. 34).

The evolution of grounded theory has seen a shift from a pure affiliation with symbolic interactionism to a methodology regarded as "an umbrella covering several

different variants, emphases, and directions – and ways to think about data" (Charmaz, 2009, p. 128). Constructivist grounded theory allows for theoretical triangulation as long as the researcher is transparent about philosophical frameworks being used (Oliver, 2012). Indeed, Corbin and Strauss (2008) support the interplay between symbolic interactionism and critical theory in grounded theory research, knowing that "to understand experience, that experience must be located within, and can't be divorced from, the larger events in a social, political, cultural, racial, gender-related, informational, and technological framework and, therefore, these are essential aspects of our analyses" (p. 8). The convergence of these two theoretical frameworks will result in *critical grounded theory*, focusing on both individual action and social structure (Burbank & Martins, 2009; Oliver).

"Critically interested grounded theory methodology has important potential for contribution to the generation of substantive and formal middle-range theory that is relevant to everyday life experience and is useful to the promotion of emancipatory social change to improve the health of populations" (Kushner & Morrow, 2003, p. 41). Using a dual lens will allow the researcher both upstream and downstream approaches to viewing complex healthcare issues (Burbank & Martin, 2009). Critical grounded theory moves the researcher beyond 'rich description' and 'giving voice' (Charmaz, 2006) to understanding "what *is* in order to ultimately liberate us from the destiny of what *has been*" (Morrow, 1994, p. 320).

Methods

Recruitment Strategies

Following ethical approval from Horizon Health Network, preliminary recruitment strategies included a meeting with the manager of the nursing unit to present the research project, "gaining entrée to the research setting" (Davis, 1986, p. 49) and introducing myself as the researcher, responding to questions or concerns in an effort to reduce feelings of unease or vulnerability, and discussing confidentiality in research. As I was known to some employees in the study setting and education settings from previous work, it was emphasized that only those who had not had previous contact with me in those contexts would be eligible to participate. Recrutiment posters (Appendix A) were placed by the nurse manager of the department in common staff areas such as the nursing station and staff lounge. Letters of invitation (Appendix B) were sent via mail to all eligible staff members. Study description, consent forms, and researcher contact information were included in the package. The nurse manager was requested to refrain from acting as a 'gatekeeper' to the study in an effort to avoid participant coercion and potential power imbalances (Miller & Bell, 2002).

Setting

The emergency department (ED) was purposefully selected as the site for this study. The site was chosen based on my judgment that the ED is a setting with high potential for 'information-richness' (Louiselle & Profetto-McGrath, 2007) that would allow for significant sampling in terms of nurses with exposure to a wide variety of patient populations who may be considered "other" (Patton, 2002).

Sample

Purposeful sampling "refers to a decision made prior to beginning a study to sample subjects according to a preconceived, but reasonable, initial set of criteria" (Sandelowski, Holditch-Davis, & Harris, 1992, p. 302). Purposeful sampling was used at the beginning of the study to select "subjects who can readily articulate their experience of the area under investigation" (Cutcliffe, 2000, p. 1477). This sampling strategy was used to gain insights into the scope and complexities of the phenomenon of interest: *what is going on* within the nurse *when personal and professional values collide while providing care, or observing the care of other nurses, and how does this affect nurse behaviour*, from registered nurses who work in the ED. Sampling aimed to capture nurse participants who represented a diverse range of demographics (e.g. gender, years of nursing experience, years of experience in the emergency department, previous employment in other areas of health care) (Lousielle & Profetto-McGrath, 2007). The most important criterion, however, was that participants have at least one year of experience working as frontline nurses to ensure exposure to situations in which they may have experienced values tension. This initial sampling strategy was a beginning point prior to theoretical sampling. Glaser (1978) argued that the researcher initially selects the sample where the phenomenon of interest occurs; decisions for data collection are based on "a general sociological perspective and on a general subject of problem area" (p. 45). "Initial sampling in grounded theory is where you start, whereas theoretical sampling directs you where to go" (Charmaz, 2006, p. 100).

Theoretical sampling, a method used in grounded theory studies, is described as "the process of data collection for generating theory whereby the analyst jointly collects,

codes, and analyzes his data and decides what data to collect next and where to find them in order to develop his theory as it emerges" (Glaser, 1978, p. 36). The goal of theoretical sampling is to select informants who can best contribute to the evolving theory by "clarify[ing] the properties and relationships among emerging concepts" (Wuest, 2007, p. 248). Participants are selected based on emerging findings as the conceptualization progresses to gain insight into and refine categories and to fill in gaps in the developing theory (Charmaz, 2006). "Theoretical sampling is based on the need to collect more data to examine categories and their relationships and to assure that representativeness in the category exists" (Chenitz & Swanson, 1986, p. 9). Theoretical sampling is an "ongoing process of data collection that is determined by the emerging theory and therefore cannot be predetermined" (Becker, 1993, p. 256). Theoretical sampling continues until saturation of categories is achieved and the theory is fully developed (Charmaz; Creswell, 2007; Louiselle & Profetto-McGrath, 2007).

For the purpose of this study, final sampling to search for confirming and disconfirming cases was conducted to "test, refine and strengthen the theory" (Louiselle & Profetto-McGrath, p. 269). This study sought to understand the phenomenon of interest from the perspective of frontline ED nurses. The voices of other stakeholders, such as managers, educators or regulatory bodies, were not added as they would not have the same perspective as frontline nurses who experience and manage tension among values due to their different roles and perspectives. For this reason, theoretical sampling in this study entailed continued data collection from within a pure sample of frontline nurses until emerging conepts were clarified and saturation was achieved.

49

Sample Size

Sample size is never known at the onset of a grounded theory project. Data are collected until saturation is achieved and no gaps remain in the emergent theory. Saturation, the point at which data become redundant and no new information is gleaned, can typically be reached with a sample of 10 to 15 participants (Creswell, 2007; Louiselle & Profetto-McGrath, 2007). Reaching saturation, and thus sample size, was dependent on the need for data to inform theory development (Charmaz, 2006; Wuest, 2007). Factors that influenced sample size were the scope of the research question and data quality obtained from participants (Morse, 2000). "The constructivist view…recognizes diverse local worlds and multiple realities, and addresses how people's actions affect their local and larger worlds. Thus, those who take a constructivist approach aim to show the complexities of particular worlds, views, and actions" (Charmaz, 2006, p. 132). To develop a robust theory within this study that is representative of the complexity of the experience, diversity in experiences of the phenomenon of interest was sought (Cooney, 2011; Hamilton & Bowers, 2006). Saturation was achieved when after interviews with eight nurse participants, having a level of diversity in age and length of employment, no new dimensions or properties of categories were obtained.

Inclusion Criteria

Recrutiment aimed to sample English-speaking men and women over the age of 19 who were employed as registered nurses and provided direct patient care in the emergency department of one tertiary hospital. Registered nurses with diploma, baccalaureate and graduate education and at least one year of working experience were eligible to participate.

Sample Profile

The study setting employed 65 registered nurses, three of whom were male. Within two weeks of sending individual letters of invitation to all eligible nurses and placing recruitment posters in the ED staff lounge and nurses' station, eight nurses volunteered to participate in the study. The final sample consisted of eight registered nurses employed in the ED of one tertiary care center in urban Atlantic Canada. Participants in the study ranged in age from 23 to 50; the mean age being 32. Four participants were in the 20-30 age category, three in the 31-40 age category, and one in the 41-50 age category. All participants had completed their formal nursing education in Canada. All were baccalaureate prepared with one having completed one or more courses toward a Master of Nursing Degree. Professional nursing work experience ranged from one to 12.5 years (mean 6.3 years); years working in the ED ranged from five months to nine years (mean 4.3 years). Five participants had worked in the ED for their entire careers; only one participant had previous experience working in another hospital. Despite their eligibility to participate, no male nurses volunteered for the study. Having the male perspective would be valueable in understanding the influence of gender on the phenomenon of interet, thus enhancing the explanatory nature of the theory that was developed.

Data Collection

Data were collected through semi-structured interviews with participants and from my field notes and memos. As characteristic of qualitative approaches to inquiry, I was the instrument of data collection (Creswell, 2007). While similar approaches are taken in both grounded theory and ethnography, the focus during data collection in these

two distinct methodologies is different. In ethnological studies, the focus is on examining a particular culture from the perspective of its members in order to understand social behaviours. While grounded theory also is interested in socially constructed interactions, its emphasis is on *all* factors involved in a phenomenon and how they work together (Pettigrew, 2000). So, while the ED culture was considered as a variable in the process being investigated, the phenomenon of interest in this study was how nurses responded to patients when personal and professional values are in conflict. In looking at all variables involved in a phenomenon, grounded theory methodology encourages the researcher to consider possibilities for action and change (Pettigrew).

Interviewing

Semi-structured, digitally audio-recorded interviews were conducted with all participants and transcribed verbatim by the researcher. Participants provided consent to one interview lasting approximately 60-120 minutes. Interviews were scheduled at times and locations that were mutually agreeable to both researcher and the participant and ranged in length from 50 to 90 minutes. Interviews allowed participants to tell their stories in their own words and facilitated the development of the researcher-participant relationship (Kvale, 2006). "Language is telling – not only of acts and facts, but also of views and values, and of feelings, priorities and involvements" (Charmaz, 2004, p. 988).

Interview questions (Appendix C) shape the data that are obtained; interview questions determine how participants respond and therefore the knowledge that is gained (Charmaz, 2004). As recommended by Wuest (2007), one overview question that acted as a catalyst for participants to engage in telling their stories was created. Probing questions were prepared in the event that a participant was hesitant to share his or her

experience or to obtain greater detail – "filling out the descriptive picture" (Patton, 2002, p. 352).

Using the framework of symbolic interactionism, the following areas of inquiry were identified to obtain understanding of the area of inquiry (Currie, 2009). Interview questions were modified or focused to meet the demands of the emerging concepts (Wuest, 2007). The questions sought to explore: 1) aspects of the participant's understanding of self before and after becoming a nurse, 2) the participant's interpretation of the influence of external context and interactions with others on their practice, and 3) the participant's decisions about action related to patient care (modified from Currie). The data elicited using these three broad question areas enabled me to understand the phenomenon of interest from various angles: the influence of personal and professional socialization processes and the environment on values tension, how participants understand any values tension they may have experienced and the meaning it had for them, and how they manage values tension they may encounter in the course of providing patient care. Interviewing was an appropriate method of data collection for this study in that it offered a way to obtain detailed information about nurses' personal experiences and observations.

Field Notes and Memos

Field notes, "written records of observational data produced by field work [that]…consist of descriptions of social interactions and the context in which they occurred" (Montgomery & Bailey, 2007, p. 67), were used as data to inform the developing theory. Following each interview and throughout the process of data collection and analysis, I kept reflective field notes of thoughts, feelings, impressions,

and ideas that arose as participants shared their stories. Theoretical memos, "records of the researcher's developing ideas about codes and their interconnections" (Montgomery & Bailey, p. 67), were also kept and analyzed as data throughout the study.

Saturation

Saturation is the point at which data yield no new understanding of the phenomenon under study. When information gathered provides no further insight, a sense of closure, or saturation, of the categories being examined is achieved (Creswell, 2007; Louiselle & Profetto-McGrath, 2007). Charmaz (2006) argues that saturation is more than observing repetition or redundancy in data. *Theoretical saturation* is the ultimate goal of grounded theorists, and this occurs when new data no longer provide theoretical insights nor reveal new properties of theoretical categories. "Saturation is not seeing the same pattern over and over again. It is the conceptualization of comparisons of these incidents which yield different properties of the pattern, until no new properties of the pattern emerge. This yields the conceptual density that when integrated into hypotheses make up the body of the generated grounded theory with theoretical completeness" (Glaser, 2001, p. 191). The methods of data collection outlined above were used simultaneously with data analysis, through the process of constant comparison, until no new categories emerged.

<div align="center">**Data Analysis**</div>

Digitally audio-recorded interviews were transcribed verbatim by the researcher following McLellan, MacQueen and Neidig's (2003) Qualitative Data Preparation and Transcription Protocol. Transcriptions included non-verbal aspects of interviews such as pauses, looks, body postures, long silences, the physical setting (Poland, 1995), and

background noises (McLellan et al.). To protect the anonymity of participants, all identifiers (names, locations, etc.) were masked in transcriptions with alternate identifiers (Creswell, 2007). Digital recordings and data were stored on a computer in a password protected file known only to researcher. Paper transcripts and consent forms were stored in a separate file in a locked cabinet that could be accessed only by the researcher.

Data analysis in grounded theory is done with the intent to generate a substantive theory that enhances understanding of human behaviour (Sheldon, 1998; Wuest, 2007). Constructivist grounded theorists claim that the theory developed is inconclusive owing to the contextual and interpretive influences in data collection and analysis (Creswell, 2007).

Theoretical concepts were co-constructed through the inductive process of constant comparison. In the constant comparison method of data analysis, the researcher continually goes back and forth between data collection and data analysis comparing information from the field with emerging categories (Creswell, 2007; Kendall, 1999). "In this way theory generation is inductive, with categories emerging from the data and becoming more focused as the research progresses" (Sheldon, 1998, p. 47). The result is an inductive theory 'grounded' in the data (McCann & Clark, 2003)

Charmaz's (2004) constructivist approach to data analysis is more flexible and less prescriptive than Strauss and Corbin's (1990) structured procedure for analysis. Charmaz does describe steps to follow in the process of data analysis but emphasizes that the methods are not "recipes" and advocates creativity in the analytical process.

Accordingly, data analysis began with open coding, "the process of breaking down, examining, comparing, conceptualizing and categorizing data" (Strauss & Corbin,

1990, p. 61). Transcipts were coded line by line, codes were examined for similarities, and categories were defined (Creswell, 2007). "Overall, this is a process of reducing the database to a small set of themes or categories that characterize the process being explored" (Creswell, p. 160). Categories were further reduced to develop theoretical concepts. Concepts "are derived inductively from the data but then deductively checked out and modified as new data are collected" (Wuest, 2007, p. 243). Concepts were examined to determine their interrelationships. This is the basis of the grounded theory. Existing theory and published literature were theoretically sampled to further develop the theory (Kendall, 1999). The constant comparative method of data analysis continued until collected data no longer provide new insights. At this point, the categories were considered to be saturated (Creswell; Kendall).

Rigour

Trustworthiness

Charmaz's (2006) criteria for establishing trustworthiness were used to ensure research validity: credibility, originality, resonance, and usefulness. Validation in qualitative research refers to assessing the "accuracy of the findings, as best described by the researcher and the participants" (Creswell, 2007, p. 207) and speaks to the "goodness" (Morrow, 2005, p. 250) of the inquiry. Qualitative inquiry, regardless of vigorous implementation of trustworthiness strategies, can never be considered irrefutable; "it can at best persuade" (Lincoln & Guba, 1985, p. 329). Careful attention to the transcription process such as accurate punctuation, pauses, laughter and italics for emphasis as well as checking and rechecking transcriptions prior to beginning analysis, enhanced trustworthiness (Easton, McComish, & Greenberg, 2000; Plummer-D'Amato,

2008). The consolidated criteria for reporting qualitative research (COREQ) checklist was used as a guide to promote complete and transparent reporting. This tool aims to "improve the rigor, comprehensiveness and credibility of interview and focus-group studies" (Tong, Sainsbury, & Craig, 2007, p. 350). Rigor was additionally enhanced through the feedback of thesis committee members during the process of data analysis.

Credibility

Credibility refers to "how we ensure rigor in the research process and how we communicate to others that we have done so" (Gasson, 2004, p. 95). The study methods facilitated an understanding of the ED setting and the topic of inquiry that has both depth and breadth. The collected data were sufficient to ensure that no new categoried emerged and support the substantive theory that was generated. Systematic analysis of data used the process of constant comparison. In addition, the description of study findings and the discussion that follows will demonstrate sound connections between data, analysis and argument. In turn, readers of the research should feel confident that enough evidence is provided to support the substantive theory that was constructed (Charmaz, 2006).

Peer debriefing was conducted in an effort to explore, through dialogue with the research committee, interpretations of meaning (both conscious and unconscious) and to make researcher situatedness visible in the study (Lincoln & Guba, 1985). Peer debriefing exposed me to the questions of others who are experienced in qualitative inquiry and/or the phenomenon of interest (Louiselle & Profetto-McGrath, 2007). Thesis supervisory committee meetings were documented, analyzed, and retained for the audit trail (Lincoln & Guba) as evidence of peer debriefing. Peer review is considered to be a rigourous test of the credibility of qualitative analysis (Mays & Pope, 1995).

Dependability refers to the integrity of the research process; confirmability to the "objectivity" of the findings. "Findings should represent, as far as is (humanly) possible, the situation being researched, rather than the beliefs…or biases of the researcher" (Gasson, 2004, p. 93). Dependability and confirmability were addressed by keeping an audit trail that can be described as "a detailed chronology of research activities and processes; influences on the data collection and analysis; emerging themes, categories, or models; and analytic memos" (Morrow, 2005, p. 252). The audit trail ensures transparency in methodological and analytical decisions and minimizes researcher bias (Plummer-D'Amato, 2008).

Originality

The findings of this study provide new insight into the basic social process that nurses employ when faced with values tension. While existing literature is rich with studies that describe the effects of nurses' personal values, attitudes, and preconceptions on patient care, this study extends and refines current knowledge by enhancing understanding of the tension that nurses experience when personal and professional values collide. The categories that were co-constructed are conceptualized in a way that has not been noted in the literature to date. The study's findings have significance in that they can be used as a beginning point toward positive change in the study setting and offer new possibilities for future research on the same topic in other clinical settings.

Resonance

The categories and conceptual model that were constructed represent the complexity of the process that was identified as *Juggling a Way of Being*. The constant grating tension that was experienced by the participants is exemplified as it was heard in

their voices. The use of direct participant quotations facilitates reader understanding of the depth of the participants' struggle to reconcile the internal tension they experience in the workplace.

Member checking entails having participants provide feedback to the research findings and constructions of meaning. Focus groups and telephone calls were conducted with participants who had already been interviewed as a means of member checking emergent findings in the data; the purpose was *not* to obtain new data. Participants (n=4) reported that they saw their stories reflected in the conceptualization of the generated theory and that they could identify with the categories of *Tension 'in the moment', Assimilating Internal and External Stressors, Adjusting the Patient-Centered/Nurse-Centered Lens According to my Interpretation of the Situation, and Achieving a Point of Action or Inaction*. They indicated that the idea of *Juggling a Way of Being* from moment-to-moment resonated with them as being true to their realities. In an additional effort to assess the study's resonance, findings were presented to registered nurses in the ED who did *not* participate in the study (n=2). These individuals also indicated that the social process that was genereated was meaningful to them and reflected their experiences while working in the ED.

Usefulness

The findings of this study are relevant to the everyday lives of ED nurses who experience personal, patient, and environmental factors that lead to tension in the moment. The findings resonated with participants and non-participants in the study setting, and therefore could be useful to nurses within this department. Transferability refers to the extent to which research findings can be generalized to other contexts

(Morrow, 2005). As the sample consisted of nurses who work in one ED in one hospital in Atlantic Canada, it is unknown whether the findings are transferable to other clinical areas or geographical locations. The researcher's responsibility is to provide sufficient information to allow the reader to make decisions about generalizability (Lincoln & Guba, 1985; Morrow). In this study, transferability was addressed in rich, thick descriptions of the researcher as instrument, sample, context, methodology and process, analysis of data and determination of saturation (Morrow; Plummer-D'Amato, 2008). There are several implications for nursing practice, education and research noted in Chapter Five. These indicate that the study can contribute to the advancement of nursing knowledge and can be a beginning point toward improving nurses' and patients' experiences in the clinical setting.

Reflexivity

Reflexivity, or theoretical sensitivity, "means that the writer is conscious of the biases, values, and experiences that he or she brings to a qualitative research study" (Creswell, 2007, p. 243). To fully understand the participants' meanings, the researcher must first understand her own biases and beliefs. The reflexive researcher "situates" her own meaning in an effort to keep it from shaping the data (Charmaz, 2004). Researchers are influenced by their personal and professional experiences and knowledge as well as by the review of literature. Strauss and Corbin (1990) discuss theoretical sensitivity as the researcher's ability to be insightful and give meaning to the data. It is recommended to step back and ask, "What is going on here?" (p. 47). The researcher is skeptical of concepts that emerge quickly and validates them through the process of constant comparision.

Demonstration of reflexivity is a strategy that was used to establish trustworthiness in this study. In qualitative inquiry, the researcher must scrutinize the biases, values, interpretations, decisions and experiences that she/he brings to the research process (Charmaz, 2006). Casting the initial problem statement within a personal context (Creswell, 2007) served to situate myself into the research process and "allow the reader to decide how and to what extent the researcher's interests, positions and assumptions influenced inquiry" (Charmaz, p. 188). Memoing and the use of a reflexive journal (Lincoln and Guba, 1985) were exercised throughout the study and this documentation was examined as data in the process of constant comparison (McGhee, Marland, & Atkinson, 2007). In the research report, reflexivity is transparent in the description of my own thoughts and feelings during the process of the study and in acknowledging the co-construction of meaning inherent in grounded theory methodology.

In the process of ensuring reflexivity, I recognized that the constructivist approach to grounded theory accepts that the emergent theory is co-constructed and contextually situated. "Thus, constructivists attempt to become aware of their presuppositions and to grapple with how they affect the research. Grounded theorists can ironically import preconceived ideas into their work when they remain unaware of their starting assumptions. Thus, constructivism fosters researchers' reflexivity about their *own* interpretations as well as those of their research participants" (Charmaz, 2006, p. 131).

Ethical Concerns

Prior to entering the research setting, ethics approval was obtained from Horizon Health Network. Voluntary, informed consent was acquired at the outset of participant involvement (Appendix D). The consent form described the research process, anticipated

time requirements, as well as potential risks and benefits (Archbold, 1986). At the beginning of a qualitative project, the researcher does not know the direction that the inquiry will take (Archbold; Miller & Bell, 2002; Nunkoosing, 2005). "This raises questions about what it is that the participant is consenting to" (Miller & Bell, p. 54). For this reason, as Miller and Bell recommend, "consent should be ongoing and renegotiated throughout the research process" (p. 53).

The focus of inquiry was to gain understanding of how nurses deal with opposing personal and professional values when personally providing care or observing the care of other nurses. Storey-telling describing inequalities in patient care proved to be highly relevant in this study. In understanding this process, it was important to understand the "types" of patients who were the recipients of inequitable care in order to understand the process underlying nurse behaviours. These patients may already be stigmatized, marginalized, labeled, or judged as 'other' for whatever reason and their anonymity was protected.

Due to the nature of the inquiry, there was concern at the outset of the study that nurses may have felt vulnerable and chosen not to participate. Archbold (1986) suggested that researchers may not want to disclose what is being studied in detail to avoid influencing participants' responses and behaviours. The focus of the study was presented to potential participants in a manner that reduced feelings of vulnerability without being deceptive or covert (Creswell, 2007). It was important for me to frame the study in a way that recognized that nursing is a human process. As nurses, we all react to things uniquely; we all have our own "tipping point". This study looked at a very sensitive issue, and participants needed assurance that my intent was not to punish but to

support them, to hear their stories, and to increase understanding of the humanness of nurses and the patients for whom they care.

The researcher-participant relationship inherently has a power imbalance. Although reciprocity is the goal during the co-construction of meaning, it is the researcher who ultimately analyzes, interprets and publishes the data. I disclosed to participants that I had previously worked with some nurses who were working in the ED at the time of the study but that confidentiality would be maintained by masking names in the research report. Pseudonyms were used to protect participant confidentiality and potentially identifying demographic data were disguised (Archbold, 1986).

Conclusion

The literature suggests that when personal feelings cloud nurses' ability to develop caring relationships with patients, inequalities in patient care occur. Although the role played by nurse attitudes in the provision of sub-standard care to patients is well documented, there is a serious gap in the literature in relation to what is going on *within the nurse* when personal and professional values are in conflict.

Constructivist grounded theory was a good methodological fit for this research project which sought to understand a process underlying behaviour. The critical and symbolic interactionist perspectives that informed the inquiry were well suited to the question of how nurses, despite being socialized to a professional ethic of caring, can provide 'care' that lacks compassion and neglects the professional standards of therapeutic relationships and social justice. A paradox can exist between a nurse's personal biases and professional ethics. That this paradox can result in care that contradicts standards of practice and negatively impact client outcomes is concerning.

63

Understanding the internal tension that nurses experience when personal and professional values collide and when inequalities arise in the course of providing patient care will give nurses important tools that can encourage reflective practice and be beginning catalysts for change.

CHAPTER IV : FINDINGS

The findings of the research are presented in Chapter Four. The purpose of this grounded theory study was to generate a substantive explanation of the internal tension that registered nurses (RNs) experience when personal and professional values collide in clinical practice and how that tension affects their actions. The specific aim of the research was to answer the following question: What is going on *within the nurse* when personal and professional values collide while providing care, or observing the care of another nurse, and how does this affect nurse behaviour? The study explored 1) nurses' understandings of self before and after becoming a nurse, 2) nurses' interpretations of the influence of external context and interactions with others on their practice, and 3) nurses' decisions about actions related to patient care.

The participants in this study were registered nurses (RNs) who were employed by a single health authority in Atlantic Canada. Data consisted of single interviews with eight nurses working in the emergency department (ED) of one tertiary care center.

The research methodology was constructivist grounded theory. The goal of constructivist grounded theory is to develop an abstract analysis of participants' worlds based on interpretation of their meaning of interactions with the social structures around them. The theory that is generated is co-constructed as the researcher interacts with participants and their worlds and engages in the research process (Charmaz, 2006).

The analysis of each RN's interview demonstrated how each nurse experienced internal tension when personal and professional values collided and how they understood the causes and consequences of that tension. The data suggested that internal tension arose from moment-to-moment in clinical practice and was multifactorial. Personal

attributes, how one was raised, and life experiences along with the professional values that nurses are socialized to hold were integral aspects of how nurse participants perceived situations they encountered and how they were motivated to respond. Simultaneously, participants experienced tension from the external context they were situated within: the nature of the ED environment, the culture of the nursing unit, and the people around them.

In this study, I used a constructivist grounded theory methodology informed by symbolic interactionism as well as critical social theory to generate a theoretical rendering of the tension that nurses experienced when personal and professional values collided in clinical practice and how that tension affected their behaviour. The theory that was co-constructed describes the process that occured as RNs experienced tension *in the moment* as they struggled toward a way of being. The main concern of the nurse participants in this study was the constant grating tension that they experienced as they struggled to deal with competing demands, both internal and external. The theory includes antecedents and three phases: 1) Assimilating Internal and External Stressors, 2) Adjusting the Patient-Centered/Nurse-Centered Lens According to my Interpretation of the Situation, and 3) Achieving a Point of Action or Inaction. The process of *Juggling a Way of Being* was enacted in each care encounter where nurse participants experienced tension among personal and professional values. Contextual antecedents to the process were both intrinsic, *Being a Person AND a Nurse,* and extrinsic, *Being Influenced by External Factors*. These antecedents will be described followed by an explanation of the basic social process of *Juggling a Way of Being* along with the conceptual model that was generated.

Intrinsic and Extrinsic Antecedents

Two categories (Being a nurse and a person, and Being Influenced by external

factors) constructed from the data revealed that there are both intrinsic and extrinsic

factors that precede the process of *Juggling a Way of Being,* each with sub-categories that

further explain their meaning. *Being a Nurse AND a Person* encompasses nurse

participants' personal values and attributes, motivation for nursing, and professional

values. *Being Influenced by External Factors* includes the environment around the nurse,

both the culture of their specific nursing unit and the nature of the emergency department

itself; and the people with whom nurses work.

Being a Person AND a Nurse

One category constructed from the data was *Being a Person AND a Nurse*. This

category is constituted by the sub-categories of personal values and attributes, motivation

for nursing, and professional values. In describing who they were before and after

entering the nursing profession, participants shared stories of having personal values and

attributes, having a motivation for nursing, and having professional values. These sub-

categories illuminate understanding of the factors implicit in the tension that nurse

participants experience when faced with colliding personal and professional values and

their decisions about how to behave in value-laden situations, as reflected in the

following comment by Madeline.

> one thing that always stands out to me is…um, they put up posters if you want to
> be a SANE *[Sexual Assault Nurse Examiner]* nurse? And I won't …because I
> don't believe in the morning after pill (Madeline)

Having personal values and attributes. Participants spoke of how their

upbringing shaped who they were as people. Before ever becoming nurses, these women

were socialized to hold personal values and beliefs learned from cultural, spiritual, and family teachings of what is right and wrong and how to be a good person. "Maybe because I'm [ethnicity], I have a different perspective" (Maggie May). These early influences were markedly important and early values were deeply entrenched as noted in Maggie May's comment, "I won't betray my own values" and Madeline's reflection on coping with paediatric deaths.

> I think what helps me the most is…the hardest thing to deal with is when kids die. And, like, I believe that all kids go to heaven, so I think that helps me the most, because then when they do die, at least I think they're in a better place. Whereas if I didn't have that, it might be harder…And I also think that sometimes no matter what you do and somebody dies and maybe not in the ER but maybe the next day but you always find out, I always think, like…well, that was…that was their time and God's plan and no matter what we did…so I think that helps me a lot, too. (Madeline)

Participants articulated how having strong family supports influenced who they had become as adults. They reflected on their good fortune to have a personal support network, knowing that not everyone has the same resources. Maggie May said, "I was lucky enough to have somebody who loved me" and Madeline stated, "I guess, it's just…different life choices…maybe not even choices, just different….situations…maybe that they had than me".

During interviews, participants described how their personal life experiences were important in their ability to identify with patients. Zoey articulated this in her description of caring for a patient with bone cancer.

> I looked through the file, oh my God, she's got bone cancer. Well, that's the same cancer my mother has, I know how painful that can be! So I was like, 'nobody is allowed to say she can't have anything for pain, she's got bone cancer for God's sakes!' (Zoey)

The ability to identify with patients was important to these nurses in being able to empathize with patients *in the moment*.

> But, it's not a stretch of the imagination…I got in lots of trouble when I was a kid…I'm very aware that it could have been me as easy as her…So I can empathize with her. (Maggie May)

> it's hard when people come in and they are on drugs or they're intoxicated. It's hard for me to develop a relationship with them because I don't really…I feel bad that they're in that situation but I don't really understand it because I've never been in that situation. (Madeline)

> Participants described personal attributes that were important to their success as a nurse. These included "being a people person" and working well in stressful situations; that is, being "nice", "friendly", "nurturing", and "personable"; "not mean". Some participants recognized that they were nice to a fault in that their quiet shyness and tendency to avoid confrontation could inhibit their ability to deal with stressful situations. As participants defined the attributes that enabled them to nurse well, they also reflected on those of "other" nurses described as being "rough around the edges"; that is, being "always right", "poor listeners", "bossy", and "aggressive". Participants suggested that nurses' attributes range on a continuum from nurturing to rough around the edges.

Having a motivation for nursing. Participants reflected on what drew them to nursing. They told stories of wanting to help people and wanting to make a difference. They shared personal experiences of seeing nursing as a meaningful profession in which they could connect with other human beings and positively touch their lives.

> when I was really young, one of my best friends had Hodgkin's Lymphoma. And he was going to the hospital all the time and just them building relationships with nurses; I thought it was something that I might like. (Myrtle)

as a family member of someone who was dying…Palliative care nurses are the greatest human beings that I have ever met in my entire life. They are phenomenal. And that is how every RN should behave. Completely holistically. (Pearl)

Participants defined a "good nurse" as "putting yourself in someone else's shoes. Really removing your judgments and being the person that you would love to have as a nurse." (Zoey) and someone who can "create an environment for a family or a young child going through something that's safe and allows them to find care, and to take care of them and make them feel like they've been really looked after while they're in this time of stress" (Myrtle), someone who doesn't distance themselves from patients (Pearl), who is reassuring (Lila), connected (Liz), kind, caring, approachable, flexible (Bette), confident, and non-judgmental (Zoey).

> when I say 'caring' I mean more than putting the IV in or getting the morphine or something to help their pain. Caring is treating them like a person. Walking in with a smile on your face…Just building that little connection. (Liz)

> I think…being, um…kind, caring, um, approachable, so if somebody wants to talk to you or ask you something they can. Just uh…organized…I don't know, like a people person, a social person, because this is your job, you are talking to people and you're…you know…I think it helps, it makes you a better nurse…if you're…well-rounded. (Bette)

The idea of nursing as a *way of being* was raised as participants shared their thoughts. They described two distinct types of nurses: those who are *Real Nurses* and *Those who Work as Nurses*. They saw themselves and their co-workers fitting somewhere on a continuum between these two extremes. Real Nurses were described as "good" nurses, but more specifically, "people that feel like they're born to do this job." (Zoey) Maggie May emphasized this by saying "you don't choose nursing…nursing chooses you. You ARE that person – good nurses…people who are real nurses…it's

70

who they always were". Conversely, Those who Work as Nurses were described as follows:

> some people have said they are not, they're, they're not meant for that job. There are people that have told me at this place that said, 'it's not for me'. (Zoey)

> they're really good nurses from 7:30 to 7:30. Once 7:31 comes around, they're done. And it does not matter…what's going on, they will give their report – and that is their job – and they will walk away and never give this place another thought…some of those nurses chose nursing because it was a stable career, it's good money, and blah blah blah… there are some nurses who work as a nurse… when their shift ends, they're done…they're not vindictive, they're not callous,…but they keep an emotional distance. (Maggie May)

Having professional values. Participants reflected on the professional values and beliefs that they had learned since becoming a nurse. They spoke of the nurse's responsibility to patients and being accountable for the care they provided; for example, by refusing to abandon a patient in need at the end of their shift, or double-checking medications to prevent patient harm. Being accountable also meant doing the right thing for the right reason. Maggie May articulated this moral aspect of professional accountability in her statement, "when you're morally accountable… you would want someone to do that for you, you should do that for them".

Since becoming nurses, participants had learned to deal with tension between values by developing new skills as described by Zoey.

> it has really given me a lot of confidence. And I've heard other nurses say that it allows you to find your voice…when you feel, like, either you have a confrontation with a patient, a family member or another colleague, you're allowed to, or you're enabled to stand up for yourself more than the life before nursing. (Zoey)

Dealing with value-laden situations became easier with time and experience as Bette stated.

maybe earlier in my career it was harder where I was less experienced with those types of situations. But now I find it a lot easier to…you know, to…I don't know, to either go between…like maybe you're looking after both patients that were in the car accident. The one caused it and the one that's injured from it. Um…but I find now, with more experience, and I've just seen more and learned more, that I, I don't know, maybe just have a different coping mechanism that…I don't know how to explain it…I think it's just time and experience…um…I can just deal with the situation better. (Bette)

Likewise, Maggie May also spoke of the value of time, "the longer you've been nursing, the more willing you are to go, 'I don't get why you did that. Tell me why'".

Participants described how nursing had encouraged them to be more accepting of others' differences and less judgmental. When sharing a storey about caring for patients in the context of abortion, something she personally was not 'OK' with, Maggie May said, "…but that's me. That's not you." Madeline described how she had become more open to differences in the following statement,

> I think the main difference is that I'm more open, because I grew up in a very conservative… strict family, and now I'm more open to other…not necessarily that I agree with things that other people do, but I'm more open to it, I don't judge them. Before I would…if I saw someone drunk on the street. Now I'm more…open, I guess, open-minded and not as judgmental. (Madeline)

Participants also expressed an enhanced ability to look at the bigger picture and to try to understand where people were coming from since becoming a nurse.

> I guess before, like say you saw someone drunk on the street, you would just kind of think, "oh, look at that person! I can't believe they're like that", or if you saw someone who is homeless…But now you think of all the different factors that could lead them… like low economic status, or being kicked out of their house, or abusive relationships, or there are so many factors. (Madeline)

> I really had the same values growing up, but in the sense that I grew up in a small town and perhaps was really…sheltered in a way and didn't really realize what goes on in the city and what we have. It's given me a better appreciation for people and people's lives, maybe, and that things are not…you know, what I thought they were…homelessness and drug addictions. It's not something that I really thought…was in *[this city]*. (Myrtle)

In summary, the category *Being a Person AND a Nurse* reflected a nurse as someone who held personal values and attributes, a motivation for nursing, and professional values all of which influenced who she or he became as a person and as a professional. This category revealed that there were both personal and professional factors that influenced how nurse participants thought, felt, and acted in the clinical setting. As reflected in Figure 2, there was a constant tension within and among these factors that shaped the nurse, both as a person and a nurse.

Figure 2. Being a Person AND a Nurse
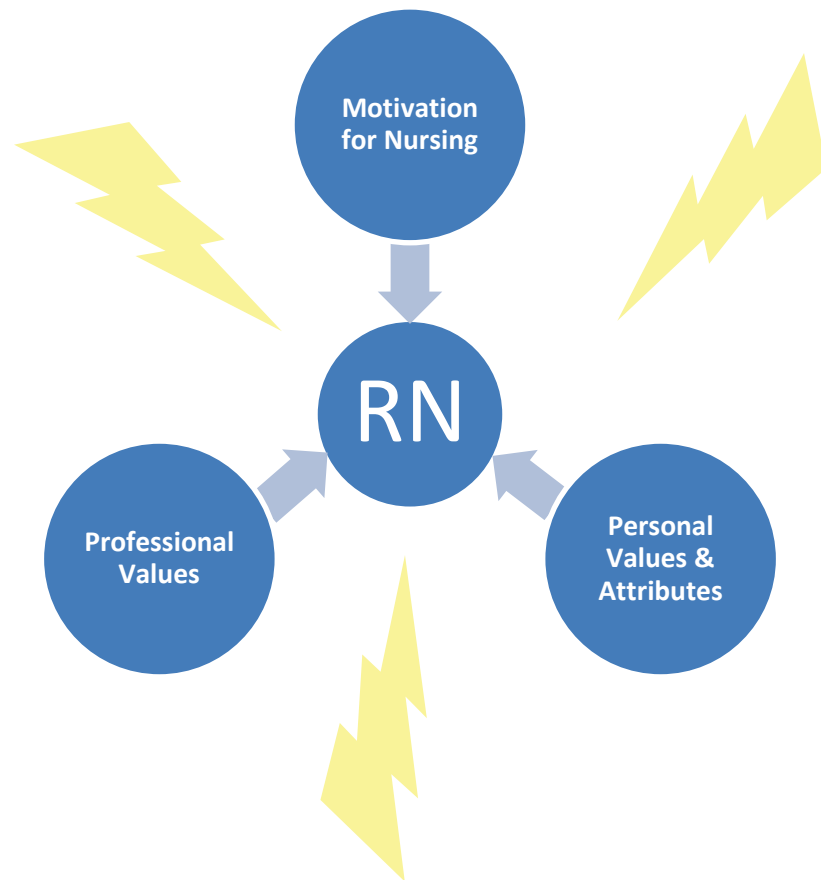
Being Influenced by External Factors

A second category constructed from the data was *Being Influenced by External Factors* which included the sub-categories of being influenced by the external environment (the nature of the ED and the culture of the unit) and being influenced by the people in the environment. These sub-categories expanded understanding of the external factors inherent in the tension that participants experienced when faced with colliding personal and professional values and their decisions about how to behave in clinical situations. The nurse participants clearly articulated how the ED environment and the people with whom they worked affected their thoughts and actions.

> I feel guilty because I don't feel that I do well for my patients. We shouldn't…nursing was never meant to be task-focused. And yet…here we are. In a very task focused area, where we get crapped on by the floors because the patients are coming up, they've been in the beds for 16 hours, you know, something got missed, they're not happy they're getting the admission, the SBAR *[report sheet]* wasn't filled out to their liking, everything at the end of the day all fall down to us (laughs). And it's frustrating! We're trying to do the very best we can with the very least amount of frustration for everybody, but we…we don't win. (Lila)

Being influenced by the environment around me. The environment in which nurses work was described as being a major factor in determining how they felt about, and behaved in, any given situation. They differentiated between two aspects of the environment: 1) the nature of the ED and 2) the culture of the unit (unit norms).

Being influenced by the nature of the ED environment. The ED was described as a task-driven environment. Indeed, participants expressed that it was not the place for caring *about* patients. Pearl said, "it's easy to distance yourself downstairs". Participants struggled with the tension between wanting to care *about* their patients in an environment that barely allowed them to care *for* them. The task-driven nature of the ED was

74

described as a barrier to getting to know patients and their stories. Participants reported

that task-drivenness kept them from being able to take the time to talk with patients and

families. Lila said, "We don't do that in emerg. That's not an emerg thing." This left

nurses feeling like they were cheating their patients of the holistic care that they

deserved, as articulated Lila.

> *[in other care areas]* people come in, they get better, they go home. You teach
> with them…it's a more holistic type of nursing. Downstairs we are so task-
> oriented as nurses, I think that…not necessarily that we are cheating our patients,
> we are, but we're cheating the patients because we don't have enough time to
> spend with them…we're cheating them of the basic concepts of nursing. Like, if
> you're lying in the bed I'm going to go in start your IV, give you your medication,
> send you to Xray, draw your blood, do all that. But there are so many people all
> the time with ambulances coming in and patients coming from the waiting room
> that we don't actually spend any time getting to know anybody. We don't spend
> any time getting to know anything about their illness, you know, 'in five seconds
> or less, can you tell me why you're here today?' (Lila)

It was clear that task-driven nursing had negative consequences for patients. It also

became clear that working in a task-driven environment came with personal costs to

participants who yearned to be 'good' nurses.

> And where I worked before, that's all I ever wanted to do, like that patient
> population was all I ever wanted to do. I love it and I still do and…but, again,
> there's no tasks and I kind of like the task part. So I like the whole thing. And
> downstairs you can't really do the whole thing and upstairs there are no options,
> so it's hard to find the middle ground – to be an actual real nurse. Which is what I
> want to be; a real nurse. One who can do the tasks and, you know, do the whole
> holistic thing.   And it's hard to find that. (Pearl)

Myrtle described the task-driven orientation of ED nursing as "militant" and went on to

say "we get so busy that we get a task-oriented focus, too. Like, if 500 things need to be

done in five minutes, I mean it's hard not to become task-oriented." Militant nursing was

reinforced when patients were accompanied by police or prison guards as described by

Madeline, "you don't really develop a normal relationship with them (laughs) cuz there's

guards there". Lila described working in the ED using animal analogy to reflect the

environmental barriers that she faced when providing care to her patients.

> I just like to get to know people. I, I like to know more than…how's your belly pain? Is it better? Is it worse? Do you need more morphine? Do you need to go to the bathroom? Do you need a new IV bag? …That's not nursing. That's a monkey job. Monkeys can do that. They've been taught. I don't' want to be a monkey. (Lila)

> It's the fact that we sit around waiting for the doctors to see the patients. So if they're really busy and you have a bunch of level 3s *[Canadian Triage & Acutity Scale - level 3 indicates patients need to be seen by a physician within 30 minutes]* that are waiting six hours…some of the doctors are happy if you go and start stuff, some of them yell at you because, 'well, what were you thinking?' The patients are yelling because they see you sitting and talking to whoever you are working with 'well you're not looking after us'. Well, it's not that I'm not looking after you! I…my hands are tied! There is really nothing I can do right now. I can't give you anything for pain until the doctor sees you. Until we decide what's going on I just can't send you for XYZ Xrays and CT Scans, you know!...makes me feel like I'm useless. Like I'm just a little pigeon sitting on a pole….waiting for something to fall out of the sky. It's not a good feeling. (Lila)

In addition to its task-oriented nature, the ED was described as a stressful, fast-

paced, and demanding work environment. Participants shared stories of surviving in

chaos. Working in chaos included being short-staffed, critically overloaded with "beds

wrapped around the desk" (Lila) and feeling a lack of support in the midst of it all, "we

were rockin'…and I was there by myself." (Maggie May) The high-acuity of the

department and the 'mixed-bag' of patients that come to the ED added to chaos in the

workplace. Surviving in chaos meant working in settings with too many people and too

much noise as described by Maggie May and Zoey.

> …just her presence…you knew your workload was going to triple, and…there were some days…when you had six and seven people wrapped around the desk. The volume in the room, you couldn't hear yourself think, you know, it was…just not great. And then to have her as the cherry on top was like, oh sweet mother of God, shoot me in the head! And so you almost had to do rock/paper/scissors. 'OK who's gonna contain her?' (Maggie May)

Because there is a time…where you're in the trauma room, and there's 15 people flying around, and you're supposed to be charting and listening to everybody and you've got to use your 'outside voice' inside, and it's, it's just something that comes from within...I hear myself speak a lot louder in a calm tone and inside I am freaking out a little bit. But it's my voice where I can help…make order out of chaos. (Zoey)

They shared how this chaotic environment affected their behaviour. Zoey described

becoming 'snappy' when faced with a stressful work environment. Myrtle echoed this

thought in describing how she had become 'short' with patients when feeling

overwhelmed with the chaos of the unit. Participants reported that being snappy or short

with patients was often in response to juggling multiple demands and feeling as though

they were unable to accomplish all that had to be done. They recognized that their

responses to patients were often unwarranted, "I've definitely caught myself being short

with someone and they've done absolutely nothing wrong…they need care and you're so

stressed that you maybe…" (Myrtle) Zoey reflected on a time when her response to

surviving in chaos was noticed by a patient.

…a patient, and I was so busy, and he asked me for a sandwich. Okay, so I went and got a sandwich. I came back and, of course, it was ham and he said, 'I don't eat ham'. So I had to go all the way back to the fridge and look through the sandwiches. So when I get back to him, I kinda tossed the sandwich and said, 'there ya go' and I'm on my way. And he said to me, 'if you don't like your job then you shouldn't be here'. I said, 'what do you mean?' He said, 'the way that you threw the sandwich at me'. And I said, 'I didn't throw the sandwich at you, sir' but then I thought about it, and I thought I'm sure I looked totally pissed off cause I was! (Zoey)

Madeline worried about how her patients would perceive her as a person and a nurse

when she was working in chaos.

Sometimes when it's so busy I don't feel like my patients feel like I have a personality (laughs) because I go in and I say 'here's your drug and I'll be back in 20 minutes to do your vital signs' It's…you don't have time to…I mean I always try to say 'my name's Madeline I'll be your nurse' but I try not to…when it's real busy you can't sit and chat, sometimes you don't have time. When I put people's

IVs in I try to make small-talk, ask them about their pain and anything that's going on with them, but sometimes you just…give them their pills and don't see them for an hour. You just don't have time. And I guess I feel like my patients think, that's always what I think, my patients are going to think I have no personality! (laughs) (Madeline)

Time was also described as a major barrier to care. Participants emphasized how they were constantly working against the clock and how this affected them and the care they provided. Working against the clock saw participants approaching interactions with patients in a way that was direct and "a bit more closed-ended so, you know, you're not going to be stuck in the room for a long time." (Bette) Time was described as limited and nurses were required to ration time amongst their patients. Lila described the angst this rationing created within herself.

we're just so bombarded that it doesn't seem like we get there on a consistent basis. I can get there sometimes if it's not busy and you have five minutes to spend with people. But it's not a five minutes that you can spend with every one of your patients. And you feel guilty. Cuz if you spend 15 minutes or 20 minutes in a room with one patient, then what haven't you done for the other nine? And what has your partner done while you were in there for 20 minutes, cuz six other people have arrived? And then how far behind are you? And then you've got the doctors who finally decide to see everybody and then they've left you the stack of orders 'that tall'! And then it's back to the tasks! We're like hamsters on a wheel…around and around we go…sometimes we stop for water, sometimes we stop for food, maybe even a bathroom break, but in general, that's what we do…around and around… (Lila)

Maggie May recognized that patient's cues could be missed when working in a chaotic environment with major time constraints. She worried that there were time when she had missed cues from patients who needed her to be emotionally present, "I'm sure that there have been people right in front of me that have been just desperate for me to notice that I looked right through…because… I'm… too busy." (Maggie May)

Clearly the nature of the ED environment played a significant role in how these nurses felt and behaved at work. Participants described feeling frustrated with

environmental barriers to care and guilty when unable to provide the type of care that they wanted to give. They spoke of trying to do their best despite it all – aiming for resilience in chaos.

> When you're operating at 400 and 500% capacity, you can go six hours and not realize that you've peed your own pants (laughs). Like, holy shit! When was the last time I ate or went to the bathroom? Like it gets that bad. And a lot of times, even with a really good nurse, including myself, do I always see the cues that someone gives me? No!...Do I try? Absolutely. (Maggie May)

Being influenced by the culture of the unit: Unit norms. Surviving in chaos, working against the clock, and task-orientation were described as expected norms for any ED. Zoey, who has worked in other EDs, said,

> you really have to sort of, I like to sorta sit back and observe, well, who is an ally, who is a friend and what's the dynamics going on here? What is the culture of this department, because I've made the mistake of sorta feeling like, well, this is emergency everybody does the same thing, but it's not the case. (Zoey)

This spoke to the influence the culture of the specific work environment had on the nurses who worked there. This idea of unit culture was echoed by all participants. Unfortunately, the nurse participants described several negative unit norms that affected their thoughts and actions.

Participants spoke of times when patient distress was dismissed. Maggie May gave an example of a time when a miscarrying teenager was seen in the ED and "everyone was, like, rolling their eyes and whatever." (Maggie May) Zoey told a similar storey of a teenager's post-abortion distress being dismissed by a co-worker. In that situation, the nurse justified her behaviour by saying "'she is only here with a hangover and we don't treat hangovers.'" (Zoey) Patients who were dismissed also included those who visited the ED repeatedly and those with minor ailments as described by Madeline.

you'll have to deal with someone who, like someone who just died and then in the next room…a patient's complaining about their toe. It's just so hard to think 'I have to care about your toe right now'… (Madeline)

Participants shared stories of nurses setting rules. This was sometimes done to protect patients: "…she can't walk into the lady who's dying of ovarian cancer while I'm putting a foley in and, you know, invade her space…it's not going to happen" (Maggie May), but setting rules was more often done in an effort to exert control. Pearl reflected that this may have been an example of oppressed group behaviour: "well...they can't control a lot; cuz the doctor controls most of it, so it's kind of their way to exhibit some kind of control over the situation." Pearl raised the idea of nurses using rules to overcome a sense of powerlessness that they experienced in their work environment. She also reflected, however, that some nurses were 'bossy' by nature and wanted to exert control in any clinical situation, "And they don't…care. They just don't. It's all about them, it seems." (Pearl) Myrtle described this as being 'military'.

> So I feel that's what I would mean by 'military'. We follow this rule just because it's a rule, not because…not using our judgment and letting things slide when they can. Sometimes we get kind of controlling for no…no real reason. (Myrtle)

Nurse-centered rule setting ranged from enforcing unit protocols such as two visitors per patient "to keep the unit scarce of people" (Myrtle), to more overt expressions of power.

> one thing that I think we all struggle with is sometimes when they come in with some form of mental health they can be agitated and upset. And we make more rules that make them more agitated and upset. Where if we let them go out for their cigarette and come back, sometimes they're a whole different person and a lot more calm. But because we want to have control of the situation we say 'no'. (Myrtle)

> I won't tolerate it... I've told patients…in their face, "this is my house and in my house you do as I say. And I don't come to your house and behave that way and you will not behave that way here" And if they don't like that, I can show them where the door is. If they can get a better deal somewhere else, they are welcome to go there and get it. (Maggie May)

80

Dismissing and rule setting were nurse-centered unit norms that occured when patients were perceived as being bothersome, a "waste of time", or "stepping out of line" – not behaving according to how the nurse expected them to behave while in the ED. 'Stepping out of line' could include patient behaviours such as non-conformity to nurses' rules, agitation, aggression, profanity, asking too many questions, or interfering with other patients' care.

The ED culture was influenced by many different nurses with different personalities and "styles" of nursing. Participants described the range of nursing styles from the holistic practitioner to the abrupt, task-driven practitioner. Working with abrupt nurses created tension within participants when they observed approaches that were "a little too 'tough love'…a little too much sometimes." (Myrtle) The care of the task-driven co-worker was described as focused on the "sickness side, the physical side…like get the IV, get the drugs in…walk away. Go vital them again in ten minutes." (Liz) Partcipants described some nurses as 'rough around the edges' and difficult to approach which created tension in a workplace that requires teamwork and collaboration.

> there's maybe a couple of them, a couple of the more senior nurses that I wouldn't approach, cuz I'm scared of them, so I most definitely wouldn't…they're just very, uh…they seem rough around the edges, they're very loud, they're very opinionated, um, they just do whatever they want basically. They're not…they're not warm and fuzzy and you don't feel like you could approach them I guess. (Bette)

While Bette saw these traits in more senior nurses, other participants described seeing these traits in younger, less experienced co-workers. All participants wondered if it was time, or experience, or personality that drove nurses to this style of nursing, and they worried about the possibility of themselves becoming "that harsh and haggard nurse" (Zoey).

81

Another unit norm expressed by participants was being silenced by co-workers. They told stories of times when their opinions were dismissed. Lila described a sense of futility when describing the response she received from a co-worker after approaching her with a care issue, "'Well, it's my patient and I'm going to do what I want'" (Lila) Maggie May described a similar situation when, "I was basically told to mind my own business." (Maggie May) Myrtle described the difficulty of advocating for patients when the result was to be dismissed by peers. Her storey illuminated that in order to be a voice for a vulnerable other, participants first had to have their own voices heard.

> I just said, 'just so you know, one of these time we're going to miss something on this person and it's not going to be good when it happens'…but it was like, 'yeah…I know we are but today is not the day and I know nothing is going on'…I don't know, it's just hard sometimes (Myrtle)

Nurse participants felt silenced when working with older, more experienced nurses. They described a hierarchy or pecking order within this ED culture that prevented nurses from using their voice, whether to protect patients or themselves.

> I want to tell them off! And I don't do it cuz I'm new there. I think if I had more experience I'd have a lot more to say, but just because I'm the new person I can't. But I, I don't think it's fair and it drives me insane. (Pearl)

> …they've been there forever...*(voice quiet)* and a lot older than me…they're not usually new grads. If they were a new grad, you'd probably be more likely to say 'what are you doing?' But when they're older, and their senior, and they may be the charge nurse …sometimes it's hard to… (Madeline)

Participants noted that fear of angry backlash from co-workers perpetuated their silence.

> Ohhhhh.....*(laughs)* I couldn't. We've got some strong personalities in there and I just couldn't…Yeah, there are some with strong personalities that are wonderful nurses, but yet, some of us may feel we can't, we can't approach them. (Liz)

> They're scary! *(laughs)* And, too, they don't care what you think…I don't think they would care what I would have to say…And I know that all of these people have been talked to by the unit manager and they don't change. Cuz they're just like that… (Madeline)

In an environment in which there were so many negative unit norms, participants spoke

of the importance of finding a role model and mentor. Nurses that were role models were

experienced, knowledgeable, competent, approachable, kind, calm, and holistic in their

practice. Participants looked up to colleagues who took pride in their work and were

non-judgmental.

> I find a lot of nurses in the department that I look up to take pride in their care,
> take pride in their work, and I find that's one of the biggest things that seems to
> make the difference. They take pride in delivering care to a patient. And, so, you
> know, in that pride follows with taking the extra time, giving the family care,
> doing things to a "T" and not taking short-cuts, things like that. And people who
> are open-minded and not judgmental. (Myrtle)

Role models inspired participants to be "Florencey" – to give the best care possible, to

practice holistically and with accountability.

> I can think of one in particular and, um…you know, she not only gets the patient
> the meds that they need and, you know, (laughs) monitors their vitals, but,
> like…she makes them comfortable and well taken care of like it was her own
> grandmother, you know, how you should treat everybody. (Pearl)

It was evident in the voices of the participants that they experienced tension when caring

for patients in an environment that was chaotic, fast-paced, and task-driven and that had a

culture with many nurse-centered unit norms.

Being influenced by the people around me. The participants clearly articulated

that the people around them made a difference in how they thought and behaved at work.

Depending on your group was reiterated by participants again and again as they

discussed how co-workers influenced them both positively and negatively. In keeping

with the previous finding of being silenced, nurse participants spoke of changing their

behaviour to "fit-in with the crowd". Maggie May said, "It's almost like a pack

mentality. Because you're safe if you're in the group." This statement highlighted, once

again, the existence of a power imbalance within, and between, nursing peers. Liz

echoed this feeling.

> I don't like confrontation. And I feel it would be confrontational, even if I tried
> not to be…Maybe we're afraid, um…the other person will get mad at us, that it
> would come across as us being confrontational so they would get mad at us. And
> we work with these people. I mean I see them almost more than I see my
> husband. (Liz)

Even the most patient-centered nurse could be swayed by the pack as Zoey explained.

> And this doctor was saying, 'what is wrong with you? You cannot believe that
> that is true!' She said 'you're enabling. You are allowing this behaviour to
> happen' and I said, 'okay, it's annoying. For sure'. And I did kinda, I did go to her
> side at the end, and felt like, you are right. And I just lost all of my empathy right
> there. (Zoey)

There were consequences for going against the pack. Participants described the

fall-out as including gossip, being "put in their place", and "hung out to dry". They used

violent imagery ("World War III", "a storm", "yelling", and "a blow-up") to describe the

consequences of going outside the expectations of the pack. Clearly, there were great

risks to the nurse for refusing to follow the crowd.

> like, I'm starting to pick that up down there. Like, I'm not one to go with the
> crowd in most things in life. Like, I'm not about being a follower and minding
> my own business and keeping my mouth shut. I don't do that, I've never been
> that person and I don't ever want to be that person. But…I also have to weigh the
> pros and cons of me opening my mouth and what kind of storm it's going to
> bring. And sometimes it's just not worth it. (Pearl)

Zoey and Maggie May, both highly engaged in patient-centered care, shared stories of

times when their moral outrage gave them the courage to take the risk and refuse to

follow the crowd. Their patient-centered orientation outweighed the potential risks to

themselves.

Participants described the importance of group cohesion and peer support on how

they felt and behaved at work.

I'm really lucky and work with a fantastic team, like my rotation, and I don't tend to have that problem…we do seem to have a really supportive team that will back each other up when we need it. So that makes the work environment a lot easier and it makes going to work a better place when you have people who you know will step in and care for you when you need help or if you, you know, if you're swamped, they'll come right over and give you a hand. I think even though…that's just work ethic, if my assignment is swamped and you are coming over and helping me it still gives me that confidence that if, you know, you had to stand up for a patient, you know that person's kind of behind you. (Myrtle)

I think it depends who you're working with they can make or break your day. I was working with a nurse I felt, like, this girl is my nemesis, she is so grumpy and she doesn't like me for whatever reason. It's uncomfortable, but I am going to just try to…keep on keeping it on because otherwise it is going to bring me down. (Zoey)

Nurse participants felt a sense of togetherness with, and were positively influenced by, supportive, approachable, like-minded peers. Conversely, working with others holding opposing views or disagreeing with others' care instilled feelings of disconnectedness and negativity. Madeline shared,

once I triaged someone who was drunk and I brought them in and the next thing I knew, one of the other nurses was wheeling them out and they hadn't even seen a doctor yet…well, she just said 'he's drunk, doesn't need to be here' and just wheeled him out. (Madeline)

Bette described feeling sad when observing the care of another nurse that she viewed as unjust. While Madeline and Bette both had strong reactions to their co-workers' actions, they were not incited to the point where they would speak up against what they were observing. The risks to themselves were too great and outweighed their responsibility to the patient. Participants felt tension when they observed practices that they believed to be inappropriate but felt silenced in a culture in which "you are safe if you run with the pack". Maggie May, on the other hand, described standing up for patients and voicing her thoughts, "I'm sorry, but I think…B.S!" She reflected,

...there are ways to make people understand that you don't like them. And I've seen physicians do it where they think someone's an asshole and...because they want you to suffer a little bit, and I don't think that's their call... (Maggie May)

In these situations, Maggie May's strong patient-centered orientation and moral courage enabled her to fully advocate for patients despite the risks to herself.

Participants described nurses as being on a continuum ranging from the *exemplary nurse* to the *Bad Apple*. The nurses who participants admired were described as "well-rounded". These nurses were viewed as competent, hard-working, and caring. When observing such care, participants saw compassion and a willingness to take the time to *go above and beyond* the call of duty for patients and families. The exemplary nurse was viewed as patient-centered, approachable, and empathetic. These nurses were described as caring for the patient's entire well-being, "not just medically but...their comfort and everything about them" (Pearl). The care and compassion that exemplary nurses provide was emphasized and these nurses were described as having "a giving, a nurturing quality...almost a mothering quality." (Zoey)

Conversely, participants spoke of nurses who were described as abrupt, rude, intolerant, uncaring, outspoken, and negative. "There's a few...there's a few bad apples in every bunch, right?" (Bette) The Bad Apples were not admired by participants despite the fact that many were considered intelligent and competent with technical skills and physical care. The care given by Bad Apples was task-driven and lacked compassion, "it's very...like militant and just, you know...there's nothing..."Florencey" about it *(laughs)*. They're just...they're just not very nice... (Bette) Bad Apples were viewed as having strong personalities, being rough around the edges, and being antagonistic to patients and co-workers. They were unwilling to "go out of their way" to take time with

86

patients. They did not listen and were "always right". Bad Apples had a range of nursing

experience, whether in the ED for a short time or an entire career, and were considered to

be jaded, hardened, and burned out.

> I find they are in every place. They don't have to be younger; they don't have to
> be older. I just find…I don't even know…they don't even have similar
> personality traits, like relationship status or anything. Cuz sometimes you're like,
> 'oh, well they're miserable at home'. Well, no! They're not, they're just…that's
> who they are and…they're just really outspoken, bossy people…like actually
> giving a shit about your patient. Like, they don't. A lot of them just don't. This
> is just a body in there with…you know, a presenting complaint. And they're
> going to do, you know, follow their little check-list, and do what's on there to take
> care of that patient. They don't care about what brought them here and how
> they're feeling overall, and how to take care of them outside to make sure this
> doesn't happen again. (Pearl)

> I…have a hard time with her care. Because she's abrupt. She doesn't
> listen…she…has the ability to…frustrate people and make them angry and yell at
> her. And it's really hard cuz…there could actually be something wrong with
> them, but she's already made up her mind before they even enter the room what's
> going on with them. (Lila)

The eight participants painted a vivid picture of the external factors that

influenced how they felt and behaved at work. The ED environment, the culture of their

unit, and the people around them played significant roles in determining how they

responded in clinical situations as depicted in Figure 3. Participants experienced tension

when faced with environmental barriers to providing the care that patients required. They

described tension in the environment where nurses interacted with both *exemplary nurses*

and *Bad Apples*. Participants experienced tension when they felt silenced or that they

must conform to the way of the pack in order to prevent risks to themselves.

The first two categories described above, *Being a Person AND a Nurse* and *Being*

Influenced by External Factors reflected the intrinsic and extrinsic/contextual factors that

promoted tension 'in the moment'. These factors can be seen as antecedents to the basic

social psychological process that was called *Juggling a Way of Being.* When nurse

participants experienced tension they expressed agonizing thoughts and feelings that

could be seen in reflections such as, "I had a really hard time…being OK with that"

(Maggie May) or "in certain situations, you, you may feel strongly against it, but…"

(Bette)

Figure 3. Being Influenced by External Factors
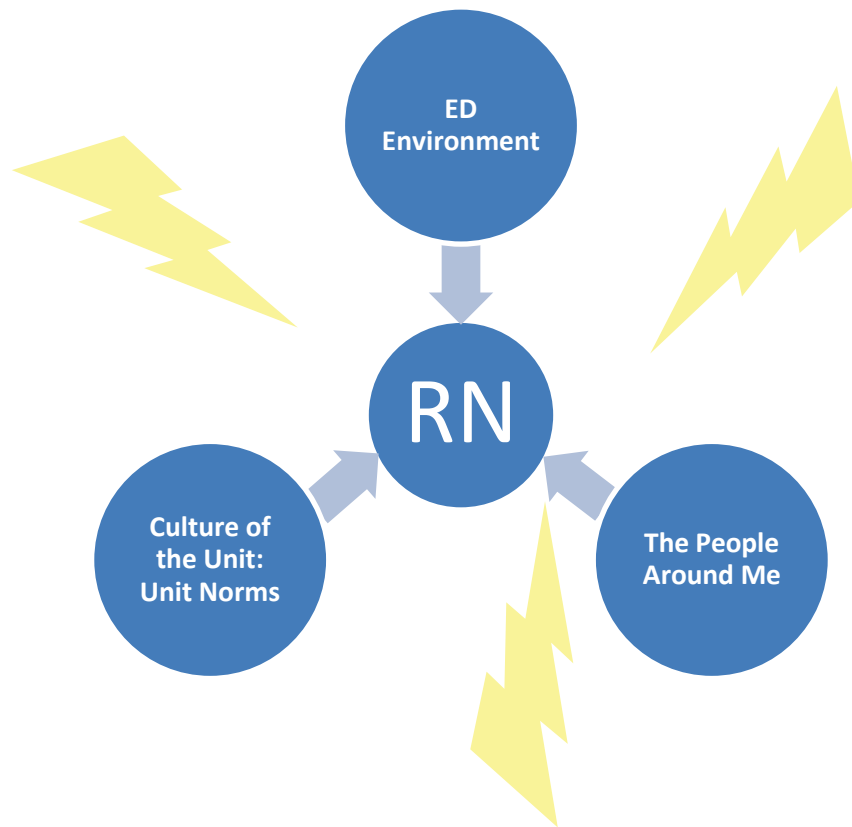
Tension 'in the moment'

The main concern of participants that emerged from the data was *"tension 'in the moment'"*. Participants described experiencing tension as they wrestled with competing personal and professional values and with being true to themselves as the adults they had become while at the same time being a "good nurse" and meeting the expectations of professional practice. These eight nurses articulated tension as they constantly gazed through these dual lenses. While the nurses dealt with this tension between personal and professional values, they also experienced tension as they interacted with the people and environment around them. Intrinsic and extrinsic tensions collided, each influencing the other and creating intense moral strain within the nurse. Participants articulated that they continually evaluated the situations they faced through these two lenses. Each care encounter demanded a new assessment of what was happening and how they should respond. Thus, the tension they experienced was dependent on what was going on around them in that moment in time.

As participants reflected on difficult care situations, they described *tension 'in the moment'* as they tried to "do the right thing". Sometimes doing the right thing meant keeping personal values "in check" in order to provide the care a patient required. In keeping one's personal values in check, nurse participants gazed through the lens of the professional values that they had been socialized to hold. Participants reflected that all patients deserved to receive care that was fair, equitable, non-discriminate, and holistic. Tensions arose, however, when care encounters put these nurses face-to-face with situations that challenged what they *personally* held to be "right" or "wrong".

I guess where your personal values, um, come into play, um…just certain situations, you, you may feel strongly against it, but…you're not…that's, that's your personal opinion, and you're still here and you still have a job to do to look after this person and treat this person with, you know, the respect that they deserve. (Bette)

I think, 'OK you can't let this affect your judgment, you have to act as if…as if this is nothing'. Because we get things that might be against…not necessarily against your values but that make you go (gasps), like prisoner or we have abortions all the time that you just need to…it's not my life, I don't know what's going on. Treat the person who's here today and care for them and what they need. (Myrtle)

Bette and Myrtle described the tension they felt as they were pulled to gaze through the lens of their personal values while feeling the professional responsibility to keep that lens closed.

Participants described needing to feel that they had behaved in a good way; that they were good people. Tension in the moment arose in difficult care situations as they struggled to reconcile competing personal and professional values in a way that allowed them to achieve this moral imperative. Maggie May articulated this as she reflected on a situation when she cared for an intensely dislikeable patient.

Do I think he had an epiphany and was going to be a nicer person once he was healed? Absolutely not. But in that moment, it wasn't about me being nice to him, it was about me being a good person. And so the only person I would have been hurting, not to be nurturing to him, was me. Wouldn't have hurt him, cuz I don't think he has that much of a soul…but I do…you have to be kind to yourself and allow yourself to be that caring person so that you can be OK with you the next day. (Maggie May)

Participants clearly expressed the tension they experienced as they struggled with conflicting personal and professional values. Each moment in time saw these nurses shifting back and forth as they internalized what was going on around them and wrestled with the dual sets of values that they held. Like sandpaper rubbing together, they moved

back and forth between personal and professional frameworks of what is "right" and "good".

Participants were required to make decisions in the moment about how to respond to the tension they experienced. Their behaviour was dependent on which value had the greatest "pull" in the moment for the current situation, and the people and environment around them. Nurse participants described internalizing their tension and determining, in the moment, if they would follow a path of patient-centeredness or nurse-centeredness. The process was dynamic and nurses described shifting their orientation of care at any time in a clinical situation, moving on a continuum between patient-centeredness and nurse-centeredness from moment to moment as reflected in Figure 4.

Tension 'in the moment', was the main concern voiced by the eight participants as they reflected on difficult care situations. The core category that emerged from the data, *Juggling a Way of Being,* depicts how participants processed their main concern related to the collision of personal and professional values in the context of the ED.

Juggling a Way of Being

The theory that was generated in this research was named *Juggling a Way of Being*. Together, researcher and participants co-created a conceptualization of the basic social psychological process of how nurses experienced and managed tension in the workplace. The intrinsic and extrinsic factors previously described were antecedents to the experience of tension 'in the moment'. Nurse participants experienced internal tension between being a *person* and a *nurse* and at the same time experienced tension from *external factors*. The eight nurses reported a continual tension as they moved back and forth among the lenses through which they gazed: personal, professional, and

91

Figure 4. Tension 'in the moment'
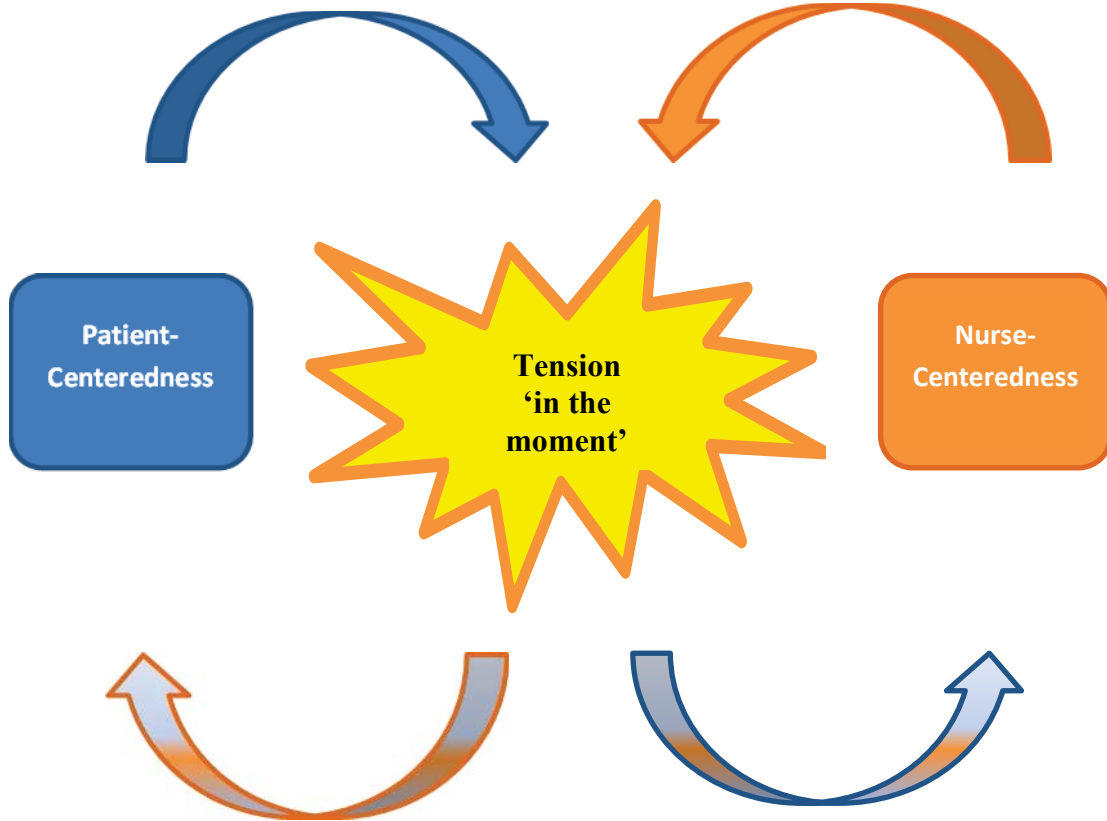
environmental. Participants were constantly evaluating the situations they faced. Each unique moment in time incurred tension when personal, professional, and environmental factors merged in a way that left the nurse unsure, consciously or unconsciously, of how to respond to the situation.

The process of *Juggling a Way of Being* included three phases: 1) *Assimilating Internal and External* Stressors, 2) *Adjusting the Patient-Centered/Nurse-Centered Lens According to my Interpretation of the Situation*, and 3) *Achieving a Point of Action or Inaction*. Participants leaned toward a particular way of being based on how these processes unfolded, which will be explained below. This way of being can be envisioned as a continuum, ranging from a *patient-centered* to a *nurse-centered* orientation to care.

While the theory is presented in phases, it was not a linear process. Nurse participants continually shifted along a continuum of patient-centeredness to nurse-centeredness depending on the ethical lens they were using, the circumstances in the moment, and their ability to manage their tension. They experienced a grating friction, like sandpaper rubbing together, as they leaned toward a way of being. The eight nurses were neither completely patient-centered nor were they completely nurse-centered. They constantly shifted between both ends of the continuum as they responded to what was going on both inside and around them.

The process of *Juggling a Way of Being* was constructed as participants reflected on the following questions: 1) Can you tell me about a time that sticks out in your mind when you wrestled with conflicting personal and professional values in the course of patient care? (This could have been when you were personally providing care or when observing the care of another nurse); 2) You are a nurse but you are also a person. Help me to understand who you were before you became a nurse; 3) How do the people and other factors (things, events, etc.) around you influence what you do at work?; and 4) How do you make up your mind about what you are going to do at work (when personal and professional values collide)? The basic social psychological process that was generated, *Juggling a Way of Being*, will be explained using the voices of the participants whose reflections shaped the theory.

Assimilating Internal and External Stressors

The first phase of the process of Juggling a Way of Being was called *Assimilating Internal and External Stressors.* In this phase, participants wrestled with the intrinsic and extrinsic factors that caused them to experience tension. It was a time of internalizing

what was going on around them and attempting to make sense of it by drawing on their personal and professional values. Assimilating Internal and External Stressors included sub-processes of *wanting to do the right thing, struggling with irritants, leaning toward a way of being,* and *considering risks and rewards*.

Wanting to do the Right Thing

A sub-process of *Assimilating Internal and External Stressors* was *wanting to do the right thing*. Doing the right thing, according to these nurses, was not the quick and easy thing but that which was for the long-term benefit of the patient. As participants struggled to do the right thing, they reflected on the values about which they cared deeply – both as people and as professionals. This was a moral imperative, "it was about me being a good person" (Maggie May), which weighed heavily on participants even after their shifts were over.

> it's at the end of the day when I go home at night what bothers me about my practice. That's what I think of when I think of that. What's something that wasn't done right that I can't stop thinking about at the end of the day. (Myrtle).

When faced with situations in which they struggled with the care they, or others, provided to patients who were regarded as difficult, participants aimed to uphold professional obligations. Maggie May said, "I'm supposed to be professional and do what's best for you." Bette echoes this in saying, "you're just trying…you want to treat everybody with the respect and the dignity and everything that they deserve when they come through the door", and Madeline spoke of drawing on the Code of Ethics for Nurses (2008) when faced with caring for patients that were challenging to her.

While participants made efforts to uphold professional obligations, they experienced tension because of the other hat that they wore – that of being a person.

94

Bette described internal tension as she tried to remain patient-centered in a situation that

challenged her personal values:

> So when you're looking after the drunk driver and the injured victim is right
> across the hall, like just to maintain your professionalism and still treat that
> patient…with the type of care that they're entitled to, but inside, you feel like, you
> know, "uh, that bugger", but…you know, you can't show that to your patient.
> (Bette)

Maggie May, a nurse who leaned greatly toward patient-centeredness, expressed the

same internal tension when she described the power imbalances that were created by

nurses, including herself, at times, "you have to be responsible for what you do. And we

do play God". Participants described "putting on a happy face" when in challenging

patient situations in an effort to meet care requirements. This need to mask their true

feelings caused tension within the nurse but was essential "out of respect for the patient"

(Zoey).

When participants were processing what was going on when caring for difficult

patients, they made attempts to look at the bigger picture. For example, they reflected on

the challenges that patients with homelessness, mental illness, and addictions face and

how there were limited community resources to support them. They expressed a sense of

frustration knowing that these patients, who were often seen repeatedly in the ED, were

being sent back to the community without having their underlying problems addressed.

Myrtle reflected, "it's sad because you know that…whatever you do for them

today…next week they'll be back…we're just discharging them to the same thing…with

no help." (Myrtle) In looking at the bigger picture, participants often felt a burden of

accountability for the situations they found their patients facing. They reflected on the

determinants of health and systemic factors that acted as barriers to patients' life chances.

We're not really…doing anything to truly help them. We're feeding them and curing or fixing whatever's wrong at that moment and then sending them back to the same thing that's caused this... And I don't feel like we have any programs that actually try to help people. It's…it's just sad when you discharge them to the street again. And it's almost…you know…you know there's no help in our city for things like that. And the same with mental health, when we discharge them, it just seems like we don't…But it's hard, I mean, how do you cure those things? How do you fix those problems?…But it's just sad sometimes. (Myrtle)

Myrtle described a sense of hopelessness when looking at the bigger picture. The inability to 'fix' patients and the systemic factors that impeded their wellness also left participants feeling frustrated and angry. Pearl expressed feelings of anger when she described patients as being failed by the healthcare system. Maggie May shared feelings of frustration with structural factors that prevented people from reaching their full potential and recognized that healthcare leaders must advocate for systemic change.

We have created this…self-feeding monster…if we don't change it soon, we are going to have a society of people that are going to need assistance to wipe their own ass. (Maggie May)

Considering the bigger picture enabled the nurse to empathize with the difficult patient. Looking at all of the factors that influenced a patient's situation, rather than just what was in front of them in the moment, enabled participants to care about the person inside the patient. "And you can't get mad at her… because I honestly believe that most people like her…we did it to them…" (Maggie May)

Participants spoke of the importance of caring non-discriminately. Maggie May reflected, "you have to be very careful to treat the hooker the same as the tycoon." Caring equitably required nurse participants to acknowledge their own personal values that may have been incongruent with the care encounter they faced. For example, in speaking about caring non-discriminately, Myrtle said,

I think you can. As long as you keep your values in check. Does it always happen? Probably not. But I think that…I had a prisoner the other day who was…you know, someone who could make your belly turn, and he got the same care that everyone else did…I think as a human you do…definitely have some…sort of negative thoughts about… (Myrtle)

Caring non-discriminately meant accepting the patient unconditionally.

one thing I try to do, and I'm not always successful for sure, I mean we can't always get along with everyone (laughs), but to just accept people for who they are, no matter what their background is. We don't know what happens in people's homes, what happens behind closed doors. And so it's just important that when they're in front of you to treat them as if they're no different than anyone else in the department and give them the respect and…do all you can. (Myrtle)

Participants were all in agreement that not all patients were likeable. There was a need to mask their dislike in order to provide non-discriminate care. Madeline reported that although it was unrealistic to like every patient, "you still have to act like you do *(laughs.)"* Participants shared stories of times when co-workers' dislike of patients influenced their behaviour. Maggie May reflected on such an experience and said,

And because …she's a hooker… that probably doesn't have any family, nobody gave a rat's ass about her…I don't have to like you. That's not why I'm here. (Maggie May)

Providing equitable care, accepting others' differences, and masking one's dislike created tension within the nurses as they struggled to balance personal and professional values. Even participants who leaned more toward patient-centeredness experienced this tension within.

Assimilating Internal and External Stressors allowed participants to recognize their own humanness and propensity to be judgmental. A nurse's professional values would instruct care that was void of judgment. Maggie May said, "I'm supposed to be non-judgmental, which is impossible because I'm human." As participants worked to do

the right thing, they were required to reflect on this human tendency to judge. Accepting

this human limitation preceded any action to prevent the enactment of judgmental care.

> I think as a human being, sometimes it's hard to not make judgments in your head. I think I would be lying if I said in my head I wasn't thinking, 'what the heck? How do people do that?'… So I think…that's one thing we do sometimes to try to keep those judgments out, cuz I think sometimes they're…it's hard not to think them. You can…not act on them, for sure, but I'd be lying if I said in the back of my head that you don't… (Myrtle)

Participants reflected on their responsibility to acknowledge their own values and beliefs

in order to provide care that was non-judgmental. For example, Maggie May said, "I'm

allowed to have a personal opinion… and I can keep my pie-hole shut about that" and

Bette reflected, "there are definitely moments when you have to…you know…just be

Florence, and do your work, and keep your opinions to yourself."

> Participants who wanted to do the right thing engaged in reflective practice.

> We're all judgmental sometimes, it's hard not to be (laughs), but somebody who maybe can be judgmental and then say, "oh shit, I shouldn't have done that" and then come back on track, and people who can admit that they've made a mistake, who can take ownership and say, 'shoot! That was me. I'm sorry I made a mistake' and that's the end of it. And that's better than passing things along. (Myrtle)

Being a reflective practitioner facilitated personal and professional growth and

encouraged participants to consider other ways to manage situations in the future.

Myrtle accepted that there were times when she was unable to prevent her own attitudes

and judgments from influencing her care and described a process of reflection that

followed, "afterwards I do think, 'what will I do better next time?'" Reflective practice

sometimes occurred when participants experienced tensions with how they felt after

providing care to patients. Maggie May described her feelings about times when her care

was influenced by negative judgments, "Do I feel bad when I do it? Yes. Do I try to

correct it? Yes." Participants reflected on feelings of guilt for having negative attitudes towards patients as Bette shared, "And I know that's awful, but…I guess I feel guilty that I feel that way. Like you shouldn't feel that way."

Wanting to do the right thing encouraged participants to internalize deeply about professional accountability and promoted reflection on their own humanness. Being a reflective practitioner helped participants to find ways to provide non-discriminate care when they were faced with value-laden care situations. This part of *Assimilating Internal and External Stressors* saw participants leaning toward patient-centeredness, although they continued to feel tension as they wrestled with competing personal and professional values. While participants were processing how to do the right thing, they simultaneously were struggling with irritants.

Struggling with Irritants

Struggling with Irritants, a sub-process of *Assimilating Internal and External Stressors*, reflects participants' reactions and responses to patient characteristics that 'pushed their buttons'. The following statement exemplifies what was meant by struggling with irritants, "this woman was…irritating, annoying, interfering, in your face, she was persistent, um, she had no respect for other patients." (Maggie May) Irritants were factors that greatly influenced participants' ways of being in a particular moment in time. These were described as negative stressors that caused participants to lean away from patient-centered approaches to care. Participants described three major irritants that they faced in the ED: 1) dealing with difficult patient attributes, 2) seeing the same patients repeatedly, and 3) patients who were, or were thought to be, responsible for their situation.

All eight nurse participants talked of difficult patient attributes. They provided a diverse list of irritating patient characteristics including verbal abuse of the RN, abuse of the system; behaviour that was rude, disrespectful, "in your face", demanding, attention-seeking, exaggerating, or manipulative; complaints about wait times, not following the nurse's 'rules'; accessing the ED with non-urgent concerns, teen pregnancy, and health not being a priority. The participants described patients with the above characteristics as *difficult*; however, the data suggested that these patient attributes were *irritants* to the nurse in that they were not consistent with what the nurse expected of the patient. As participants told stories of dealing with difficult patient attributes and how this affected their thoughts and subsequent action, a great vacuum of empathy was noted in their stories that leaned away from *patient*-centeredness far toward *nurse*-centeredness.

> Well, there's a difficult patient who is swinging and spitting at you, or there's a difficult patient who you say "don't eat anything" and you go in the room and they're eating something, or you say 'you can't go for a smoke because you need to wear oxygen' and the next thing you know they're gone out for a smoke! Those patients are difficult. And then there's the patients who are…question every single thing you do…which they're allowed to…but I guess it's just kind of the way that they do it…so there's lots of difficult patients. (Madeline)

> …you're like, 'they're manipulating us!' They want to be here! They're not functioning in society. Um, it's frustrating. Cuz you're thinking, OK there's people sitting in the waiting room, there's people sitting in these beds, they're not getting seen cuz you're looking after this person who, yet again, has…drank the antifreeze. But they would only drink it after they called to see what doctor was on in the ICU before they drank it! (Lila)

This same nurse-centeredness was noted in participants' recollections of seeing the same patients repeatedly. These patients were called *repeat offenders*, a label that implied guilt or criminal behaviour. Repeat offenders were described as frustrating; they were demanding on the system and on nurses in that they took time away from more urgent patients. Participants shared that repeat offenders received care that was "not the

best" (Madeline). This meant that their complaints were not always investigated fully, or their care was more distant as described by Liz.

> …their tone with them is different. Yeah, I'd have to say their tone is different; they're not as attentive as they would be to a different patient. Just things like that…well, we go in and, of course, we usually vital people every…hour. Patients like that, some of the nurses don't. 'She's fine. She's done it before'. (Liz)

Participants reported that while dealing with the irritation of seeing the repeat offender, they also recognized that they should take the patient seriously.

> …repeat offender people. So people that are in…a lot. You know, somebody that comes in with belly pain. If they come in with this abdominal pain that's been seen…you know, 16 times since January?...and you'll go, 'oh, they've been here 16 times and they've never found anything wrong with them, blah, blah, blah'…You can't just assume that because somebody's been there 15 times this week for the same complaint, you know that they actually have nothing wrong with them. And I think people often pass judgment because we see these people…a lot. (Lila)

Patients who were considered to be responsible for their situation, or blameworthy, were irritants to participants. They struggled with conflicting values when caring for patients deemed to be responsible for what brought them to the ED. On the one hand, personal values promoted feelings of anger and distain; while on the other hand, nurse participants' professional values told them that they should care non-discriminately and with complete acceptance.

> And you're looking across the bay and there's the woman that he hit, and you know…all injured or whatever. And it's hard, because they're…you know, they have no idea what they've done or they don't know what's going on, they don't even realize the severity of their situation, yet they may be quite injured too, and you're looking over at that poor innocent person, and um….so it's hard… (Bette)

> You know, a lot of times they'll come in with, you know, like infections or…feeling unwell, and…I just look at them and I'm thinking, 'well, maybe you shouldn't have been putting all those drugs in your arm and maybe you wouldn't be so sick.' (laughs) And I know it's a terrible thing to think, but, you know, you kinda can't help it. (Pearl)

The participants' stories of struggling with irritants reflected the tension between personal and professional values. Tension was created as participants simultaneously internalized *wanting to do the right thing* while *struggling with irritants*.

Leaning toward a Way of Being

Leaning toward a Way of Being was found to be a sub-process of *Assimilating Internal and External Stressors*. As participants internalized, they found themselves leaning toward a *way of being*, or an orientation of care. This *way of being* fell anywhere on a continuum from *patient-centeredness* to *nurse-centeredness*.

Being patient-centered. Participants who were patient-centered were primarily motivated to meet the patient's needs. When patient-centered nurses saw unfair treatment being given by others, they felt angry and embarrassed for their profession. As they experienced this tension, they reflected on their own practice.

> Oh, I would never be them. I can't. Like, I've noticed that a lot of them are really abrupt with how they speak to people and they have no issue kicking people out of the room and just different things that they do. That's not me. I can't do it. And…they're like, 'oh, you'll learn, you'll learn'…but I can't. I'm not that person. Like, I'm not saying I'm the nicest person ever created, I'm not a Saint! *(laughs)* But…I can't be that mean and that heartless to people. I just, I don't know…I just can't. (Pearl)

Participants reported that when leaning toward an orientation of patient-centeredness, they had the ability to empathize, see the humanness of the patient, identify with the patient, and recognize when they had reached their "tipping point" and how to manage it. They saw individuals as unique, "You just have to have a different…outlook on each relationship and tailor it to what the patient needs." (Myrtle). Patient-centeredness was a way of being that spurred participants to challenge care they saw as unfair.

And I always think, okay that person has lost their compassion so that is going to make me, and maybe it's not, maybe I don't even make that decision, but something switches inside of me, and I feel like I need to be that nurse that the patient needs. (Zoey)

'I will vouch for you because that was unnecessary'. And… because it was just…it crossed a line of being well I'm not sure if they're quite frozen or not to being just downright mean. And, I mean, I wouldn't have done that to a dog. I wouldn't do it to a person. And…they did. (Maggie May)

A patient-centered orientation enabled the nurse to be empathetic. This included trying to understand the patient's circumstances, trying to understand the meaning patients assigned to their situation, and overcoming initial preconceptions. Participants reflected on the importance of trying to understand the patient's situation. For example, Maggie May said, "you don't have all the facts when people come in. You just know…what's wrong with them. Not how they got there." Knowing the patient's storey was described as looking at the bigger picture: considering their personal and financial supports and resources and looking at the emotional aspects of the patient's circumstances.

I just always feel like I'm so blessed to have good family support and everything in my life that I would never need anything like that and these people are…abused, and maybe don't have support and maybe don't have family…maybe don't have…whatever situations in their life that brought them to that place. (Madeline)

I have no idea but I can guarantee you that she didn't wake up one day and go, 'I want to be a hooker!' I'm sure that wasn't her aspiration in kindergarten. (Maggie May)

Participants articulated how important knowing the patient's storey was when providing care. True caring was described as considering the whole patient, their circumstances, their resources and challenges. I meant looking beyond what was in front of them in the moment in time.

…for patients who come in all the time and their family gets to know you and you know them, to distance yourself from those people, it's…you look like you just don't care. And you have to! You have to care about that family, you have to care about the little brother at home who's not sick but is so stressed out because he feels like his parents are only dealing with the brother who's sick. You know, you have to know everything that is going on so you can treat not only your patient but treat their family. Because, you know, maybe this little oncology patient's mom kind of chirps at you a little bit today. And, you know, you're so offended that she did that, 'oh, she's such a B' but you don't know that she's trying to back to work, and her son at home is acting out, and her and her husband are fighting. You know, if you don't take the time to talk to her you don't know that, and you say, 'oh, you're so rude. 8's mom – she's a B'. If you don't take that time you don't know. (Pearl)

While recognizing its importance, trying to know the patient's storey also created tension within the nurse who worked in an environment that was chaotic and fast-paced.

I'm just not…although I have the skills, the ability, and the brain to do it, I'm in the *way* wrong place. I need to bond with patient and with families and get to know them and do teaching with them and education and try to…um…cuz you get to know why they're here! Why did you land in this bed? Let's talk about that stuff! (Lila)

Having empathy was also described as trying to understand the meaning patients assigned to their situation.

…and he grabbed my hand and said, 'thank you so much. I'm not ready to leave my wife yet.' And that really…I just never forget him…oh, it just felt so fulfilling. So fulfilling. (Liz)

That patient is having the worst day that they'll ever have in their whole life. Scared. Confused. Not understanding what's going on. Fifteen people around their bed. I don't ever want to be there…because it's got to be the most scary feeling in the whole world. (Lila)

Patient-centered nurse participants recognize that the ED was an unfamiliar and often frightening environment for most people. While participants were socialized to the ED environment and felt comfortable there, most patients were not. Patient-centeredness promoted consideration of these fears and anxieties as Madeline reflected, "you have to remember…cuz it's so routine to us and this person's probably really scared."

Empathizing could also include overcoming an initial preconception, attitude or feeling about a patient. Maggie May described this as "crossing over" and shared experiences of this phenomenon when caring for intensely dislikeable or blameworthy patients.

> …even when… the parent was at fault…if you want to be angry at them because they were negligent…when you see how *(voice breaks)* broken they are, you can't be mad at them…you can only feel sorry for them and be very nurturing to them because sometimes you don't know you're an asshole until you've paid the ultimate price...And even drunk drivers, I can feel bad for…did I go to the Hampton court house and help to fry his ass? Yes, I did...but I still felt bad for him. (Maggie May)

> She was pretty hard. When she first came in she was really standoffish and…um…not pleasant at all. And, um…I wasn't super, overly, kind to her when she first came in. I don't really know what changed. I think…I made a joke about Jello or something, and…from then on we were just kind of friends *(laughs)*. (Pearl)

Maggie May reflected, "usually there is something that triggers that" when talking of crossing over. While she was unable to articulate what that trigger was, the deeper meaning in her words, and in the words of all participants, suggested that the trigger was seeing the humanness of the patient and feeling another's pain. Maggie May shared the following storey:

> We had, a short while ago, um…two stab victims within five minutes of each other roll in. One of them, of course, deceased the other one was the 'stabber' and…you know…but I still felt for this guy. Like, I was doing compressions in the trauma room on a 17-year old boy who came in looking like a wax figurine, still talking and screaming and begging for help, completely oblivious to us being present because he was so anoxic he did not know we were there. He was just…young healthy heart that just didn't stop. And…at one…he might have been in the room eight minutes, arrested, and we tried to revive him but there was no way. There was nothing going to happen. The boy who stabbed him was in room 23 which is directly across. The curtains were open in that little room by the nursing station. So he, from his stretcher, could see me doing compressions and I could see him. And the look on his face, if I had put a shotgun to his chest and pulled the trigger…there couldn't have been a worse look on his face. The remorse and the pain that I saw in his face…I, my heart broke for him. And even

105

though…and, you know, in the course of events we found out that it was self-defence…but in that moment, had I judged him…I'd have been wrong. (Maggie May)

Pearl reflected on her experience of seeing a paediatric cancer patient as a person.

> Like, I'd call him names or tease him or whatever it was, it made a difference because his hospital stay wasn't just about his illness. It was about him and getting to know him and talking to him about whatever he wanted to talk about. So it made a difference… (Pearl)

Seeing the humanness of a likeable patient, such as a child with cancer, was not difficult for Pearl. She told another storey in which she again saw the humanness in a patient, this one a dislikeable alcoholic who was judged by her peers.

> …because he is still a person! And if he was in his right mind he wouldn't be calling me those names. When he sobered up I was cleaning his head (cuz no one wanted that job, no one wanted to clean all the gross blood off his head), so I did it. And, uh…he started sobering up and he was like, 'oh, dear, you're so nice. You don't have to clean that. I'm sure you have lots of other things to do'. And I wasn't going to leave all that crusty old blood on his head! *(laughs)* Even though he was going to the drunk tank, I still couldn't do it! You know?! I just can't be that mean! (Pearl)

Seeing unfair treatment of this patient incited Pearl to be patient-centered and to see the person inside the "difficult" patient. Similarly, Liz reflected on seeing unfair treatment of psychiatric patients by her peers.

> I don't like that. I don't like that. I kinda like the psych area, like I am, I have an interest in that, I really do. Um…and no. I don't think it's fair to the patient to…cuz I know they can probably feel it and, and I just don't like it. (Liz)

Participants who leaned toward a patient-centered orientation of care tried to identify with the patient. This was described by the nurses as being able to see themselves in the patient. Maggie May reflected, "I could have been her…I seized different opportunities that maybe she didn't have?...We just had different breaks." Similarly, Zoey shared that being faced with others' health challenges and vulnerabilities

106

made her thankful for her own fortune, "But thank God that wasn't me. That's what I say all the time; thank God that is not me." (Zoey) Identifying with the patient meant that participants recognized that patients were people first; human beings, like themselves, who had feelings and made choices in the context of their own life circumstances.

> I think every single one of us has made a bad choice in life, has made a wrong decision in life and it just so happens that the deck of cards you go dealt you were either able to come out of that situation or you were able to cope with the situation. Maybe it's because of your family support, maybe it's because of your friends, but any of us could be in that situation. And we just have to…try and help those people who are in those situations, and try, whether it be get out of the situation or just cope with the situation they're in. Or if it's abuse and giving them resources or something like that, cuz, we don't…like, I think anybody could be there. (Myrtle)

> …well, they're people and they've got feelings. And I don't like feelings being hurt or anyone being disrespected. Cuz, I'm sure it's happened to me before. I don't like it, so I don't think someone else would like it. (Liz)

Patient-centered nurse participants recognized when they had reached their tipping point and had a plan for how to manage their tension. Tipping points were unique to each nurse based on the values they held the closest. Patient-centered nurses were able to reconcile the tension they felt at tipping points and provided care even when they did not agree or understand.

> …when you have a Jehovah's witness patient who won't receive blood products but their hemoglobin is 60 and they're not doing well, and you're just like 'oh, if you would just take some blood, you would live'. I think that's another situation where it's…it's mentally draining on yourself because…I guess your personal beliefs, like, 'take the goddamn blood, you'll feel better!', you know, but if that's their belief, that's um, sometimes it's frustrating and you're watching this person die and you know they could be…they could maybe have a chance if they took that blood but…that's against their beliefs. So, sometimes, some of those situations may be a little bit frustrating. (Bette)

> I think it can be difficult when we get these patients who are morbidly obese and smoke ten packs a day and have had three heart attacks (laughs)! So when they come back in, you just sometimes feel like saying, 'you know what's causing this! You know how to stop!'…I think sometimes it's hard to not get frustrated. But I

107

don't think getting frustrated is necessarily a bad thing, as long as you…don't act on it, you act as if they're any other patient and you just kind of forget it and move on. Cuz, there's always going to be some things that frustrate us. You just have to know how to…handle it and keep going (laughs). (Myrtle)

Sometimes, in situations like these, participants' frustration became so great that they recognized a need to step away from the care encounter. This was done in an effort to prevent their negative feelings from influencing patient care. Reaching a tipping point was a critical time when tension could cause the nurse to lean more toward a *nurse-centered* orientation of care.

Being nurse-centered. As participants assimilated the tension they experienced, there could be a shift toward the nurse-centered end of the care continuum. Participants with a nurse-centered way of being were primarily motivated to meet their own needs. There was a marked lack of empathy for patients. This was sometimes accompanied by an image of the nurse as a victim and was often the result of participants feeling unappreciated. Pearl reflected, "why am I going to take time out of my day, my busy day, to go back into their room to try to make someone feel better who is just not going to appreciate it?"

> There was a baby that came in once and I was drawing blood on her and I didn't get it right away but I could feel it right there so I was kind of wiggling the needle and the mother tried to grab the needle out of my hand. And she made me so mad, and another nurse came in and put her arm in between us and I got the blood and it was fine. The mother absolutely flipped and started swearing at me, there was no way I could connect with her. I couldn't even go in the room. I really, it really scared me that she tried to reach for my hand cuz she said 'well the last nurse poked and it came right away' so she thought I was doing it wrong and she just didn't understand that sometimes it just takes a second to get it. But she was screaming in my face and I could never connect with that mother and I didn't think she deserved to have a baby (laughs). But I could never connect with her because she was so rude and mean to me for no reason, just cuz she didn't understand, even though when I was trying to get the blood I was explaining…but it didn't matter. Oh, she was so mad, she started throwing things…oh, it was ridiculous… (Madeline)

Participants did not always recognize their nurse-centeredness. In the following

comment, Madeline was reflecting on the importance of being "nice" to patients. She

believed that she was focused on the patient's needs, but the end of her storey revealed

her deeper motivation – not to be embarrassed or look like a "bad nurse". Ultimately, her

concern was primarily for herself:

> I just, you have to remember any patient you take care of, you could meet them
> somewhere outside of work, too, so you have to think of that…you might meet
> someone. A nurse told me once that she took care of a patient and she met them
> on the street a couple of weeks later, and her first thought was, 'was I nice to
> you?' And I don't want to have that feeling. (Madeline)

Leaning toward a nurse-centered orientation of care saw participants justifying action or

inaction, distancing, doing what they 'had' to when they would rather not, determining

the patient's deservedness of treatment or situation, and passing judgment and labeling.

Justifying action or inaction was a nurse-centered internal process used for two

purposes: 1) to place blame with the patient or 2) to excuse one's own behaviour. Action

or inaction was justified when the patient had no "real" reason to be in the ED. This was

determined by the nurse's perception of what was, or was not, an appropriate reason to

visit the ED.

> …we had a patient that came in that wanted their ears flushed…at two in the
> morning…'well, we've already talked to the patient advocate this week'….That's
> fine…you're here because your ears are blocked but you're going to have to wait
> your turn…'Well. That's just unacceptable!'…Well, unfortunately you're not
> dying right now. People are dying inside, so…we'll be more than happy to look at
> your ears, but you need to sit down. Like, you need to get out of my face at this
> point. (Lila)

Blaming the patient was also seen in actions or inactions that were justified based on how

the patient behaved while in the ED. For example, Liz explained how she could not

develop caring relationships with patients if she felt they treated her poorly, "some

people, they're not as appreciative or, or…make you feel like you've helped them. So, no, I don't think you can have that kind of relationship" (Liz). Participants also justified their inability to form caring relationships with patients, as Myrtle said, "I know that's horrible, but *(laughs)*…well, I guess maybe sometimes it's not horrible because sometime those patients don't want those relationships either. They don't want to connect." Blaming patients reduced participants' sense of responsibility and justified their action or inaction.

Participants also justified action or inaction in an effort to excuse themselves. For instance, Pearl reported, "I, personally, have a hard time with mental health. I am not a mental health nurse. I tried to do it where I used to work…and I was never trained on how to do it properly. You know, you learn a little bit about it in school, but not much." Similarly, Maggie May excused her action or inaction in her comment, "I only had her in passing". Madeline reflected on a situation in which a patient was judged incorrectly based on negative preconceptions. She excused her care in her remark that even if the patient had received appropriate care, it would not have made a difference to her outcome:

> …so we thought she was an overdose…her son said she she'd overdosed before
> and she does this sometimes and what really happened was she had the worst
> headache of her life and was taking all these pills to take the headache away…and
> she had a big bleed and she died. So it's…she was treated as an overdose instead
> of giving her a CT Scan right away, like, we all thought she was an
> overdose…they said in the end that even if she had the CT Scan right away it
> wouldn't have made a difference for her. (Madeline)

When participants leaned toward a nurse-centered orientation of care, they were inclined to distance themselves from patients. Several participants referred to *doing*

protocol which they defined as meeting mandatory physical care requirements in the

absence of nurturing or support.

> There isn't the stroking, there isn't the 'you're going to be OK', there isn't the, you know…you're very…um antiseptic and clinical…it's not the same as when you… you give that…that extra mile…you clinically tell them what's going on and you make sure they're informed and they're up to speed and that, you know, you reassure them but you're not…nurturing…you stand at arm's length. (Maggie May)

> But you still have a job to do and you're tending to this patient so you have to make sure his basic needs are met…I might not go out of my way to do something extra special…but that's…you know… (Bette)

Distancing negated the person inside the patient as described by Lila, "I would feel very

sorry for the person that got stabbed. But we always tend to find out what actually

happened...And so, it's like, you know what? You're here, you're a patient, you're a

piece of meat, we're going to patch you up and send you off."   Distancing served to

protect the nurse from becoming emotionally engaged with patients who were disliked.

Maggie May, when describing such an experience, said, "my heart was not in it".

> Participants recognized that despite their strong negatives feelings toward some

patients, they still had a job to do. This was expressed as *doing what* has *to be done*

despite not wanting to. When feeling this way, the nurses internalized their tension and

could have thoughts such as, "she's there and now she's my problem and I have to deal

with her." (Maggie May)

> It's your job! You have to…but sometimes it is hard, you…just try and…'ok, I still need to look after you, but'…sometimes, yeah. Just thinking in my head, like, you know, 'what an arsehole but I've got to make sure his bleeding's controlled and do this…like, I may not like you right now but I still have to look after you'. (Bette)

In these situations, "mandatory" care was provided but without any regard for the patient

as a person. Thus, doing what "had" to be done was a nurse-centered way of being.

When leaning toward nurse-centeredness, participants could determine that "dislikeable" patients *deserved* their unfortunate circumstances or the unfair treatment they received. "I didn't feel one bit bad for him and I thought, 'Oh. You're finally going to get judged…you got what you deserved, you bastard.'" (Maggie May) This occurred in encounters that greatly challenged the nurses' personal values such as in cases of abuse or drunk driving.

> I thought he shouldn't even be allowed in the room. For making up a foolish storey like that, he shouldn't even be allowed around that child for the rest of his life. That's it. (Pearl)

In these highly emotive situations, personal values could take precedence over professional values of non-judgment and caring relationships and cause participants to lean toward nurse-centeredness.

When participants leaned toward a nurse-centered way of being, they were more willing to pass judgment and engage in labeling. In a storey about a sex worker who was seen frequently in the ED, Maggie May recalled that "she was just a piece of garbage that nobody cared about." Participants shared stories of patients being labeled as repeat offenders, frequent flyers, drug-seeking, crazy, attention-seeking, unintelligent, and bad parents. Certain disease processes were associated with negative behaviours, and patients could be labeled based on their diagnosis as Bette described.

> There's quite a few patients that have problems with, like, pancreatitis. So there's several people that I can think of that come into the department frequently and…I mean, it's a pain thing, it always is, but unfortunately, you can't judge or tell how much pain somebody's really in. When they tell you they're having pain, they're having pain; you can't say that they're not. And unfortunately, some of those patients get…um…used to their narcotics, so they get labeled as 'drug seekers' which can affect how they are treated in the department also. And it's…it's touchy, cuz, you know….they may, they may legitimately be in a lot of pain and maybe they've actually been off narcotics for six months but now they're having

an acute episode or…But I know, just thinking of some of the ones that you may see often…a pancreatitis patient may be one type of them. (Bette)

Considering Risks and Rewards

A final sub-process of the phase of *Assimilating Internal and External Stressors* was *Considering Risks and Rewards.* Caring incurred both personal risks and rewards for participants. As the nurses engaged in assimilating their stressors, they considered the potential personal gains or vulnerabilities that could come from the care they provided. Participants described rewards as including a sense of pride in work, being appreciated, making a difference, and developing connected nurse-patient relationships. Zoey shared, "this is a great profession and I am really proud to be in this." Caring could also leave the nurse feeling vulnerable and therefore some participants built walls to protect themselves from the personal pain that sometimes accompanied caring. "So you walk away. And cuz you're human…you have to." (Maggie May) Pearl reported that protective walls were important to her when she felt that caring deeply about a patient caused her too much personal pain and Lila shared a storey that illuminated how protective walls were used to insulate her from feeling like a 'bad nurse'.

> So I don't have to…let you in. I don't have to care about your situation if I don't think I can do that right now…*[developing nurse-patient relationships]* is important, but it also makes it harder, because…if I see…them as just a patient…that's OK. But if I see them as that single mom with three kids at home who is struggling to pay the bills, that's too much for me…because I just want to help them! And…*(begins to cry)*…and…I want to be able to…help them. And sometimes you can't. (Pearl)

> …sometimes it's easier to do that than it is to actually…try to…emotionally…connect and cope with these people. It's almost a protecting mechanism to us, I think. To me, it is. Um…because I don't have to deal with that now. I've done what I have to do, I've met the obligation of what the physician wants and now…you know, you're not happy, you're never happy, you're always mad when you come in, your wife is belligerent when she comes, so…I'm not going to put myself into the mess of you telling me I'm a bad nurse

and a bad person because you're not happy with what we're doing. I can beat myself up by myself. I don't need any help...I know when I'm a good nurse and I know when I'm not a good nurse. (Lila)

Protecting oneself from personal pain was necessary when participants felt too vulnerable to engage in caring connectedness. It was a protective mechanism for the nurse who truly cared deeply for patients, but it ultimately left the patient vulnerable and emotionally abandoned.

Assimilating Internal and External Stressors, the first phase of the process of *Juggling a Way of Being*, has been described as the way in which participants struggled with conflicting values and the tension that was a result of that conflict. Assimilating Internal and External Stressors saw the nurse wanting to do the right thing, struggling with irritants, leaning toward an orientation of care or way of being, and considering the risks and rewards that came with caring. Assimilating Internal and External Stressors, a process used to deal with tension, was itself fraught with tension. As nurse participants moved into the next phase of the process of *Juggling a Way of Being*, called *Adjusting the Patient-Centered/Nurse-Centered Lens According to my Interpretation of the Situation*, they wrestled with both internal tension and external tension from the people and environment around them.

Adjusting the Patient-Centered/Nurse-Centered Lens According to my Interpretation of the Situation

The second phase of the theory, *Adjusting the Patient-Centered/Nurse-Centered Lens According to my Interpretation of the Situation*, is an internal process that was dependent on how participants internalized the personal, professional, and environmental tensions they experienced. The phase of *Assimilating Internal and External Stressors*

114

saw the nurses leaning toward an orientation of care, somewhere on the continuum of patient-to-nurse-centeredness. Where they came to rest on this continuum determined how they would perceive a situation at any given moment. *Adjusting the Patient-Centered/Nurse-Centered Lens According to my Interpretation of the Situation* contained two sub-processes: *A Patient-Centered Perspective* and *A Nurse-Centered Perspective*.

These first two phases of *Juggling a Way of Being* were distinct processes that occured in unison. A nurse's orientation to care was fluid and dynamic. A nurse was neither completely patient-centered nor nurse-centered but was influenced in her way of being by the intrinsic and extrinsic factors described above. There was a constant back-and-forth as participants struggled with tension: tension with competing personal and professional values, tension with environmental stressors, and tension as they shifted along a continuum of patient-centeredness to nurse-centeredness and leaned toward a way of being in each moment-in-time.

A Patient-Centered Perspective

A sub-process of *Adjusting the Patient-Centered/Nurse-Centered Lens According to my Interpretation of the Situation* was *A Patient-Centered Perspective*. When leaning toward a patient-centered orientation of care, participants perceived the situation they encountered from the patient's perspective. A patient-centered orientation enabled the nurse to see the person inside the patient, to see the worth in every human being, and to see the vulnerability of the patient. Having a patient-centered perspective facilitated nursing presence, an interpersonal process that is characterized by caring connectedness, holisism, and going beyond they "science" of nursing to "be with" the patient in their experience. When nurses are present, they are open to the patient's uniqueness and

vulnerability. Nursing presence is a way of being and relating to the patient that facilitates their well-being and, in turn, the well-being of the nurse (Covington, 2003; Doona, Chase, & Haggerty, 1999; Finfgeld-Connett, 2006). Swanson (1991) defined presence as *being with*; that is, "simply 'being there', conveying ongoing availability, and shared feelings, whether joyful or painful…it is becoming emotionally open to the other's reality" (p. 163).

Seeing the patient as a human being was described as accepting someone for who they were, regardless of the "lines and drains" or whether he was the drunk repeat offender:

> And this other man who comes in and he's always drunk when he comes in and his hemoglobin's in his boots every time and he needs blood and he's just a mess. And…(laughs) I saw him the other day and I was, like, 'how's my favourite patient today?' And he's like, 'Oh, dear! I'm so happy to see you!' (laughs) And I just like him! And everyone else hates him! And they don't want to go in and see him but I think he's sweet! (Pearl)

Seeing the person inside the patient allowed caring connectedness to occur as Maggie May described, "so you develop a more intimate personal relationship…you look them right in the eye and you talk to them like they're a person and they know that you see them. And that's a big thing…like, if you don't see them…"

When a care encounter was perceived from the patient's perspective, participants recognized the worth in the unique human being relying on them for care. Seeing the patient as valuable encouraged presence. Maggie May said she had "learned the value of being humble and just…being there". Participants reflected that "being there" for patients takes time, and this required them to make decisions about which patients required their presence most urgently.

116

A guy's like, 'oh, I'm having chest pain, I think I'm having a heart attack' and the guys like 39 years old. The odds of him having a heart attack are pretty slim. And if he is, I can fix that. But…you know, I don't think he warrants me going in and talking to him and finding out what is going on and letting the wall down. Cuz I don't think it would make that much of a difference. But, you know, the…15 year old kid who has terrible things written about himself all up his arms and cut marks all over his wrists and who won't even make eye contact with me. That guy warrants the wall coming down. Because there is something going on with him that someone has to get out before this kid kills himself. (Pearl)

Participants recognized the influence they can have on patients 'in the moment'. Maggie May emphasized this in saying "I may be the first person that they meet that tells them they have any worth at all." Similarly, Bette shared,

But…I mean if I have the time and somebody is trying to talk to me about it, then I'm going to talk to them. Cuz you don't want to shut them down, they've just tried to kill themselves. If they are trying to open up to you then I think you should take that opportunity…to, to talk to them. Or try to make the time at least. Tell the girls, 'I'm going to be busy for a little bit.' (Bette)

Perceiving a situation from the patient's perspective also enabled the nurse to see the patient as vulnerable. Participants described patients as vulnerable to power imbalance in the nurse-patient dyad, and to the emotional pain that accompanied being shut out and made invisible. Nurses' words, tone of voice and body language were noted to be important in creating a safe place for patients to receive care. Maggie May reflected that nurses "have that kind of power to damage…If they are there just seeking one person to give a shit about them…" Participants reflected that when patients are treated without compassion, the lack of caring connectedness left them vulnerable. Myrtle reflected that even patients who seemingly did not "want" a therapeutic relationship were left isolated when no attempt to connect was made by the nurse.

I can't think of anyone who doesn't want someone to connect with them and just come in and get something done, whether they pretend they don't or have this façade, I think it's just…I don't know, I just don't think it can be real. (Myrtle)

117

A Nurse-Centered Perspective

The second sub-process of *Adjusting the Patient-Centered/Nurse-Centered Lens According to my Interpretation of the Situation* was *A Nurse-Centered Perspective.* If participants leaned more toward nurse-centeredness in the moment, they perceived the situations they faced from their own perspective. A nurse-centered way of being encouraged the nurses to focus on the irritants they struggled with in care encounters. When perceiving a situation from the nurse's point of view, participants described seeing the same patients repeatedly, assuming that patient complaints were not "real" or valid, assigning blame or responsibility, and determining their own behaviour based on the patient's behaviour.

Participants leaning toward nurse-centeredness had little compassion for the patient who was seen repeatedly. This was reported as being related to feelings of exasperation with seeing the same thing over and over again. Patients who were seen repeatedly were described as manipulative, draining, and demanding.

> …the chronic, like the repeat offender, the patients that come in all the time. You know, they've just been there for so long, they've seen them so many times, and they're the ones they're kind of quick to…you know, just kind of put them off and… (Bette)

Rather than caring connectedness, these patients received "blunt", "unfriendly" "attitude" from nurse-centered care providers. Nurses were "mean", "short-tempered" and "impatient" with repeat offenders.

When participants made assumptions that patient complaints were not real or valid, the care they provided was negatively affected, as described by Madeline:

> I think people judged him, and I think they thought, 'oh he's just on drugs'…and they didn't really care, but when they realized there was really something wrong with him, all of a sudden there were ten people there, and I thought, 'Where were

you before?! I went to CT Scan all by myself with him acting wild!' So all of a sudden there were all these people around and they wanted…when you know somebody's sick for sure it's definitely a reason. (Madeline)

When participants perceived patient complaints as unreal or invalid, patients were investigated less fully, ignored, labeled, and dismissed. And sometimes patients were even tricked.

> First you figure out if they really are *[having a seizure]*, and the one thing we do, which is really not that nice, is if they're having a seizure and it's not a real one, if you hold their hand up…and if they smoke themselves in the face it's usually real but if they move it to the side you know it's not real (laugh). And it happens all the time. We go to all the codes and you'll go to a code on the psych ward and the patient will be "seizing" but you know they're not, and you know if you take their hand and put it over their head you know they're not going to hit their face because you wouldn't do it to someone who was really seizing. (Madeline)

There was an absence of empathy in this nurse-centered way of being. Indeed, participants could feel the need to ensure that co-workers were aware of the patient's illegitimate reason for being in the ED. Lila, for example, described stopping new physicians before entering the patient's bedside, "'Before you go see them, you need to understand what this person's come here with, like, what baggage.'"

When perceiving a situation from the nurse's perspective, patients who were considered to be responsible for their situation were at risk of receiving task-driven care. When participants blamed patients for their situations, they entered the relationship with feelings such as intense dislike and distain. These feelings saw nurses acting in ways that met patients' essential physical needs without being "warm and fuzzy". As Bette reflected, "I would make sure their basic needs are met but, you know…would I go out of my way to…you know, 'you're a monster, you just stabbed this woman ten times!'" If the patient was responsible for a particulary violent crime, participants might avoid the

patient as much as possible, believing that the patient did not deserve their time. Pearl

reflected on her feelings about caring for an intensely dislikeable and blameworthy other.

> Honestly, I think I would be the most cold-hearted human being in the entire world. I...*(sighs)*...I, yeah, I would have no use for them. I'd go in and be like, 'Hi', put their blood pressure cuff on, 'Here are your pills' and walk out. I wouldn't say, 'how are you today? Are you in any pain? Are you having any chest pain?' I don't think I'd care. Because you know what? If they're dying of a heart attack...so what? *(laughs)* And I know it sounds horrible, but it's true. (Pearl)

These overtly nurse-centered statements were in stark contrast to a comment from Zoey,

a nurse who leaned far toward patient-centeredness, "I will give them the benefit of the

doubt".

Participants described how patients' behaviour determined their own behaviour.

They articulated an expectation of being treated "nicely", "really, really well", "friendly",

"with respect", and "with appreciation". Zoey said, "Everybody knows if you're nicer to

your nurse you're going to get better care."

> Like the ones that treat you really, really well and treat you with respect, you don't mind doing a little something extra for them...versus the ones who feel like they're in a hotel and they deserve everything that they're asking for...I don't know...and maybe you shouldn't do that, but...that's, that's the way it works, like if you treat people nicely, you get nice things back, so...it's a two-way street *(laughs)*. (Bette)

In addition to being respectful and appreciative, there was an expectation for patients who

were responsible for their situation to show remorse. When patients' behaviour did not

comply with these expectations, participants felt angry that patients had "crossed the

line". If patients behaved "badly", the nurses felt warranted in taking whatever action

they considered necessary.

> I'd rip your face off if you cross the line. I've wrestled many a psych patient to the ground and I've held them there while they spit and screamed or whatever, and I have no problem doing that, but I would never maliciously go out and hurt

somebody or do something for no…for no reason…but if you cross the line I'll make you accountable for what you did. So, there's a balance. (Maggie May)

There was a great void of empathy in situations in which participants perceived patients to be behaving badly and not following their expectations. When the nurses leaned toward the nurse-centered end of the care continuum, they did not attempt to understand why patients behaved as they did or try to see the bigger picture as a nurse who was more patient-centered in that same moment would.

Adjusting the Patient-Centered/Nurse-Centered Lens According to my Interpretation of the Situation, the second phase in the process of *Juggling a Way of Being,* involved participants looking at the care encounters they faced with a more patient-centered or nurse-centered orientation of care following the phase of *Assimilating Internal and External Stressors*. A nurse's way of being, whether patient-centered or nurse-centered, was constantly shifting along a continuum as she processed what was going on both internally and externally at any given moment in time. Once a situation had been assessed and perceived through a patient-centered or nurse-centered lens, the nurse achieved a point of action…or inaction.

Achieving a Point of Action or Inaction

The third phase in the process of *Juggling a Way of Being* was *Achieving a Point of Action or Inaction.* After *Assimilating Internal and External Stressors* and *Adjusting the Patient-Centered/Nurse-Centered Lens According to my Interpretation of the Situation*, the nurse would reach a point of action or inaction depending on whether she was more patient-centered or nurse-centered at that moment in time.

Achieving a Point of Patient-Centered Action

Participants articulated various patient-centered actions that could be taken when a situation was understood from the patient's perspective. These included breaking the rules, going above and beyond, refusing to go along, and making up for another's unfairness.

Patient-centered nurses were described as ones who would "break the rules" when necessary to meet the patient's needs. This meant that they would take risks when it was worth it; that is, when patients would be benefited. This could range from disclosing "too much" personal information in order to bond with a paediatric patient, to allowing a parent to hold their deceased baby despite contrary instructions from the coroner. Breaking the rules saw participants making decisions about what was most important in a situation and weighing the potential consequences for themselves regarding their actions.

> I was going to let that mother hold her baby…and if the coroner walked in I'd be in so much trouble…And what are they going to do, fire me?...sometimes I look at rules…as a guideline. And you have to use your discretion…So yes, I broke the rules…I think I did a good thing…and if somebody wants to put a letter in my file because I put ink on a baby's hands…kiss my ass, I don't care. (Maggie May)

Breaking the rules could also mean modifying one's approach to "fit" the patient. Madeline described how some nurses connected with patients by taking an approach that could be considered unorthodox.

> …you kind of change a little bit to who you're talking to. Like there's some nurses who I look up to and they're kind of rough around the edges and they would talk to the…I don't know the drug dealer that's swearing at them and they're talking back and joking and swearing back which I could never do, but then they know not to do that in front of other people. So I think that's good… (Madeline)

Participants spoke of *going above and beyond* as a patient-centered action. They described going above and beyond as doing more than was expected or required, and the

range of what going above and beyond could entail varied. For some, it meant helping

patients and families find meaning in their situations, being present, and connecting. To

other participants, going above and beyond meant more superficial actions such as

"you'll give them an extra fresh glass of water or throw in an extra warm blanket here

and there." (Bette) Maggie May shared a storey about a time when she helped a family to

find meaning in a tragedy. She described going above and beyond as being mutually

beneficial.

> And then this other nurse and I decided, because all this mother talked about was the next day they were supposed to get her hand prints and her foot prints done…(voice breaks) this kills me every time I talk about it. (crying) And so we took the ink roller and we rolled her little hands and her little feet and we put them on paper. So we made a whole bunch of them so that we'd get good ones. And after my shift I got my husband to drive me…and the father came to the door, and he took them. (crying) And then the next day, I went to the funeral parlour and they were in shadow boxes…oh, it was so nice…Yeah, we didn't have to do that. (Maggie May)

According to the participants, nurses who leaned to patient-centeredness at a

moment in time would make a decision on whether to respond directly or indirectly to

treatment that they considered to be unfair in other nurse's practice. Direct action taken

when the patient-centered nurse's values collide with co-workers' care involved "refusing

to go along'. This could be enacted as refusal to participate, confronting the other, and

advocating for the patient.

> I expect that they will try other means of making the patient comfortable and actually addressing the real reason that patient is there – not just, 'well I don't want to deal with it, so I'll give them another prescription for Percocet and then they're not my problem anymore'…And I…went to the physician, I told her what I knew…I asked the physician not to give her another script. (Maggie May)

Participants also described taking indirect action when observing care that they

felt was unjust. They described this as "making up for another's unfairness" which

could entail "sneaking in" or "smoothing the waters". Liz said, "usually if it's on my side, I can pick up and I'll go in and see the patient…That's about it. I don't say anything…" Others used this same secretive strategy for dealing with other nurses' unfair treatment of patients. For example, Bette reflected, "I'll find a reason to go into that person's room to do something, just to make sure is everything ok…not to micromanage, but just to make sure that they're being tended to…properly." Zoey made up for other's unfairness by approaching the patient with "a little extra spring in my step…armed with happiness or cheeriness, that they might be pissed off with something and maybe I can help change that… it's not out of, it's not in competition…it just makes it happier for everybody." As Madeline said, "you're kind of approaching the situation but you're not really…I don't say anything." While indirect action was carried out with good intent, it did not address the underlying problem of the co-worker's nurse-centered care. Indirect action was patient-centered but done in a manner that incurred as little risk to self as possible.

Achieving a Point of Nurse-Centered Action or Inaction

In the moment of a care encounter, a nurse who leaned more toward nurse-centeredness would reach a point of nurse-centered action or inaction. This could include *doing protocol*, distancing, reacting to irritants, experiencing fear that influenced behaviour, and making judgments/labelling.

Doing protocol was described as the acceptable minimum standard of care. Maggie May said, "I would have…done…protocol, but would I have done extra? No. I wouldn't have." Doing protocol, then, was meeting basic physical needs in the absence of nurturing and support, which were identified by participants as "extra". Nurse

124

participants clearly described the task-driven care that patients received when nurses leaned toward nurse-centeredness. Whether it was in the context of the repeat offender, a patient who behaved badly, a patient who was blamed for the situation, or one who should not have been in the ED, care was described similarly by all participants.

> That's the type of situation that…I would still tend to that person's, all their, their needs, but would I go and spend an extra 15 minutes just chatting with them? Probably not. (Bette)

> Even if you don't want it to, I think it may be more task-oriented. More of 'this needs to get done' and less of…talking and connecting… get it done. Get in, get out, get it done. (Myrtle)

Maggie May said doing protocol was acceptable "as long as you don't…withhold care… you know, drag your feet and not do everything that is expected…if I really don't like you and I really can't muster it up, as long as I do the minimum standard…". Doing protocol could be considered caring *for* in the absence of caring *about*. Lila articulated this idea in the following statement:

> You can care for them…and make sure that their physical needs are met and totally never touch anything else….It's not good care. But it happens and I've done it and I'll still do it. No doubt. (Lila)

> Another nurse-centered approach was for participants to avoid that which made them uncomfortable. Nurses could physically distance themselves by delegating care to another nurse or by electing to document rather than participate in hands-on care. Physical distancing could be very overt as described by Lila.

> …well there's the patient that you ignore. We don't necessarily ignore them, but we don't go in the room if we don't have to…the patients that are just at you all the time. The ones that come in with those preconceived notions. Sometimes it's just easier to avoid the whole situation. You're a little more scarce, or you're around doing something else, or you're just, you know…you answer the questions that you have to answer and you do what you have to do, but you just don't tend to spend a lot of time with them. Even if you could. (Lila)

Distancing could also mean that the nurse engaged superficially with the patient. Participants spoke of "chatting", for example, "about the weather and other non-threatening conversation…just easy things" (Madeline) when caring for patients who made them feel uncomfortable. Zoey reflected on her discomfort in knowing how to approach patients with mental illness and how it impacted her interactions.

> So, when we have those patients come in I always say we will have to make sure that they are medically clear and that it is just a mental problem, you have a little chat with them, I will say can I get you anything? Do you need a sandwich? You need a drink? You need some tissues? And then I'm like, okay! Check those boxes! *(laughs)* (Zoey)

Distancing was a nurse-centered action carried out for the sole purpose of decreasing the nurse's discomfort in a situation; when participants distanced themselves, no attempt was made to empathize with the patient.

When participants reached a point of nurse-centered action or inaction, they reacted to the irritants that they were facing in the moment. Difficult patient attributes, patients seen repeatedly, patients who were responsible and those who did not have valid reasons for being in the ED cause nurses to experience feelings of anger and frustration. Liz described feeling rage at times towards patients. Similarly, Lila said, "I want to muzzle them…I just get what I have to do done." Participants dealt with their negative emotions by distancing and setting rules. These were times when participants reported that "you just have to do what you have to do and leave the room" (Madeline) or "sometimes you might, kind of, not lose your filter, but not be as…compassionate and start *(laughs)* laying down more rules…you've definitely lost your cool *(laughs)*." (Myrtle) Sometimes it was fear that influenced nurse behaviour as described by Pearl.

> IV drug users scare me. I know it's terrible to group them in a little group like that, but I am terrified that they're going to give me something or they're going to

be violent or…I don't know, just stereotypes and I know it's not right, but…I do think I treat them a little bit differently. Because I start IVs without gloves on with everyone. But then, with them, I'm like, 'ooh, gloves!' and then I'm really super careful…there was this young guy in the other night and he had track marks all up and down his arms, and…he…was incontinent all over himself and vomited all over the floor and, like, he was an IV drug user, you could tell. And I don't know if he had anything, but I didn't want to even go near him cuz he was grossing me out! And that sounds terrible, but you could tell, all the other nurses didn't want to go near him either. And…it…I don't know… I just like to avoid it because I really am terrified that it is going to be that one time that I poke myself with that needle. *(laughs)* Which is ridiculous, given the amount of times that I've actually poked myself, but I think that if I think about it enough I'm going to end up doing it, like subconsciously? I don't know (Pearl)

When leaning toward nurse-centeredness, participants were more apt to pass judgment and apply negative labels to patients. Identifying the patient as "not nice", "crazy", "acting like a toddler", "drug seeking", or "bad parents" allowed the nurse the opportunity to justify her own action. It was easier to judge a patient who was considered not to be a 'nice' person or to withhold comfort from those considered to be 'bad' parents.

The third phase of the process of *Juggling a Way of Being* was *Achieving a Point of Action or Inaction.* Depending on where the nurse sat on the continuum of patient-to-nurse-centeredness at that moment in time, she would engage in patient-centered or nurse-centered behaviours. The endpoint of a patient-centered approach to care involved empathizing with patients. Participants reported that a patient-centered way of being involving empathy resulted in the nurse feeling fulfilled, pleased, trusted, satisfied, motivated, rewarded, fortunate, proud, like a "real nurse" - Florencey – like they had made a difference, and connected with patients. At the same time, it also rendered some participants vulnerable when they saw patients more as human beings; engaged in intimate, meaningful relationships with them; and felt their pain.

A nurse-centered way of being was devoid of empathy and left the nurse feeling, as described by participants, angry, drained, spent, worried, empty, regretful, swayed, defeated, frustrated, sad, embarrassed, conflicted, disengaged, stressed, guilty, futile, resigned, and like a "bad nurse". At the same time, however, nurse-centeredness did enable the nurse to experience a sense of control and justification in her actions. These feelings, whether positive or negative, were internalized and became some of the factors that influenced participants in future care encounters.

Summary

The theory of *Juggling a Way of Being* explained the process that these nurses traversed as they navigated through tension in their day to day work. The findings of this study revealed that a paradox existed in that this process, which was employed in response to tension, was fraught with tension itself. The theory of *Juggling a Way of Being* is framed as including three phases (Figure 5). While it is presented in phases, it was not a linear process, but one that could move back and forth as participants gazed through dual ethical lenses and shifted between patient-centeredness and nurse-centeredness in the moment.

The process was preceded by intrinsic and extrinsic factors that created tension within the nurse. The antecedents included *Being a Person AND a Nurse*, which included personal and professional factors, and *Being Influenced by External Factors.* As unique human beings, nurse participants were socialized to hold a set of personal values and beliefs that were firmly entrenched and were integral to how they perceived the situations they experienced. The individual's life experiences, personal attributes, and motivation for nursing were influential in how they responded to situations that

128

Figure 5. *Juggling a Way of Being*
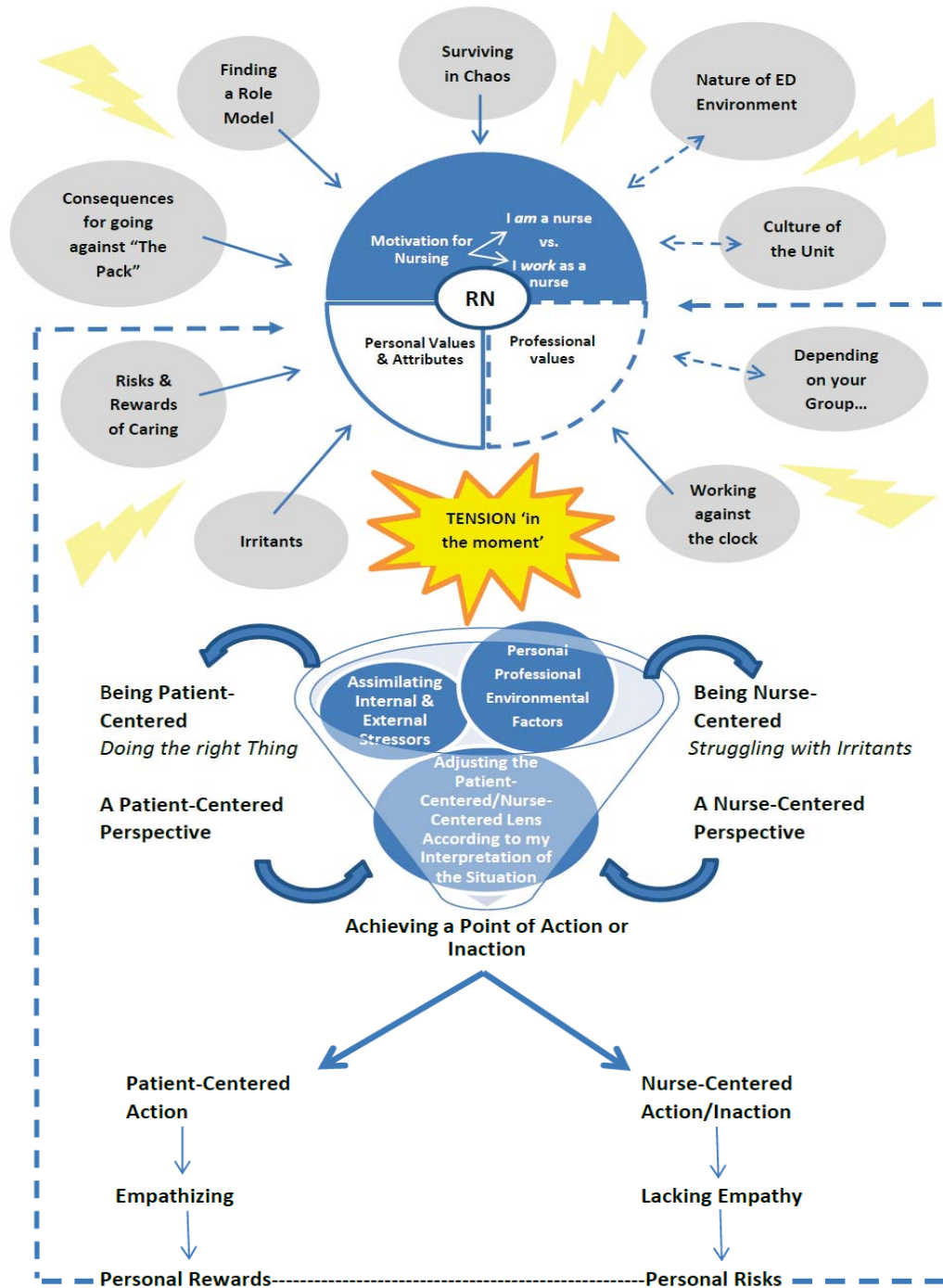
challenged their core values. Participants also held professional values that they had learned since entering the profession. While professional values were important in participants' decisions about how to respond in care encounters, in general, these values were less embedded than personal values, as indicated by the dotted lines in Figure 5. When faced with care encounters that forced them to examine competing philosophies, participants' professional values were more susceptible to forces that opposed them. Tension existed within the nurse as she attempted to reconcile personal and professional values that, at times, could be incongruent.

Simultaneously, tension was aroused by external factors including the environment in which participants worked and the people around them. Working in an environment that was task-driven, chaotic, fast-paced, and that had unit norms to gain control (dismissing, rule-setting, and silencing) often created stress for these nurses who faced barriers to providing the quality of care that they strove to give.   At the same time, working with other nurses who ranged from Florency to Bad Apples created additional tension for participants who searched to find a role model but felt pressure to conform to "the pack".

These internal and external stressors resulted in *tension 'in the 'moment'* as participants were faced with competing personal and professional values. This occurred as they perceived situations (both their own patient encounters and those of their peers) through a dual lens of personal and professional beliefs as well as in response to observations of the care being provided by others around them. Participants constantly interacted with their environment, and their personal and professional values could influence the people around them. How participants responded to tension among values

had implications for patients, families, and co-workers. At the same time, environmental factors triggered nurse participants' personal and professional values and began a process where they were required to try to make sense of situations in which they felt pulled by competing ethical perspectives. Experiencing *tension 'in the moment'* created a cross-road where participants had to decide upon a course of action as they tried to "do the right thing" and be a "good nurse" (Figure 6). These antecedents led to the first phase of the process of *Juggling a Way of Being*.

Figure 6. Reaching a Crossroad
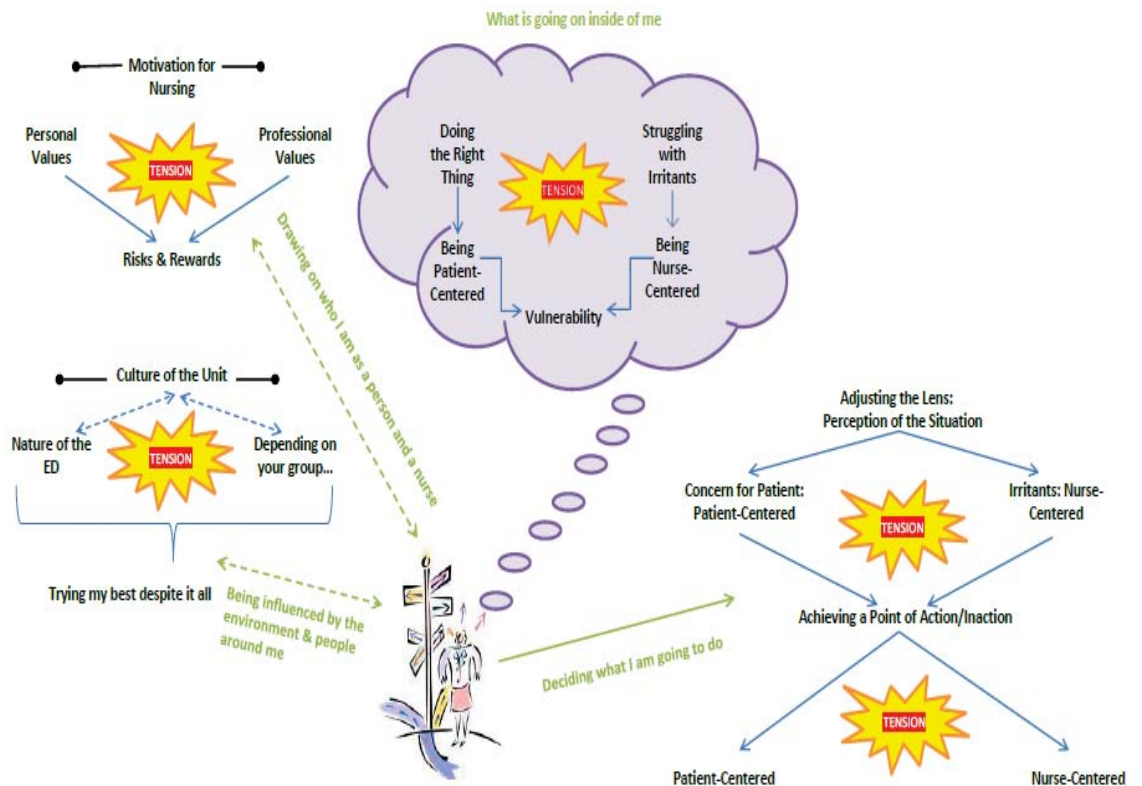
The first phase of the process was Assimilating Internal and External Stressors. In this phase, nurse participants wrestled with the intrinsic and extrinsic factors that caused them to experience tension. It was a time of internalizing what was going on around them and trying to make sense of it by drawing on personal and professional values. Looking through both ethical lenses, participants considered what actions were best in in the current situation. Doing the "right thing" encouraged these nurses to take a holistic view of the patient's circumstances, and this "big picture" thinking promoted empathy. They internalized what it meant to care for dislikeable patients, knowing that their professional ethics promoted non-discriminate care. As participants assimilated internal and external stressors, they came face-to-face with their own humanness and propensity to judge others. It was a phase of reflection as the nurses wrestled to 'do the right thing' while struggling with irritants around them and considering the personal risks and rewards that were implicit in caring.

As participants assimilated internal and external stressors, they found themselves leaning toward a way of being that could range on a continuum from patient-centeredness to nurse-centeredness. Leaning toward a patient-centered way of being promoted empathy that entailed finding ways to overcome initial preconceptions and understand the patient's circumstances and the meaning patient's assigned to their situation. A patient-centered orientation of care also supported the nurse in seeing the humanness of the patient, identifying with the patient, and recognizing when a personal tipping point had been reached and how to proceed in a way that benefited the care recipient. Conversely, if the assimilation process found the nurse leaning more toward a nurse-centered way of being, there was a marked lack of empathy for the patient. Participants leaning toward

132

nurse-centeredness engaged in internal justification of action or inaction to place blame with the patient or to excuse their own behaviour. As they processed their tension, those who leaned toward nurse-centeredness were inclined to distance themselves or assign a level of deservedness of a patient's circumstances. A nurse-centered way of being promoted judgment and negative labeling.

The second phase of the process of *Juggling a Way of Being* was *Adjusting the Patient-Centered/Nurse-Centered Lens According to my Interpretation of the Situation*. This phase can be seen as an extension of the first phase of the process; it was an internal process that was distinct from, but occurred in unison with, *Assimilating Internal and External Stressors*. As participants internalized their tension, they leaned toward an orientation of care, somewhere on a continuum of patient-centeredness to nurse-centeredness. Where they came to rest on this continuum determined how they would perceive and respond to the situation at hand. When leaning toward a patient-centered way of being, participants perceived the care encounter from the patient's perspective. This perspective encouraged the nurses to focus on the person inside the patient, the worth in every human being, the patient's vulnerability, and facilitated nursing *presence*. If the assimilation phase saw nurse participants leaning toward a nurse-centered way of being, the situation in the moment would be perceived from the nurse's perspective. This perspective encouraged participants to focus on the irritants: seeing the same patients repeatedly, assuming that patient complaints were not "real" or valid, assigning blame or responsibility, and responding in dismissive or punitive ways.

Once a situation had been assimilated, evaluated and perceived through either a patient-centered or nurse-centered lens, the nurse reached the third phase of the process,

Achieving a Point of Action or Inaction. Action took a patient-centered or nurse-centered path depending on where the nurse sat on the continuum of patient-nurse centeredness in the moment. It is important to emphasize that a nurse's way of being was fluid; that is, a nurse was neither completely patient-centered nor completely nurse-centered. There was a constant back and forth as participants struggled to reconcile the tension they experienced, and their orientation to care could shift from moment to moment. Patient-centered action could include breaking the rules, going above and beyond, refusing to go along, and making up for another's unfairness. Nurse-centered action or inaction could include *doing protocol*, distancing, reacting to irritants with anger or fear, and making judgments or labeling. There were consequences for the nurse depending on which "path" was taken. Patient-centeredness enabled the nurse to experience connectedness with the patient and resulted in positive feelings and personal reward. On the other hand, nurse-centeredness, with its vacuum of empathy, left participants feeling negative emotions such as anger, regret, and guilt. These nurse outcomes of care, whether positive or negative, were internalized and became factors that influenced the nurse when facing tension in future care encounters.

The theory of *Juggling a Way of Being* has been presented as a basic social psychological process that was used by nurse participants when they experienced values tension in the workplace. It is a process that was employed in response to tension, yet was fraught with tension itself. The nurse shifted from moment-to-moment between patient-centeredness and nurse-centeredness depending on the situation at hand, contextual factors, and the ethical lens that was used to evaluate what was going on in the moment. The result was a constant, grating tension as nurse participants continually

moved between ways of being in situations where they experienced great internal and

external stress.

CHAPTER V : DISCUSSION

Chapter Five will commence with an explanation of how the theory of *Juggling a Way of Being* with its processes of Assimilating Internal and External Stressors, Adjusting the Patient-Centered/Nurse-Centered Lens According to my Interpretation of the Situation, and Achieving a Point of Action or Inaction was co-constructed by participants and researcher followed by a discussion of theoretically rendered findings that arose from the data as well as questions remaining at the completion of the research. Throughout, findings will be compared with existing literature. The study's limitations will be outlined as well as implications for nursing practice and administration, education and research.

The intent of this study was to answer the question: 'What is going on *inside the nurse* when personal and professional values collide while providing care, or observing the care of another nurse, and how does this affect nurse behaviour?" Using symbolic interactionism and critical social theory as interpretive frameworks, a substantive theory was generated that explains the process that nurse participants used when faced with values tension in clinical practice. *Juggling a Way of Being* has been described as a basic social process that was employed by nurses as they navigated through tension in their day-to-day work.   This process, which was employed in response to tension, was fraught with tension itself. Participants experienced a constant, grating tension that could be painful as they moved back and forth along a continuum of patient-centeredness to nurse-centeredness. The process was found to be preceded by intrinsic and extrinsic factors which caused tension in the moment and began the process of juggling a way of being. Using dual ethical lenses of personal and professional values, participants assimilated

what was going on internally and externally, calibrated lens to be more patient-centered or nurse-centered, and achieved a point of action or inaction. This was a fluid process; nurses constantly gazed through shifting ethical lenses from moment to moment. This constant shifting between ways of being created a constant, grating tension within participants as they experienced intense internal and external stress. Nurse behaviours were determined by the way of being that they leaned toward 'in the moment'. The path that was chosen, whether one of patient-centeredness or nurse-centeredness, had implications for both patient and nurse. Patient-centered action benefited the care recipient with compassionate care as the nurse saw the humanness of the individual and attempted to understand the meaning they assigned to their situation. Nurse participants who leaned toward a patient-centered way of being, or cared *about* the patient, were rewarded with professional fulfillment, connectedness with another, and the feeling they had made a difference in the patient's life. Nurse-centered action or inaction left the patient isolated and vulnerable to losing their personal identity in the health encounter. Nurse participants who engaged in nurse-centered action or inaction, or caring *for*, were left with negative feelings that could persist long after the moment has passed.

Co-Construction of Meaning

The theory of *Juggling a Way of Being* was co-constructed by participants and researcher. Informed by symbolic interactionism, the theory that was generated resonates with the voices of all. It is important to reflect on this; to look deeper at those who shaped the theory. There was diversity among the eight nurses in their age, years of nursing experience, and years working in the ED. Furthermore, they represented a sample of ED nurses with diversity in philosophies of what was "right" and in their

worldviews. As they shared their thoughts, the eight nurses revealed that their

perspectives fell along a continuum between patient-centeredness and nurse-centeredness

– some leaning more toward patient-centeredness while others leaned more toward a

nurse-centered way of being. At the same time, all participants, however, described

moving between both ends of the continuum as they faced tension in the moment and

each participant brought a unique meaning to the inquiry.

Two participants, Maggie May and Lila, could be considered as representative of

the opposing ends of the continuum of patient-to-nurse-centeredness. Like all of the

nurses, Maggie May described *doing protocol* when faced with patients she found to be

difficult. She differed from all other participants, however, in that her experiences of

doing protocol were 1) when she had personally been hurt by the patient outside of the

hospital setting, and 2) when providing care to a father who had abused a child whom she

had cared for in the past. This made Maggie May very different from all other

participants in that she did not describe doing protocol to patients considered to be

irritants. Maggie May voiced an overwhelming drive to remain patient-centered in the

environment in which she worked. She tirelessly took risks to achieve her goal in her

day-to-day practice. Maggie May discussed her overt efforts to prevent physicians from

writing prescriptions for narcotics for addicted patients who frequented the ED seeking

medication. Looking at the raw data, it is clear that Maggie May would not be silenced

or go along with the pack. The hidden meaning behind her words, that which is unsaid

but underlies her philosophy of care, is that Maggie May recognized that it was not

important if patients *liked* her. She was willing to take that risk as she reflected on the

bigger picture and tried to take a holistic approach because she truly *cared about* the

person who was her patient. Maggie May was willing to *be there* for her patients even if they were angry with her in the moment.

Lila, on the other hand, despite being patient-centered at heart, had reached a point of personal exhaustion. She described herself as tired, spent and feeling empty and, as a result, found herself "taking the easy route" when faced with tension between values as noted in her comment, "I'm to the point now that…I don't take the easy way out necessarily, but at times…I will just opt for that. Today is not my day, let's just go with the easy way today…to meet the obligation of what they need for their visit, but not necessarily the…um, the most fluffiest and puffy person and, you know, all the extra stuff and, you know…spending the extra time with the family".

This issue of nurse vulnerability was echoed by all participants. Some stories stood out as heart-wrenching accounts of the personal risks that nurses face when they care. These situations were described by the most emotive of participants: Maggie May, Lila, and Pearl. However, that is not to say that the others did not feel the same intense sense of vulnerability at times, only that they were, perhaps, less inclined to share their intense feelings during interview discussions. Similarly, the two participants who reflected most deeply on the importance of being true to their own values were Maggie May and Madeline; two nurses whose views of *conservative* versus *liberal* life-choices differed greatly. It was interesting to note that the participants who inherently leaned more toward nurse-centeredness were the ones who reflected least on what it meant to be an exemplary nurse or the personal rewards that can be gained from caring relationships. These examples of participant differences are provided to increase understanding of the uniqueness of each individual interviewed and the meanings they assigned to their

139

realities. Despite their differences, the theory generated from their stories resonates with their collective voices. The theory of *Juggling a Way of Being* was co-constructed with the researcher, and it is necessary to reflect on how my own voice may have influenced the outcome of this inquiry.

This study began with questions that arose in my own nursing practice when I observed nurses giving care that I believed to be unjust. I entered this research with preconceived notions that nurses may allow their personal values and attitudes to influence the care they provide. It was important for me to situate myself in the research; that is, to acknowledge that the very questions for which I sought answers could influence the qualitative analysis I would conduct. Throughout the data collection and analysis process, I carefully maintained a reflective journal to keep my own thoughts and feelings "in check" as I made sense of what I was hearing in the participants' stories. There were times when I felt frustration when participants' perspectives were not congruent with my own as a nurse. It was important for me to recognize the potential for the nurse in me to interfere with what I was hearing and how I analyzed the data. Reflexivity was essential for me to ensure that I was capturing the perceptions of the participants and not imposing my perceptions on the data.

At times participants' words took me to the literature to help articulate their language. Charmaz (2006) supports this as part of constructivist grounded theory methodology. Constructivist grounded theory does allow researchers to use their own expertise in drawing meaning in the research process (Charmaz, 2006). As a nurse, I was often able to recognize a deeper meaning in what participants said than what the raw data would suggest. For example, as I listened to Lila share her stories, I was able to see a

hidden undertone of pain, despite her overtly angry dialogue. This finding is similar to those from an earlier study that investigated female nurses' work-related anger (Smith, Droppleman, & Thomas, 1996). In that study, anger was noted to be used as a shield in work environments in which nurses felt powerless, inadequate, and silenced. The authors reported that nurses' anger was a mechanism used when a nurse's sense of self was challenged by hostile interactions with co-workers and patients and an environment that was described as a battleground. Anger was also reported to be used by nurses in an effort to gain a sense of control and to be heard. Smith et al.'s study findings resonate with the stories that Lila shared in her interview. She provided me, a fellow nurse, with cues that enabled me to understand the intense hurt that she experienced that was masked by anger. As a nurse, I was motivated to comfort her; as a researcher, I had to learn to only listen.

The theory of *Juggling a Way of Being* was co-constructed by eight nurse participants and one nurse researcher. While the theory is one defined by the participants' meanings of their realities, it was also shaped by the researcher. Every effort was made to ensure that my own voice did not take the data in a direction that was not true to the participants' words.

Theoretically Rendered Findings

Several issues came to light through the theoretical rendering of the data. Findings of caring *for* versus caring *about*, nurse vulnerability, the enactment of power, stigma, moral courage, nurses as victims, and "*Real Nurses*" versus "*Those who Work as Nurses*" will be discussed and related to the theory of *Juggling a Way of Being*.

Caring *For* versus Caring *About*

The concept of caring *for* versus caring *about* (de Reave, 2002) was raised as

nurse participants explained their thoughts and actions 'in the moment'. In the phases of

Assimilating Internal and External Stressors and *Achieving a Point of Action or Inaction*,

participants described "doing protocol" while in situations that caused them to lean

toward a nurse-centered way of being. Doing protocol describes caring *for* patients;

meeting physical care needs in a timely manner and competently performing skills and

tasks. In a study of moral concerns of intensive care nurses (Cronqvist, Theorell, Burns,

& Lutzen, 2004), caring *about* and caring *for* were identified as separate dimensions of

caring. Caring *for* was defined as task-oriented and driven by a concern to fulfil work

duties. Caring *about* was found to be motivated by a need to do the "right" thing and was

rooted in a genuine concern for the patient and an awareness of patients' vulnerabilities.

This study found that nurses experienced tension when they perceived personal or

structural barriers to caring *about* patients. Swanson's (1991, 1993) theory of caring

supports the idea that caring *about* requires the nurse to see the person inside the patient.

She notes that caring involves the nurse centering on the patient, engaging in the

relationship, being there, sharing feelings, protecting, preserving dignity, believing in,

and going the distance. Along with these interpersonal aspects of care, Swanson notes

that performing competently and skillfully is part of the caring process. Swanson's

theory argues that completing tasks is only one aspect of caring, and that doing protocol

is, in fact, not caring at all as it lacks all other dimensions of caring.

Caring *about* can be viewed through the lens of Swanson's (1993) writings of

nursing as informed caring for the well-being of others. An underlying assumption of

caring is that nurses' primary focus is on the well-being of others. Caring "must take into account what it means to be whole persons who are becoming, growing, self-reflecting and seeking to connect with others" (p. 353). Swanson's theory proposes that caring entails five processes. The foundation of caring is *maintaining belief* in the patient's ability to persevere through, and find meaning in, health challenges. *Knowing* involves trying to understand the meaning that patient's assign to their situations and resisting forming assumptions. *Being with*, being emotionally present, shows patients that they are important and connected to the nurse. *Doing for* entails actions taken by the nurse that include the provision of competent physical care and the maintenance of the care recipients' dignity. *Enabling* in caring provides knowledge and/or resources that facilitate the well-being of patients. Caring *about* could be defined as "a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility" (p. 354).

Participants reported that seeing the patient as valuable encouraged presence which is in keeping with Swanson's theory of caring. This occurred in the phase of *Adjusting the Patient-Centered/Nurse-Centered Lens According to my Interpretation of the Situation* when one had a patient-centered perspective. Interestingly, Pearl talked of the importance of the patient seeing the nurse as a human being as well.

> Honestly, I think if…people see you as more than just…'the nurse', like, almost if they see you as a person, then they're more apt to form, like, or trust you, not to just form a bond but to trust you and open up. Because…I just went in, did my thing, 'Hi, I'm so-and-so, I'm your nurse, going to this, blah, blah, blah' and just, you know, went on my merry little way. But then when I actually took the time and made a joke, she's just like, 'oh, she's not so bad'. (Pearl)

That the patient must see the nurse as a person is supported by Travelbee (1971) in her writing of the establishment of rapport in the nurse-patient relationship.

Travelbee's writings describe a human-to-human relationship between nurse and patient that is mutually significant; one in which each participant perceives and responds to the humanness of the other. Travelbee argues that a *human-to-human relationship* is the means by which the purpose of nursing is fulfilled. The human-to-human relationship is established when the nurse and patient have developed rapport; it can only occur when both nurse and patient relate to each other as unique human beings. Travelbee articulates this as *emerging identities,* when nurse and patient begin to perceive each other as unique individuals. A bond begins to form as the nurse starts to recognize how the unique human being who is the patient perceives and feels about his/her situation. In response, the patient begins to see the nurse as a human being rather than the personification of "a nurse".

It became evident in the voices of all participants as they described the processes of *Assimilating Internal and External Stressors, Leaning toward a Way of Being,* and *Being Patient-Centered*, that each had a personal tipping point; circumstances that would cause them to care *for* patients; to meet physical care requirements with no attention to the patient's psychosocial needs. Nurses were required to assimilate the stressors inside and around them and clearly articultated their struggle with irritants that often pushed them toward a nurse-centered way of being. Irritants were noted to include difficult patient attributes, and situations in which the nurse had to see the same patients repeatedly, patients who cause their own health problems, and those who do not behave "appropriately". Macdonald (2003) suggests that these types of patient characteristics and behaviours challenge nurses' sense of control. Nurse-centeredness could be explained from a philosophical point of view as "the idea that we are fundamentally inclined

towards self-preservation…A life-preserving drive that is natural to us all, produces tensions for us when we recognize that we ought to act for the benefit of others under circumstances that place us at risk" (Pask, 2005, p. 250). Patient, nurse and environmental factors merge to create a "perfect storm"; a situation in which the nurse denies the human being inside the patient and leans toward a nurse-centered way of being. In these circumstances, nurse participants' actions are driven by their own needs rather than those of the patient; the professional values they hold are overtaken by personal values in that moment in time. In moments like these, participants perceive and enter the care encounter with a focus on the personal and external forces that cannot be reconciled. Personal values, irritants and environmental stressors in the moment create a stronger pull than the professional values of empathy, holism, and connectedness. Rather than providing care based on a careful assessment of the person inside the patient, the nurse enters the situation with the goal of causing as little discomfort to herself as possible. For the patient, this results in distant, fragmented care that objectifies them as a problem to be managed.

Findings revealed that no nurse is fixed at one point on the continuum of patient-centeredness to nurse-centeredness but, instead, that each nurse constantly shifts back and forth between ways of being. The phases of *Assimilating Internal and External Stressors, Leaning toward a Way of Being*, and *Adjusting the Patient-Centered/Nurse-Centered Lens According to my Interpretation of the Situation* revealed that depending on the specific situation encountered, and the tension-causing forces faced in that moment in time, nurse participants will lean toward a particular orientation of care. Each nurse will respond depending on the situation at hand and their own tipping point – conditions that

145

push them toward patient-centeredness or nurse-centeredness. This constant back and forth, as they gaze through dual ethical lenses of personal and professional values, creates a chaffing tension within the nurse. The nurses in this study described intense feelings of personal pain as they wrestled with the process of *Juggling a Way of Being*. If they internalized their stressors and leaned toward a nurse-centered way of being, they experienced feelings of anger, both with patients and the environment; erecting barriers to holistic care, feelings of regret when choosing a way of being that is not true to their vision of the ideal nurse, feelings of frustration with co-workers who have created a culture of distant care, and with themselves for participating in unit norms. These feelings are in direct contrast to those experienced when leaning toward patient-centeredness. On these occasions, nurses reported feeling fulfilled and like they had made a positive difference in another's life when care was focused on the needs of the patient. This continual back and forth between ways of being creates great tension within the nurse as she determines, in the moment, how a situation will be managed.

As participants engage in decision-making in the moment and lean toward a way of being, judgments are made as they assimilate what is going on around them. The limitation of justice is one's humanness; that is, decisions are made, in the moment, whether or not ideals of justice will be upheld. Our humanity guarantees that moral decision-making is incredibly complex; there are immeasurable judgments that can be made in any circumstance (Rawls, 1971). This is an important point to consider when examining the findings of this study. Nurses, as caring professionals, are humans first. Being human ensures that ethical decision-making is an intricate process that is influenced by emotion. "We are…vulnerable in our humanity, and there will be times

when we will look away from where intrinsic value lies, being drawn instead to more ego-based concerns" (Pask, 2005, p. 253). Nurses must be supported to reflect on their humanness, embrace it, and consider ways to balance their personal and professional selves.

Nurse Vulnerability

Another finding of this study was the vulnerability experienced by participants when they allowed themselves to care *about* patients. Participants articulated deep feelings of pain and hurt as they shared stories about times when they had developed meaningful relationships with patients. As they told their stories of caring connectedness, they displayed raw emotion that persisted long after the patient encounter had occurred. As they shared intimate memories of patients with whom they had developed strong nurse-patient relationships, they suggested that being present brings nurses both joy and heartache. Their own vulnerability became important in the processes of *Assimilating Internal and External Stressors* and *Considering Risks and Rewards of Caring*.

"Empathetic caring and interpersonal skills are at the core of the nursing role. However, the cost of providing this empathic nursing care can contribute to caregiver compassion fatigue" (Lombardo & Eyre, 2011). This quote illustrates the idea of compassion fatigue as an end result of the use of empathy, a thought that is echoed throughout the literature based on the early writings of Joinson (1992) and Figley (2002). These writings suggest that empathy is a double-edged sword; it is a core value of the nursing profession and essential in the therapeutic relationship, yet a paradox exists in that empathy also is the "cost" of caring to the nurse (Crumpei & Dafinoiu, 2012; Robins, Meltzer, & Zelikovsky, 2009; Sabo, 2006).

147

In contrast, I would argue that to be empathetic is to focus on the patient, to perceive and understand their experience as they give it meaning, and to communicate this understanding in a way that the patient knows the nurse understands them in their current situation (La Monica, 1981). The empathic nurse does not experience transference of patient feelings/emotions/pain; rather receives professional reward from this "being with" patients in their vulnerability (Robins et al.). The participants' stories suggest that *rather than empathy*, it is emotional contagion, "an affective process wherein the individual's responses parallel those of actual or anticipated emotions…an unconscious attunement to and absorption of a client's trauma" (Sabo, p. 138), that is the cause of their distress. Prolonged, continuous and intense contact with patients in which nurses enact sympathy (emotional contagion) rather than empathy, can result in vulnerability. This can progress from a feeling of discomfort that fades with respite from the situation, to loss of emotional endurance, to the inability to recover from the sense of vulnerability (Knobloch Coetzee & Klopper, 2010).

In addition to sympathetic caring *about* with its risk of emotional contagion, nurses are also vulnerable to experiencing moral distress related to environmental barriers to caring *about* patients. The Canadian Nurses Association defines moral distress as occurring "when a decision is made regarding what one believes to be the right course of action, but barriers prevent the nurse from carrying out or completing the action" (CNA, 2003, p. 3). Participants described surviving in chaos of the ED, limited time; feeling powerless, silenced and dismissed; lack of support from peers, and a sense of futility about trying to live up to moral and professional standards. These environmental barriers to caring *about*, experienced repetitively over time, create a perfect recipe for moral

distress. Environmental constraints can negatively affect a nurse's personal and professional integrity, and cause feelings of resignation, frustration, anger, and pessimism (Burston & Tuckett, 2012). It appears from the stories of the eight nurses that they experienced vulnerability from both sympathetic caring and moral distress from environmental barriers to care.

Participants considered potential risks to themselves from establishing caring relationships with patients as part of the process of *Assimilating Internal and External Stressors*. To protect themselves from vulnerability, participants described the need to 'put up walls'; to make decisions about when to connect with patients at a deeper level and with whom they would engage in such relationships. In the effort to protect one's self, "s/he may refuse to hear, or deny the voice of the patient and react strategically or coercively, as opposed to responding opening and communicatively" (Sumner, 2001, p. 929). Avoiding feelings of vulnerability by distancing self from patient severs the potential for connectedness and leaves nurse and patient in isolation from the other (Malone, 2000). It remains unclear which patients can trigger the "wall coming down", as Pearl described it, and the process nurses use to determine when they will be fully present with patients. From the voices of these eight ED nurses, being present was not something that happened regularly in their practice. What makes nurses lean toward nurse-centeredness - whether it is primarily self-defence against feeling vulnerable related to tension among values or the chaotic environment in which they work - remains unclear. However, participants all described nurses who were abrupt, uncompassionate, and task-driven. Could *Bad Apples* be mislabelled? Could they, in fact, be caring practitioners behind protective walls? Lila described behaviours in herself that could be

identified as those of a Bad Apple. The reality of Lila's situation, however, was one of

intense personal pain, exhaustion, and professional emptiness that required her to erect

barriers as a protective mechanism. Perhaps nurses labeled as Bad Apples, like Lila,

were responding to prolonged exposure to environmental stressors of surviving in chaos,

working against the clock, lack of control, a culture with unit norms of being silenced and

dismissed, and the constant feeling of being unable to provide adequate care to patients.

These unfavourable contextual factors, over time, can result in burnout (Hooper, Craig,

Janvrin, Wetsel, & Reimels, 2010; Najjar, Davis, Beck-Coon, & Doebbeling, 2009;

Young, Derr, Cicchillo, & Bressler, 2011) which is manifested in cynicism, anger,

depersonalization, and distancing (Dunn, 2009; Hooper et al.). Irurita and Williams

(2001) found that workplace stressors threatened the integrity of nurses and resulted in

"omissions of care, ignoring patients, inappropriate interactions, and evidence of *rough-

hand* care" (p. 583).

> It is difficult to be a healing presence with others if one's own vessel is empty. When
> we give of ourselves to others at a time when we need to replenish our own sense of
> vigor, the quality of that relationship may deplete rather than nourish either
> participant (Dunn, p. 40).

Regardless of the cause, nurse vulnerability is a significant finding in this study. It

was noted during interviews that these nurses were pleased with the opportunity to talk

about their feelings regarding their work. They faced complex situations, traumatic

events, and experience constant grating tension in their day-to-day work. No matter

which orientation of care they lean toward in the moment, they are left with intense

emotions that sometimes are long-lasting. Environmental stressors and sympathetic

emotional labour can result in negative feelings of moral distress, oppression, anger,

frustration, exhaustion, anxiety, fatigue (Davenport & Hall, 2011), loss of control,

uncertainty, helplessness, and inability to express feelings (Heaslip & Board, 2012).

Enactment of Power

Critical social theory was used as an interpretive lens in this study. Critical theory

brings attention to ways in which culture can sustain social inequities (Merriam &

Simpson, 1995). A critical perspective aims to examine how some groups "are

constructed as belonging to the social fabric, whereas others are left on the margins,

constructed as 'Other'" (Kirkham & Browne, 2006, p. 324). Critical research seeks more

than understanding of this process; it strives to find new possibilities for the future

through critical reflection (Merriam & Simpson; Mooney & Nolan, 2006). The study's

findings were also examined through a feminist lens. Using a feminist perspective

encouraged looking at finding from the vantage point of the participants as women and

examining the social processes that were in place that created oppression for women, and

the female-dominated profession of nursing, in the workplace.

A significant finding in the research was the enactment of power that was

described as occurring both nurse-to-patient and nurse-to-nurse. Nurse participants

referred to power differentials as being relevant throughout the process of *Juggling a*

Way of Being. They described how the antecedents of the culture of the unit and the

people around them were influenced by power. They also demonstrated that power

dynamics were a part of the processes of *Assimilating Internal and External Stressors,*

Wanting to do the the Right Thing, and *Adjusting the Patient-Centered/Nurse-Centered*

Lens According to my Interpretation of the Situation. The nurse-patient dyad is one with

inherent power imbalances (Higgins, et al., 2007). "The person, who has become the

patient in need of professional assistance, now has vulnerabilities beyond the

fundamental human vulnerability…The patient comes to the illness-induced interaction

hopeful that this exquisite vulnerability will be acknowledged. This sense of hope…is

derived from the spiritual core, and is a yearning for a recognition" (Sumner, 2001, p.

928). Participants described both overt and subtle acts of power that were used in

situations with "difficult" patients. From the manipulative psychiatric patient, the

demanding family, the patient who did not "need" to be in the ED, to the patient whose

behaviour did not meet the nurse's expectations, people were described as having

"crossed the line". Each nurse told stories of patients receiving care that included an

unnecessary rule setting, abrupt, confrontational tone of voice, and being "put in their

place" by outright statements such as "this is *my* house and in *my* house you do as I say".

More subtle forms of exerting power were noted in nurses avoiding patients for whom

they did not want to provide care or not offering comfort measures such as a warm

blanket or a glass of water to a "dislikeable" other. Although these are more subtle

expressions of control, their effects remain significant in that the patient is isolated and

silenced. Research findings have demonstrated the impact of healthcare professionals'

unwillingness to help vulnerable patients; oppressive behaviours toward judged 'others';

and on patient outcomes including quality of life, access to care, and psychological well-

being (Aguinaldo, 2008; Campbell, 1971; Chan, 2009; Chan & Chan, 2009; Higgins, et

al., 2007; Johnson & Webb, 1995; Law, et al., 2008; Matziou, et al.,; Robinson-Wolf &

Robinson-Smith, 2007; Rogge, et al., 2004; Ross & Goldner, 2009; Siminoff, et al., 1991;

Smith, et al., 2008; West, et al., 1996).

Power imbalances were also noted among nurses themselves and within the interprofessional team. Participants discussed being silenced by their peers and the consequences of "going against the pack". Participants felt powerless to stand up for their own values and beliefs or to advocate for patients when working with nurses who would "hang them out to dry". One participant described some of her colleagues as "fiercely protective of their superiority". When nurses experience power hierarchies among colleagues and work with others with conflicting goals and values, moral distress can ensue. Nurses can respond to moral distress with feelings of anger, powerlessness, anxiety and emotional withdrawal (Huffman & Rittenmeyer, 2012). Each nurse described feeling fearful at times in the workplace and that they had to make decisions about when to take the risk of standing up for themselves and when it was simply not worth the risk. Previous studies describe findings that resonate with those found in this study. Nurses in Giddings' (2005) study experienced negative consequences when they did not conform to the views of co-workers. The findings are similar to those of participants in this study who would "sneak in", the nurses in the Giddings study would provide care "out of sight" while furtively working to maintain their professional integrity. Such behaviour was also noted in Johnson and Webb's (1995) research; a phenomenon that they called "covert liking".

The eight ED nurses clearly articulated the angst they experience when working with people who belittle, dismiss, and ignore. It was significant to note that while participants described feeling intense turmoil and pain when treated in this manner, they did not reflect on how *patients* feel when *they* are belittled, dismissed and ignored. The enactment of power thwarts both nurses' and patients' sense of well-being, leaving them

"disintegrated and a feeling of wholeness is replaced with one of inadequacy" (Swanson, 1993, p. 353). Critical and feminist perspectives were used to explore the experiences, wishes and needs of nurses who felt the effects of power differentials in their workplace. Shedding light on how power is enacted can serve as an impetus for change. "When we can identify and understand how people create and sustain an oppressive social world, we have gained important tools we can use to change it" (Aguinaldo, 2008, p. 94)

Stigma

The concept of stigma emerged in the data as participants described undesirable "others" such as patients with addictions and mental illness. Stigma emerged as relevant in the processes of *Struggling with Irritants* and *Achieving a Point of Action or Inaction*. Culturally defined stigma was evident in the nurses' descriptions of attitudes and behaviours toward patients who are seen repeatedly and those who do not "need" to be in the ED. These stories reflected values that have been enculturated in the ED that make these patient characteristics socially salient (Link & Phelan, 2001). Link and Phelan conceptualize stigma as a process that unfolds when five inter-related concepts co-exist: labeling, stereotyping, separation, status loss, and discrimination. This process is supported by participants' stories of nurses labeling distinct differences in some patients which are linked to undesirable characteristics (stereotypes). For example, patients who are seen repeatedly are labeled *repeat offenders* and are associated with abusing the system by wasting time and resources. This linking of labels to stereotypes leads to the third component of the stigma process: separating *us* from *them*. The labeled person is seen as fundamentally different from those who do not carry the label. This was clearly articulated by participants in their description of repeat offenders as compared to other

patients who were more "deserving" of their time and care. The fourth component of stigma is status loss and discrimination. "When people are labeled, set apart and linked to undesirable characteristics, a rationale is constructed for devaluing, rejecting, and excluding them" (p. 370-371). Participants painted a picture of stigmatized repeat offenders experiencing care that is often distant, abrupt, dismissive, and uncaring. Finally, the fifth component of stigma is its dependence on power. For stigma to exist, a power imbalance must be in place, which is inherent in the nurse-patient relationship. The example of the repeat offender illustrates stigma as a phenomenon in which the patient is "disqualified from full social acceptance…reduced in our minds from a whole and usual person to a tainted, discounted one" (Goffman, 1963, p. 3). It also demonstrates the stigmatizing process as one in which society defines what is aberrant and provides the context in which devaluing attitudes are expressed (Jones et al., 1984).

Moral Courage

One of the external antecedents to *Juggling a Way of Being* was *Being Influenced by the People around Me*. As participants shared their stories, it was found that a sense of courage was required when they were faced with values tension. This finding is supported in the literature on moral courage which is defined as "the individual's capacity to overcome fear and stand up for his or her core values. It is the willingness to speak out and do that which is right in the face of forces that would lead a person to act in some other way" (Lachman, 2007). Moral courage occurs when nurses with high levels of moral integrity encounter situations that pressure them to act in ways that are incongruent with their values (Murray, 2010). The morally courageous nurse will advocate for the patient despite potential risks to self. They accept the potential risks,

155

believing that acting in the best interests of the patient outweighs any negative consequences they may face (Gallagher, 2010; Lachman, 2010; LaSala & Bjarnason, 2010). Maggie May, Zoey and Myrtle, nurses who leaned far toward a patient-centered way of being, were noted to demonstrate moral courage in their stories of standing up for what they believed to be right. Other participants also referred to attempts to enact moral courage but felt inhibited by the people around them. All participants, in varying degrees, reported that they had integrated the core values of nursing into their professional self. The enactment of these values, however, was constrained by environmental factors, including the people around them and the culture of their workplace. Integration of professional values did not guarantee their reflection in behaviour (Altun, 2002). What is it that motivates Maggie May's, Zoey's and Myrtle's willingness and commitment to the good of the patient over themselves (Fitzgerald & van Hooft, 2000)? What enabled them to engage professional ideals when faced with potential risk to self remains unclear.

Nurses as Victims

Several participants described themselves as being victimized by the public whom they serve. This varied from being judged for using a cellular phone at work when it was being used for dosage calculation, to being perceived as not working when sitting at the desk charting while awaiting physicians' orders. There was little reflection that these situations provided opportunities to care *about* patients – opportunities to engage with patients to discuss the feelings underlying their reactions. Participants spoke of their role being misunderstood and feeling disrespected, even verbally abused, by patients and families. These views were important in the process of *Adjusting the Patient-*

Centered/Nurse-Centered Lens According to my Interpretation of the Situation and in

leaning toward *A Nurse-Centered Perspective*. These types of situations are well

supported in the literature that describes ED nurses as being at high risk for both verbal

and physical abuse in their day-to-day work (Catlette, 2005; Crilly, Chaboyer, & Creedy,

2004; Gacki-Smith et al., 2009; Pich, Hazelton, Sundin, & Kable, 2010).

More unexpected were participants' feeling that they were deserving and in need

of being appreciated and treated 'very well' by patients and their families. Indeed, when

asked to describe particularly meaningful relationships they had experienced with

patients, several referred to times when they were given special recognition for their

work. This recognition was in absence of any reference to being present with patients or

developing an therapeutic relationship with them. Participants spoke of the importance

of being appreciated verbally and through the giving of small gifts or acknowledgment in

thank-you cards. Patients who were "nice" and expressed gratitude were described as

easier to care for and as receiving more time and attention from nurses. They expressed a

need to be recognized for working hard and surviving in chaos. Being appreciated was

presented in terms of an expectation; that nurses deserve to be treated not only with

respect but with gratitude. The importance of being appreciated was threaded across the

processes of *Assimilating Internal and External Stressors* and *Adjusting the Patient-*

Centered/Nurse-Centered Lens According to my Interpretation of the Situation and was

important in nurses leaning toward patient-centeredness or nurse-centeredness.

Swanson's (1991) theory of caring articulates that the difference between

professional caring relationships and socially supportive relationships is their dependence

on mutual benefit. In the nurse-patient relationship, "the nurse cares without obligating

the client to reciprocate…patients do not (and hopefully should not) feel a sense of mutual obligation when professional caring is provided" (p. 165). Swanson's theory argues that the participants in this study are looking to patients to fulfill a need that is beyond that which should be expected of one receiving care. Berg and Danielson (2007), in a study of nurses' perceptions of the caring relationship, found that time constraints prevent the nurse from getting to know the patient as a person. Nurses reported that having their situation validated by patients eased the strain of working in stressful environments. The need to receive positive feedback from patients has been noted similarly in other studies (Coyle-Rogers & Cramer, 2005; Newton, Kelly, Kremser, Jolly, & Billett, 2009; Rognstad, Nortvedt, & Aasland, 2004) in which the researchers argued that "when an individual expresses their appreciation to the carer…the carer's sense of self-satisfaction is realized through the results of their effort" (Newton, et al., 2009). Morse (1991), in a study that investigated gift-giving in the nurse-patient relationship, identified that the most significant gifts to nurses were those of gratitude; expressions of sympathy for the nurse's situation or efforts to "nurture the nurturer" (p. 606).

It is unclear why the nurses in the current study felt that they deserve patients' gratitude and praise. Are there both intrinsic and extrinsic factors that play roles in the nurse's need for recognition? Is the chaotic, fast-paced ED environment implicit? Could the need for recognition stem from feeling unappreciated, at times, by their peers, colleagues and workplace? Are gender inequalities implicit in this need for acknowledgment? Could regular recognition from employers satisfy this need? These questions remained unanswered; future research efforts could aim to explore this issue.

'Real Nurses' versus 'Those who Work as Nurses'

Participants described two distinct types of nurses that stemmed from their *motivation for nursing*, one of the intrinsic antecedents to the process of *Juggling a Way of Being*. They described *Real Nurses*; those who did not choose nursing but were *chosen;* who were "born" to be a nurse; who embody the values of the nursing profession. Real Nurses were holistic, compassionate, present, and inherently lean toward patient-centeredness. Participants also described *Those who Work as Nurses*. These individuals were described as choosing nursing for its security and financial benefit. They were seen as task-driven and uncaring and as leaving the "job" behind when a shift is complete.

Previous research on motivation to enter the nursing profession suggests that there are both intrinsic and extrinsic factors implicit in one's decision. Intrinsic reasons include altruism, a desire to help and nurture, being a "people person", and the wish to have their work positively affect others (Miers, Rickaby, & Pollard, 2007; Newton, et al., 2009; Rognstad & Polit, 2002; Sumner, 2001). Nursing as a "calling" has been investigated (Christopherson, 1994; Jeffries, 1998; Prater & McEwen, 2006; Raatikainen, 1997; Widerquist & Davidhizar, 1994) and described as a profession that attracts those with "a sense of obligation to work for purposes other than one's own" (Christopherson, p. 219). Compared to other nurses, called nurses are more passionate about their work (Jeffries) and place greater emphasis on caring concern for other's emotional and spiritual distress and assisting patients to find meaning within their health challenge (Widerquist & Davidhizar). Those with an intrinsic motivation for nursing embody innate personal values and attributes (compassion, commitment, kindness, courage, a sense of

responsibility, conscience, and empathy) that enable them to identify with the humanness of patients (Sumner). In contrast, those with an extrinsic motivation for nursing have been described as placing emphasis on job security, flexibility and portability. These individuals choose nursing as a career or occupation rather than being inspired to serve others (Christopherson; Newton et al.; Raatikainen). This literature sheds light on participants' descriptions of the Real Nurse and Those who Work as Nurses as having differences in their motivation for nursing.

Questions Remaining

Many questions remain at the completion of this work. It became clear that no nurse participant was confident in conflict resolution. Most participants avoided conflict with peers, choosing to follow the crowd or to "sneak in" to make up for others' unfairness. Even the most patient-driven nurse who refuses to adhere to the status quo does so without ever addressing the root of the problem. Why are nurses so hesitant to resolve conflict? Have they been given the skills for conflict resolution? Have they been encouraged to use conflict resolution skills as nurses and as women? The stories of the participants suggest that "pack mentality", consequences for going against the pack, and power differentials among colleagues are factors affecting their responses to conflict. The literature reports that interpersonal conflict in healthcare settings is a significant issue worldwide (Farrell, 2001; Iglesias & De Bengoa Vellejo, 2012; McKenna, Smith, Poole, & Coverdale, 2003; Montoro-Rodriguez & Small, 2006; Taylor, 2001; Vivar, 2006; Whitworth, 2008;) that arises in clinical practice due to differences in values, perceptions, motivations, competition for resources, responsibilities, incompatible goals (Broom, 1991), power imbalances (Iglesias & De Bengoa Vellejo), and high-intensity

work environments (Whitworth). Iglesias and De Bengoa Vellejo reported that frontline nurses most often use accommodating (27%), competing (24.3%), avoiding (24.3%) and compromising (21.6%) styles of conflict resolution. Very few nurses in their study (2.7%) primarily used a collaborative approach to conflict resolution. Compromise, avoidance, and accommodation could be related to nurses' feelings of powerlessness or the need to yield to others' to prevent backlash from peers. Poorly resolved conflict can result in job dissatisfaction and emotional distress that can lead to burnout (Montoro-Rodriguez & Small) or cause a nurse to leave the profession (McKenna, et al.). Why do nurses not receive the supports they need to develop conflict resolution skills? Assisting nurses (and all healthcare professionals) to successfully resolve conflict in the workplace can have positive effects on job satisfaction, morale and staff retention (Whitworth).

All participants described the "difficult" patient as one with certain attributes that cause the nurse to feel negative emotions. Why do nurses place responsibility with the patient, by labeling them as difficult, when the issue is actually within the nurse? The idea of the difficult patient is not a new problem in nursing. Kelly and May (1982) conducted a literature review that included documentation of this phenomenon since the 1950's. Difficult patient attributes identified in their review included those that were voiced by the participants in the present study: ungrateful, unappreciative, trivial complaints, not following the "rules", unpleasant, demanding, responsibility for situation, complaining, and attention-seeking. The nurses in this study located the difficulty within the patient. Previous research suggests that difficulty lies within the nurse-patient relationship, rather than within the patient (Macdonald, 2003; Podrasky & Sexton, 1988). Environmental factors reported to be implicit in difficult nurse-patient relationships

include time barriers (Khalil, 2009; Macdonald, 2007), low morale (Khalil), dissatisfaction in job (Macdonald, 2007), and the culture of the work environment (Podrasky & Sexton). The literature suggests that nurses respond to the above patient and environmental factors with aggression, distancing (Podrasky & Sexton) and controlling behaviours (Macdonald, 2007; Michaelsen, 2011). Labeling patients as 'difficult' can be used as a mechanism by nurses to rationalize their limited time to the most "deserving" of patients (Khalil).

Participants expressed frustration when patients did not behave in a way that met the expectation of the nurse. There was little reflection among participants about why patients may act the way they do in the ED. To what extent is patient behaviour determined by nurse behaviour? Why is it that nurses do not look closer at the fear, anxiety and uncertainty that people may express with "bad" behaviour when in an unfamiliar environment and when faced with health challenges? The stressors of hospitalization and learning the patient "role" can "cause personality characteristics to become intensified and exaggerated as basic-level coping mechanisms are employed in an attempt to restore familiarity and homeostasis" (Podrasky & Sexton, 1988, p. 16). How can nurses be helped to recognize that their own behaviour may be the cause of the patient's actions? Irurita and Williams (2001) reported that when nurses in their study leaned toward nurse-centeredness, their actions "usually increased the threats to the integrity of patients who responded by increasing their own self-protective strategies" (p. 587). This finding is echoed in other research that suggests that nurse behaviour influences patient behaviour (Breeze & Repper, 1998; Khalil, 2009; Macdonald, 2007; Podrasky & Sexton; Santamaria, 1996; Santamaria, 2000). Patients respond to nurses'

labeling, distancing, controlling and abruptness with their own coping mechanisms that may be perceived by the nurse as difficult, beginning a cycle that leaves both patient and nurse dissatisfied (Podrasky & Sexton). How can nurses be supported to understand that "persons are unique beings who are in the midst of becoming and whose wholeness is made manifest in thoughts, feelings and behaviours" (Swanson, 1993, p. 352)?

What constitutes *going above and beyond* and what motivates nurses to do so? It is unclear why there was such a range of what going above and beyond meant to this group of nurses. One could argue that the data suggest that more patient-centered nurses see 'going above and beyond' as a deeper connectedness, whereas nurses who tend to lean more toward nurse-centeredness define 'going above and beyond' as anything beyond physical requirements of care such as a glass of water or non-purposeful conversation. Research findings indicate that patients "perceive as caring those nursing ministrations that are person-centered, protective, anticipatory, physically comforting, and that *go beyond routine care* [emphasis added]" (Swanson, 1991, p. 161). It is hard to understand, then, how a glass of water or an extra blanket can be considered to be examples of going above and beyond. One study found that nurses described this concept as a giving of oneself that is "motivated by something deep inside them that then results in a response that places the other before themselves" (Fitzgerald & van Hooft, 2000, p. 487). What has happened that nurses have come to the point where they believe that providing patients with a glass of water or engaging in superficial conversation is going above and beyond? Is there an element of fear involved that keeps some nurses connecting with patients and families? At the other extreme, would Maggie May have taken the baby's footprints to any grieving family? Would she have taken them to a

family who she didn't like? Was there something about that family that made her go above and beyond? Having had the opportunity to talk with Maggie May and learn of her inherent patient-centeredness and her understanding of the meaning of empathy, I am confident that she would have "gone above and beyond" to offer this level of psychosocial support for any family, not only one who became a "favourite".

Why do nurses believe that "mandatory" requirements of care do not include connecting, being present, and caring for the whole person? Why do they believe that caring *about* is "extra" and not a professional expectation in each patient encounter? My thoughts are that nurses do not truly believe this at all but use this as a way to rationalize care in a chaotic, stressful environment with major time limitations. It could also be a symptom of nurses' struggles with inner fears when dealing with "difficult" patients; a mechanism that enables nurses to feel they are doing what "needs" to be done for their patients, thereby protecting their professional integrity. This idea of justification is supported in the literature. Khalil (2009) reported that nurses in her study gave only the "necessary" care to some patients, similar to the participants in this study who described doing protocol when caring for difficult patients. These questions that remain could influence future research efforts and beg opportunities for nurses to reflect on their work and how they nurse.

Limitations

There are limitations to this study that must be acknowledged. The findings represent the experiences of eight nurses from a single ED in Atlantic Canada. I was looking for diversity in the sample, however no male nurses participated in the study. While there were men working in the study setting, none volunteered early in the

recruitment period to participate. As saturation was reached quickly, there was limited time to recruit a diverse sample; however, had men come forward they would have been interviewed to enhance understanding of the phenomenon of interest. The view of the male nurse is not represented in the findings. The omission of the male perspective has implications for the theory that was developed as it remains unknown whether male nurses experience and manage tension among values in a way that is similar to, or very different from, their female colleagues. Having the male perspective would be valueable in understanding the influence of gender on the phenomenon of interet, thus enhancing the explanatory nature of the theory. A limitation of the study lies in this omission; it may have been helpful to actively recruit men for theoretical sampling purposes. It is unknown if the findings reflect the experiences of other female nurses working in this ED or other EDs in other geographical settings. The sample size was small, however, theoretical saturation was achieved and the data reflected a range of perspectives. While the sample reflected a range of work experience (from one to 12.5 years), none of the nurses had worked in the ED for longer than nine years. No nurses who had long careers in the ED volunteered to participate in the study, therefore the voices of long-term ED nurses were not captured in the findings. Efforts to recruit a culturally diverse sample would be helpful in understanding the influence of culture and ethnicity on how nurses experience and manage tension among values. Finally, only interview data were obtained. Therefore, it is difficult to fully understand how nurses behave in practice when no direct observation of care occurs. Participant observation would have added another dimension to understanding the phenomenon of interest and may have enhanced the explanatory nature of the theory.

Implications

The intent of this study was to enhance understanding of the social processes that nurses enact when faced with conflicting personal and professional values in clinical practice. Personal, professional and environmental factors were uncovered that influenced the process used to address the tension 'in the moment' in a way that led study participants toward a way of being. Personal factors included participants' personal values, attributes, upbringing, and motivation for nursing. Professional factors that preceeded the process included professional values that they had learned since becoming a nurse, including being accountable, non-judgmental, and looking at the bigger picture. Finally, the environment in which the nurses worked influenced how they thought and behaved in care encounters. Environmental factors included the nature of the ED (task-driven, chaotic, working against the clock), the culture of the nursing unit (dismissing, rule setting, silencing), and the people with whom they worked (exemplary nurses vs. Bad Apples, the importance of peer support, power imbalances, pack mentality, consequences for going against the pack). How participants assimilated these tension-causing factors and perceived the situations they encountered determined how they would respond. The process of *Juggling a Way of Being* caused participants to lean toward either patient-centeredness or nurse-centeredness depending on the stressors they faced in a particular moment-in-time. The discoveries of how nurses care *for* some patients and care *about* others, the vulnerabilities they experience in caring, the enactment of power in both nurse-patient and nurse-nurse dyads in clinical settings, and the importance of moral courage were particularly significant. These findings, along with the questions that arose

166

in the process of this inquiry, have implications for nursing practice, nursing education, and nursing research.

Implications for Nursing Practice and Administration

There are several implications for nursing practice that come from the findings of this study. First, nurses need avenues to express the tensions that arise in their work environments. Safe places with supports to discuss thoughts, feelings and frustrations must be put into place so that nurses can reflect on how they feel at work and how it affects what they do. Providing nurses with supportive environments where they can reflect on, and discuss, the emotional labour they experience can promote the development of coping skills, resilience, and emotional self-care (Aycock & Boyle, 2009; Dawber, 2013a; Huynh, Alderson, & Thompson, 2008). Rees (2003) found that "reflective activity appeared to enable some participants to "unknow", to hold themselves open to others' unique situations and experiences and come to a new sense of personal knowing or meaning and to acknowledge and honor their own suffering and that of their patients" (p. 51). This idea is also supported by the participants in the present study who described the therapeutic effect of having the chance to disclose their innermost thoughts and feelings in a safe setting. At the end of her interview, Zoey said, "Those are good questions. They are really thought provoking and I like things that allow me to reflect on why I do what I do, why things are the way they are". It is important for nurses to have avenues to reflect on their vulnerabilities and to consider the differences between *empathethic caring about* and *sympathetic caring* which places the nurse at risk for emotional contagion. Sabo (2006) posed the question, "Do we run the risk of pathologizing a quality of nursing that forms its foundation?" (p. 136). If efforts are not

taken to assist nurses to fully understand the meaning of empathy, I fear that the answer is 'yes'. When nurses believe that empathy leaves them vulnerable, they erect walls that distance themselves from patients. Safe places to reflect on this topic and to problem-solve with mentors could help nurses to build skills in empathic caring and self-care.

The development of reflective practice groups can be a proactive measure to address the emotional labour in nursing (Dawber, 2013a). Reflection is a tool that encourages nurses to critically examine their actions and their environments and facilitates professional development (Boyd & Fayles, 1983; Dawber). "Activities that promote self-awareness, encourage reflection, and provide support are essential to the health and well-being of nurses" (Dawber, p 140). Reflective practice groups in clinical settings require organizational support and a culture of trust and support to enable nurses to feel safe, to take risks, and to engage in meaningful reflection on clinical, ethical, and personal insights on their practice (Altfeld, 1999; Dawber; Gould & Masters; 2004; Graham, 2000; Joyce, 2000; Paget, 2001; Platzer, Blake & Ashford, 2000; Throndycraft & McCabe, 2008). Providing opportunities for reflection can have a positive impact on nurse-patient relationships, stress management, and trust and team-building with colleagues (Dawber, 2013b).

Second, the findings suggest that education should be provided to frontline nurses on topics of conflict resolution, ethical decision-making, emotional labour, compassion fatigue, moral distress and moral courage. Nurses should be enrolled in programs such as "Third Party Neutral" (NANB, 2011) to build conflict resolution skills. New understanding could be gained by providing forums on the power imbalances that exist in the nurse-patient dyad and between colleagues (intraprofessional and interprofessional).

These are difficult topics to bring forward; it is uncomfortable to acknowledge our limitations. However, it is important to address these critical issues in an effort to promote both nurse and patient wellness. Nurses must be supported to develop their professional self in reflective environments that encourage them to challenge their assumptions and reflect on differences and commonalities in the human experience (Schafer, et al., 2011). Education must be provided in a constructive and sensitive manner that recognizes the humanness of nurses. Educators should be carefully selected based on their abilities to connect with their peers and bring forward difficult content in a way that empowers the nurse (Hancock, 2008; Hayter, 1996).

Third, it is essential for nurses and their colleagues to have work places that facilitate their well-being. It is clear that work settings that normalize toxic behaviours among peers are detrimental to nurses' emotional health and create social pressure for nurses to act in compliance (Paterson, Backmund, Hirsch, & Yim, 2007). It is not feasible to change the nature of the ED; it is naturally a place of rapid turnover and chaos. Creating a shift in unit culture is possible, however (Baker, Beglinger, King, Salyards, & Thompson, 2000; Clark, 2010; Costello, Clarke, Gravely, D'Agostino-Rose, & Puopolo, 2011; Latham, Hogan, & Ringl, 2008; Lewis, 2006; Mulcahy & Betts, 2005). Nursing units must work to create a culture of support that recognizes the contributions of all team members; a culture in which nurses do not feel silenced or belittled when interacting with their peers. Together, nurses, administrators and all other members of the ED team should assess the current unit culture, create a vision for the future, engage in the change process, and continually evaluate the outcomes of their efforts. There is a need to "address current power structures and concurrent work conditions that would decrease

work environment stress, increase job commitment, and enhance job satisfaction that would ultimately result in improved nurse satisfaction and patient care outcomes" (Latham, et al.). Transforming workplace culture requires time and commitment to the review of complex social processes (Clark, 2010). Shifting the culture of a work environment requires more than changes to policies and procedures – it demands changes in individual and group values as well as a leveling of power imbalances. Stakeholders must be prepared for a slow, complex process.

Looking through the lens of complexity theory could assist in seeing "adjacent possibles" for unit culture. The purpose of complexity theory is to offer an explanation of how complex systems change due to interaction among its components (Paley, 2010; Paley & Eva, 2011). Complexity theory refers to *bifurcation points;* points of change in which the system settles at a new resting point (Livneh & Parker, 2005). Complex systems are in constant interaction with the environment and influenced by history. According to complexity theory, factors that effect system change include not only local interaction of component parts and system interaction with the environment, but also *adjacent possibles*. This refers to "proximal initiatives that are one step removed from the existing system but that indicate that substantive change is possible, and reveal directions for system change" (Alvaro et al., 2010, p. 95).

Complexity theory is relevant to the discussion of initiatives for work place culture change in that it is a way to look at human systems and how they change and can be influenced. By considering system components, relationships, interactions, environment and history, specific interventions for change can be made with the goal of creating bifurcation points and new resting points. Change efforts will target individuals

170

(component), sub-systems (components with strong relationships) and the system at large, recognizing that "essential qualities of complex adaptive systems are interactivity and interdependence" (Pritzker, 2002, p. 100). Looking through a complexity lens, those looking to create a shift in work place culture will have a holistic perspective, keeping the big picture in mind (James, 2010).

Finally, policies of inclusiveness must be developed and must be framed in a manner that is not limited to race, gender, religion, and the like, but speaks to all patients as deserving equitable care. Education on new policies of inclusiveness should emphasize unit-specific issues such as patients who are seen repeatedly and those who are responsible for their circumstances, as seen in the ED. Healthcare professionals deserve to work in environments that are supportive and where they are respected for their contributions. Policies around diversity in the work place must be developed to promote inclusive work environments (Swanson, 2004).

Implications for Nursing Education

Undergraduate education must prepare nurses for the realities of the workplace. New nurses must be prepared to cope with the tensions that arise in day-to-day nursing practice. "Nurses are required to develop their professional self within a complex world where norms strain against the good that they would achieve, and where they are faced by a contingency of circumstances that may pose them difficulty" (Pask, 2005). The findings from this study suggest that baccalaureate curricula should include content on ethical decision-making, emotional labour in nursing, moral distress, and moral courage. It is imperative that students are assisted to build the skills necessary to handle conflict in positive ways. Students should be presented with the difference between caring *for* and

caring *about* as well as the vulnerabilities they may experience if they engage in sympathy rather than empathy with patients and their families. Work settings that create barriers to the caring connectedness that nurses strive for can contribute to compassion fatigue. Students should be introduced to compassion fatigue as an end result of multiple factors, as argued by Sabo (2006), and learn of promoting healthy interactive skills that promote positive workplaces as well as ways to avoid or lessen the effects of compassion fatigue (Lombardo & Eyre, 2011). Students should be engaged in dialogue about the influence that the work environment, including the people around them, has on them as people and as nurses. Clinical post-conferences could be used as a forum to discuss how the environment affects them as they lean toward a way of being. The importance of reflective practice must be emphasized. Case studies and clinical post-conferences could be used to enhance student understanding of what it means to be reflective and its importance for both nurse and patient wellness. The power imbalance that is inherent in the nurse-patient dyad must be addressed in nursing education along with discussion about ways to empower patients. Using critical social theory as a lens may help students to fully grasp the significance of power differentials and could be used as a framework for skill-building exercises. Finally, new nurses should enter the workplace with an understanding of themselves both as people and as nurses and the tension that can arise from these dual roles. They should explore the idea of values tension and how this can push them toward a way of being, whether patient-centered or nurse-centered.

As nursing students move through their program of study, they gain nursing knowledge though the process of socialization. "One important aspect of preparing professional nurses is supporting the development of their nursing identity" (Cook,

Gilmer, & Bess, 2003, p. 311). A nurse educator must ask: how do student nurses

internalize the complex culture of nursing and develop a professional self-concept?

Through the socialization process in classroom and clinical settings, the student nurse

develops an evolving nursing identity (Bozich-Keith & Schmeiser, 2003; Cook, et al.,

2003; Shinyashiki, Mendes, Trevizan, & Day, 2006). Students enter a nursing program

with an awareness of themselves as a person and as an aspiring nurse. Throughout their

educational experience, they build upon this foundation in a gradual manner as they are

immersed in the culture of nursing (Ware, 2008). In her work on graduate nurse

transition, Boychuk Duchscher (2009) acknowledges that there are "disturbing

discrepancies between what graduates understand about nursing from their education and

what they experience in the 'real' world" (p. 1104). She describes the firmly entrenched

cultural norms and hierarchical relationships that influence new graduate transition and

that can result in job dissatisfaction and decisions to leave the profession altogether.

These findings resonate with the finding of the current study. Boychuck Duchscher

emphasizes the importance of student nurses being prepared for the reality of the

"dynamic, highly intense and conflict-laden context of professional practice" (p. 1111) by

providing them with theory about role transition.

As they develop their professional selves, students must learn to embrace their

own humanness as well as that of their patients. Taylor (1992) posed the question, "Are

nurses and patients so very different?" Her work describes how nurses and patients have

been defined according to their roles of care giver and care recipient such that the

humanness of each has been stripped. She argued that the writings of nurse scholars have

reinforced this as they

appear to dichotomize humans and nurses, as though the nurses were mainly agents of help, somehow excluded in part or total from the qualities as human beings. Even patients as humans were portrayed as passive to nature, as open systems, as goal-seeking reactors or as amalgams of bio-psycho-socio-spiritual variables. Seldom were patients described in terms of their own human qualities (Taylor, p. 1046).

Despite nurses' skills and knowledge, they share "ordinariness" with patients in their humanness. When nurses and patients can regard each other as humans, a "oneness" is created which enables both to experience human connectedness in the relationship and provides comfort to the patient (Taylor). Students should be provided with opportunities to discuss the humanness of both patient and nurse. Travelbee's (1971) Human-to-Human Relationship theory could be used as a framework as it focuses on the dignity, worth and uniqueness of every human being. Travelbee avoids the terms "nurse" and "patient" as these labels are believed to promote interactions that are not individualized but focused on the role that has been assigned to another person. She writes that the roles of nurse and patient must be transcended in order to achieve relatedness and the human-to-human relationship that is the means by which the purpose of nursing is fulfilled. Learning opportunities grounded in the works of Travelbee and Taylor could include exercises such as working with simulated patients, case studies/vignettes, and group discussions to engage students to reflect on the humanness of both patients and nurses.

Implications for Nursing Research

As this study was conducted with eight nurse participants in one ED in Atlantic Canada, the findings are not generalizable. It would be helpful to replicate this study in other EDs in other geographical settings to increase the transferability of findings. Efforts to recruit male nurses and nurses with long careers in the ED should be made, as their voices are not reflected in the findings of this study. It is unknown if gender or

longevity in the ED are variables that would alter the study's findings. This research also does not reflect the experience of nurses who work in other clinical areas.

Future research on inpatient nursing units would be beneficial, as it is unknown whether those nurses experience the same tensions and enact a process similar to *Juggling a Way of Being.* Inpatient nurses should be presented with the same interview questions to increase understanding of differences in the contextual factors of unit culture and the nature of the environment. One could hypothesize that nurses' concerns would be different in areas where patient turn-over is much less frequent allowing more time for nurses to get to know patients. It could also be hypothesized that inpatient nurses would not experience the same irritants as those experienced by ED nurses. On the other hand, it might be that some of the findings of the ED research are exacerbated as nurses get to know patients over time. Research should include participant observation as a method, in addition to interviews, to enhance the explanatory nature of this generated theory.

Several questions remained at the completion of this study, as noted above. These questions could spark new lines of inquiry, using a feminist interpretive lens, to enhance understanding of nurses' perspectives of what caring entails, why nurses seek recognition from patients, why nurses blame patients when tensions arise within themselves, and what it is that keeps nurses from reflecting on and trying to understand patients' "bad" behaviour. Future research could also focus on the idea of the *Real Nurse* versus *Those who Work as Nurses*.

Conclusion

In the process of investigating how nurses experienced and managed tension among values, understanding of the vulnerabilities of both patients and nurses was

extended. Caring and the nurse-patient relationship are considered to be core values of the nursing profession and important determinants of patient outcomes (Varcoe et al., 2004). It became clear in this study that it can be difficult for nurses to provide the caring environments that patients require when faced with the grating tension that has been identified as *Juggling a Way of Being*. The nurses who shared their stories expressed the desire to care *about* their patients but were challenged as they gazed through dual ethical lenses of personal and professional values and faced barriers within their work environment. Swanson's (1991) theory of caring is applicable to both nurse-patient and nurse-to nurse relationships. Both patients and nurses are in need of nurturing support and relationships that foster their well-being. "Human beings deserve respect as ends in themselves…Justice requires that the differences among persons and groups are to be valued" (Martino Maze, 2005, p. 549). Nurses as well as patients must be recognized and celebrated as unique individuals so that they do not lose their human face in environments that oppose those who are considered to be "other".

I set out to explore the internal tension that occurs when a nurse's personal and professional values are in conflict. What is going on *within the nurse* when personal and professional values collide? In understanding this process, awareness of differences between nurses who are able to care for patients who they do not care about and nurses who cannot, or will not, care about such patients, was enhanced. This research has advanced understanding of how nurses can acknowledge their personal values in an effort to provide sensitive, just, inclusive care for all patients.   Study findings provide insight into the process that was constructed in the context in which it occurs. New understanding was acquired that can assist in constructing strategies to implement that

176

encourage the "subordination of personal feelings in order that professional care is not affected detrimentally" (Woodward, 1999, p. 396). This study has increased understanding of the interactional processes underlying nurse behaviour when inequalities arise in the course of providing patient care. Nurses have personal and professional values that are neither separate nor combined but integrated to shape who they are as people and professionals. Nurses must be supported to continuously reflect on factors that interfere with their ability to provide ethical care; there is an urgency in the voices of the participants who have clearly described the untoward consequences of *tension 'in the moment'* for both patient and nurse.

Recrutiment Poster

Are You a Nurse Who Works in the Emergency Department?

I am a Registered Nurse and a graduate student in the Master of Nursing Program at Dalhousie University. I have eighteen years of nursing experience in areas of acute care, intensive care and nursing education. My work in health care has led to my interest in increasing the understanding about a particularly difficult situation for nurses, including those who work in the Emergency Department,: **what is going on *within the nurse* when personal and professional values collide – either while providing care, or while observing the care of other nurses - and how this affects nurse behaviour.**

I am conducting a study to learn more about the internal tension that nurses who work in the Emergency Department experience when personal and professional values collide and how this affects nurse behaviour. Nursing is a human process. As nurses, we all react to things uniquely; we all have our own 'tipping point'. In sharing your stories, a better understanding of the humanness of both nurses and patients can be acknowledged. This information may assist practitioners and decision makers in understanding the experiences of nurses and some of the issues to consider when promoting both nurses' and patients' wellbeing.

If you are interested in talking with me to find out more about the study, please contact me at 648-7123. If you then would like to participate in the study we will arrange a convenient time and place to meet.

Researcher
Heidi Mew, BN RN
Student Master's Program, School of Nursing, Dalhousie University

Ethics Approval obtained from Horizon Health Network Research Ethics Board

Appendix B

Letter of Invitation

Heidi Mew, BNRN
4CN, Internal Medicine
Saint John Regional Hospital
400 University Avenue
Saint John, NB
E2L 4L4
(506) 648-7123

March 15, 2013

Hello,

I am a graduate student in the Master of Nursing Program at Dalhousie University. I have eighteen years nursing experience in areas of acute care, intensive care and nursing education. This letter is being sent to you through your nurse manager on my behalf. My work in health care has led to my interest in increasing understanding of what is going on *within the nurse* when personal and professional values collide while providing care, or observing the care of other nurses, and how does this affect nurse behaviour?

I am conducting a study to learn more about the internal tension that nurses experience when personal and professional values collide and how this impacts patient care. Nursing is a human process. As nurses, we all react to things uniquely; we all have our own 'tipping point'. It is important for nurses to be supported in their efforts to be true to their own values and beliefs while enacting professional obligations. In sharing your stories, a better understanding of the humanness of both nurses and patients can be acknowledged. This information may assist practitioners and decision makers in understanding the experiences of nurses and some of the issues to consider to promote both nurses' and patients' wellbeing.

Being involved in this study would include one interview lasting no more than 2 hours. The interview will be conducted at a private and comfortable location on which we both agree. Following interviews, I would like to conduct focus groups with 6-8 participants to discuss themes that may arise in the interviews. Focus groups will last no more than 2 hours and will be conducted in a private room within the Saint John Regional Hospital.

Your participation is completely voluntary. You are free to withdraw at any time without any effect on your work performance appraisal. You do not have to answer all of the questions. Interviews and focus groups will be audio-taped and then transcribed. You

may not participate if you have had previous contact with me as a co-worker or instructor.

If you are interested in talking with me to find out more about the study, please contact me hospital inter-office mail using the enclosed reply letter within two weeks. I will then contact you by phone to talk further about the study. If you then would like to participate in the study we will arrange a convenient time and place to meet. You may contact me at (506) 648-7123 if you have any questions.

Thank you for your time and consideration.

Sincerely,

Heidi Mew, BNRN
Student Master's Program, School of Nursing, Dalhousie University

REPLY LETTER

Date: _____

Attention: Heidi Mew, BNRN
4CN, Internal Medicine
Saint John Regional Hospital
400 University Avenue
Saint John, NB
E2L 4L4
(506) 648-7123

I have received and read your letter of invitation to participate in your study about what is going on *within the nurse* when personal and professional values collide while providing care, or observing the care of other nurses, and how does this affect nurse behaviour?

I am interested in talking with you to find out more about the study.

Please contact me at:

Name: _____

Address: _____

_____

_____

Telephone Number: _____

Best time to call: _____

Signature: _____

Appendix C

Interview Guide

<u>Initial Question</u>:

- **What is going on *within the nurse* when personal and professional values collide while providing care, or observing the care of other nurses, and how does this affect nurse behaviour?**

<u>Probing Questions</u>:

<u>Aspects of the participant's understanding of self before and after becoming a nurse</u>:

- **Tell me about yourself before you became a nurse.**

<u>The participant's interpretation of the influence of external context and interactions with others on their practice</u>:

- **How do the people and things around you at work influence the care you give?**

<u>The participant's decisions about action related to patient care</u>:

- **Can you tell me how you came to take the action you took?**

Appendix D

Consent Form

Study Title: What is going on *within the nurse* when personal and professional values collide while providing care, or observing the care of other nurses, and how does this affect nurse behaviour?

Investigator: Heidi Mew, BNRN
                          Graduate Student
                          Master of Nursing Program
                          School of Nursing
                          Dalhousie University
                          Halifax, NS
                          B3H 3J7
                          (506) 648-7123

Research Supervisor: Jean Hughes, RN, PhD
                          Professor
                          School of Nursing
                          Dalhousie University
                          Halifax, NS
                          B3H 3J5
                          (902) 494-2456

Introduction
We invite you to take part in a research study being conducted by Heidi Mew, BNRN, who is a graduate student at Dalhousie University, as part of her Master of Nursing Program. Your participation in this study is voluntary and you may withdraw at any time. Your employment will not be affected by whether you participate or not. The study is described below. This description tells you about the risks, inconvenience, or discomfort that you might experience. Participating in the study might not benefit you, but information might be gained that will benefit others. You should discuss any questions you have about this study with Heidi Mew or her research supervisor, Dr. Jean Hughes.

Purpose of the Study
The purpose of this study is to learn more about the internal tension that nurses experience when personal and professional values collide and how this impacts patient care. Nursing is a human process. As nurses, we all react to things uniquely; we all have our own 'tipping point'. It is important for nurses to be supported in their efforts to be true to their own values and beliefs while enacting professional obligations. In sharing your stories, a better understanding of the humanness of both nurses and patients can be acknowledged. This information may assist practitioners and decision makers in understanding the experiences of nurses and some of the issues to consider to promote both nurses' and patients' wellbeing. Heidi Mew will ask you to tell her, in as much detail as you can, about experiences you have personally had, or personally observed,

when it was difficult to enact professional values in the face of competing personal values. A summary of final study results will be sent to you if you wish.

Study Design
This study involves one interview in which participants will be asked to respond to questions about your understanding of yourself before and after becoming a nurse; factors that influence your practice; and how you make decisions about action related to patient care. Following individual interviews, focus groups will be conducted with 6-10 participants at a time to discuss themes that are noted during interviews. It is important to hear the opinions and experiences of nurses in order to find ways to promote both nurse and patient wellbeing.

Who Can Participate in this Study?
You may participate if you received the letter of invitation from your nurse manager. You may participate in this study if you:
- are over the age of 19
- currently are employed as a registered nurse in the emergency department of the Saint John Regional Hospital
- provide direct patient care
- have at least one year of nursing experience
- are willing to be interviewed and audio-taped once in-person for 1-2 hours and again during a 1-2 hour focus group discussion
- understand and converse in English

Who Cannot Participate in this Study?
You may not participate in this study if you:
- have previously working in a nursing unit with or have been instructed by Heidi Mew

Who will be Conducting the Research?
Heidi Mew will be the primary researcher. Her thesis committee will also be involved in this study. These people include: Dr. Jean Hughes, PhD; Dr. Marilyn Macdonald, PhD; Dr. Linda Yetman, Phd; and Dr. Timothy Christie, PhD.

What you will be asked to do
The study interview will be conducted at a private and comfortable location that both you and Heidi Mew agree on and will take no more than two hours to complete. Participation will involve one individual interview and one focus group discussion that will last no longer than 2 hours. During the individual interview, you will be asked to tell Heidi Mew about experiences you have personally had, or personally observed, when it was difficult to enact professional values in the face of competing personal values. A set of questions will be asked about: a) your understanding of yourself before and after becoming a nurse; b) factors that influence your practice; and c) how you make decisions about action related to patient care. You will not be identified as a study participant in any reports but direct quotes will be used.

Focus groups will occur after individual interviews have been completed. The follow-up focus groups will last no longer than two hours. You will be asked if the ideas taken from interviews are correct.

If you wish to receive a summary of the study results at the end of the study, please check 'yes' in answer to the question at the end of the consent form and list your mailing address.

Possible Harm and Discomforts
There are no anticipated risks involved with your participation in this study. You do not have to answer any or all of the questions.

Withdrawal from the Study
You do not have to participate in this study. Taking part in the study is voluntary. You have the right to ask questions about the study, to refuse to answer questions during the interview and focus group, and to withdraw from the study at any time. Your employment will not be affected in any way.

If you withdraw from the study, all information collected before this point will also be withdrawn and destroyed <u>wherever it is technically possible to do so</u> unless you give permission to Heidi mew to use information collected to this point. Every effort will be made to protect confidentiality. If you withdraw from the study without informing Heidi Mew, and it is not possible to reach you to determine what you wish to be done with you information collected thus far, your data will be retained and appropriate steps will be taken to de-identify the data in reporting and in storing data.

Possible Benefits
There is no guarantee that you will benefit personally from taking part in this study. Some people may find it is helpful to talk about their experiences and having a safe place to discuss feelings of internal tension that may arise in the course of patient care. Although you may not personally benefit from participating in this study, the information gathered during observations, interviews and focus groups may benefit other nurses, patients and/or families in the future.

Confidentiality
You will not be identified as a study participant in any reports, publications, or presentations of this research. A pseudonym will be used instead of your name in Heidi Mew's field notes made during observations as well as on the taped and typed copies of the interview and focus group. None of the quotes used in reporting results will include material that could identify you.

Your information will be kept in a secure locked area. Study information will be reviewed by Heidi Mew and the thesis committee. In keeping with the University Policy on Scholarly Integrity, data will be held securely for 5 years and then destroyed

according to Tri-Council ethical guidelines. This includes audio-tapes, field notes and all data transcripts.

The study information will be kept confidential with the following exceptions: a) in cases of suspected child abuse or neglect or in certain cases of suspected abuse or neglect of adults; b) all information must be made available in response to a subpoena, court order, or search warrant; c) in circumstances of actual or possible harm or death, appropriate individuals or authorities must be informed; or d) as required for the relation of research to the Research Ethics Board (all studies may be audited at random by the Research Ethics Board). If the researcher is required to disclose information about you, she will attempt to inform you.

Anonymity
It is not possible to guarantee absolute anonymity. Heidi Mew will promise to report only information about groups of people and not to identify individual participants in the study. Although it is extremely unlikely, it is possible that individuals may be identifiable in reports, presentations, or publication of research findings due to the uniqueness of information, the small number of participants, and the geographical context.

Questions
If you have any questions about the study or about your rights as a research participant, please contact the investigator and/or research supervisor listed below:

Investigator: Heidi Mew, BNRN
Graduate Student
Master of Nursing Program
School of Nursing
Dalhousie University
Halifax, NS
B3H 3J7
(506) 648-7123

Research Supervisor: Jean Hughes, RN, PhD
Professor
School of Nursing
Dalhousie University
Halifax, NS
B3H 3J5
(902) 494-2456

Problems or Concerns
If you have any difficulties with, or wish to voice concern about, any aspect of your participation in this study you may contact:

Patricia Lindley, Director
Dalhousie University Office of Human Research Ethics Administration

(902) 494-1462
patricia.lindley@dal.ca

Horizon Health Network Department of Ethics Services
Saint John Regional Hospital
(506) 648-6094
reboffice@Horizonnb.ca

Consent Form

Study Title: **What is going on *within the nurse* when personal and professional values collide while providing care, or observing the care of other nurses, and how does this affect nurse behaviour?**

You are asked to answer the following questions. Please check 'yes' or 'no' for the following questions. In order to participate in this study, it is necessary to answer *yes* to the following 4 questions. You will be provided with a signed copy of the consent form for your records.

1. Are you over the age of 19?

    Yes_____   No_____

2. Are you currently employed as a registered nurse in the emergency department of the Saint John Regional Hospital and provide direct patient care?

    Yes_____   No_____

3. Do you have at least one year of nursing experience?

    Yes_____   No_____

4. Are you willing to be interviewed once in-person for 1-2 hours and again during a 1-2 hour focus group discussion?

    Yes_____   No_____

5. Do you agree to have the interview and focus group audio-taped?

    Yes_____   No_____

6. Do you give permission for the researcher to use the study results and quotations for educational and publication purposes?

    Yes_____   No_____

7. Do you understand that it is possible that individuals may be identified in reports, presentations, or publication of research findings, due to the uniqueness of the information, the small number of participants, and the geographic context?

    Yes_____   No_____

8. Do you agree to participate in the study?

      Yes_____   No_____

If you wish to receive a summary of the study results at the end of the study, please check 'yes' in answer to the question asking this at the end of the consent form. Please list your mailing address.

I have read the explanation about the study **"What is going on *within the nurse* when personal and professional values collide while providing care, or observing the care of other nurses, and how does this affect nurse behaviour?".** I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I hereby consent to take part in this study. However, I realize that my participation is voluntary and that I am free to withdraw from the study at any time.

_____   _____
Signature of Participant   Date

_____   _____
Signature of Researcher   Date

Chosen Pseudonym: _____

Do you wish to receive a summary of the study results at the completion of the study?

Yes_____   No_____

If yes, please list your mailing address:

_____

_____

_____

_____

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