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Sarah Lake Trudy Rudge Sandra West

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Making meaning of nursing practices in acute care

Sarah Lake, Trudy Rudge and Sandra West
Sydney Nursing School, University of Sydney, Sydney, Australia

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Abstract

Purpose – The purpose of this paper is to consider how meaning may be made of nursing practices by contrasting the rationalistic approach commonly used in the nursing literature with Bourdieu's theory of practice.

Design/methodology/approach – The data under consideration is an account of ten to 15 minutes of a larger ethnographic study of nursing practices which asks the question: how do nurses accomplish nursing within and between patients' needs for care in the acute hospital setting? The five main sources of data were: observations of and conversations with nurse participants, as well as hospital documentation (including facility protocols and patients' notes) and the observer's field diary. These were woven together to provide an account of one nurse with one patient for a few moments of her day.

Findings – Although this paper makes no attempt to speak to the rest of her workload, in these few minutes the nurse accomplishes multiple moments of nursing practice. Further, while the rationalistic approach presents the nurse as a highly skilled practitioner, Bourdieu's theory of practice not only illuminates the nurse's role as pivotal in the acute hospital setting but is also able to address the dialectical nature of the relationship between nurses' practices and the dynamics of the context.

Originality/value – The use of Bourdieu's theory of practice makes possible the study of how nurses nurse "within and between" to illuminate the everyday practices of nurses.

Keywords Bourdieu, Clinical decision making, Habitus, Nursing practice

Paper type Research paper

Introduction

In the everyday practice of nursing in acute care hospital wards each nurse will look after several patients for the duration of a shift so that there may be unfinished, competing or conflicting patient needs for care occurring simultaneously. Ethnographies of various aspects of hospital nursing such as wound care (Rudge, 1997), body work (Lawler, 1991), clinical practice (Street, 1992), the conduct of care (Latimer, 2000), managing nursing under health reforms (Rankin and Campbell, 2006) and the social organisation of ethics (Chambliss, 1996), were able to explore nursing in the acute setting in some depth. But how nurses nurse "within and between", the crucial but taken-for-granted character of everyday acute care nursing, has not been studied ethnographically. The authors' research observes registered nurses in practice and talks with them to see how they do this, exploring the question: "How do nurses accomplish nursing within and between patients' needs for care in acute care hospital wards?"

As a nurse with over 30 years' practice experience in the hospital setting who wanted to research nursing practice, the first author investigated the nursing literature (Lake, 2005). This study emerged as a way to explore nursing practice in the field. Hence it was decided to use Bourdieu's (1977, 1990, 1998) theory of practice, an approach that specifically addresses practices in the everyday world.

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This is a further development of a paper presented at the 8th Annual Liverpool Symposium on Current Developments in Ethnographic Research in the Social and Management Sciences: "The Politics of Meaning-Making/Meaning-Breaking", Amsterdam, 2013.

In the nursing literature, nurses are portrayed exercising the essential skills of critical thinking and clinical judgement to care for patients (e.g. Tanner, 2006). This approach evolved in a body of work where clinical decision making was determined as a problem-solving process (Lake, 2005), however, these attributes remain difficult to identify in the daily practices of nurses. Bourdieu's (1977, 1990) work recognises that such objective constructs as decision making are both structured and structuring (i.e. objective and subjective). Moreover, his "second break" takes another step back to realise that the objective construct is created by a "first break" with lived experience. This "second break" reveals a dialectical (rather than oppositional) relationship between objective and subjective, making possible a new way to explore practice theoretically in social space. The theory of practice is applied in this paper to illuminate several moments of nursing practice observed one morning in a hospital ward.

Methodology and method

Bourdieu's reflexive sociology (Bourdieu and Wacquant, 1992) is the methodological approach chosen for this ethnographic study, which took place in the adult acute wards of a medium size hospital in New Zealand. Hammersley and Atkinson (2007) point out that ethnography is a commitment to a set of principles for a distinctive analytic mentality. They go on to say: "this orientation involves some interesting tensions. But while these are a source of recurrent troubles for ethnographers, they are also part of the dynamic of ethnographic work, they are what drives it forward in interesting directions" (p. 230).

This study recognises this commitment and resultant tensions and is troubled by the researchers' insiderness. According to Bourdieu (2003): "Each of us […] is encumbered by a past […] and this social past, […] is particularly burdensome and obtrusive when one is engaged in social science" (p. 291). He advises that while the researcher must mobilise this past in the research, (s)he must submit these returns to the past to rigorous examination, i.e. participant objectivation. Bourdieu explains that "participant objectivation undertakes to explore not the 'lived experience' of the knowing subject […] but the social conditions of possibility of that experience and, more precisely, the act of objectivation itself" (p. 282). In this study, this concerns troubling what the researchers bring to the study, to trouble how this affects study design and ways in which the data are collected, examining the researchers' interactions with participants and the field. This labour of objectivation continues throughout writing of accounts into ethnography.

Although as a researcher the first author did not dress as a nurse while observing, and always held a notebook and pen, she was sometimes asked to lend a hand or included in conversations as a nurse, and occasionally offered a comment or question as she tried to keep up with what was happening. Discussion of similar experiences by other nurse researchers (Borbasi, 1994, 1995; Lawler, 1995; Rudge, 1995) was extended by Rudge who asked whether nurses should "ignore our insider status, or should we foreground it" (p. 58) so as to be able to realise the potential such situatedness might bring to research in nursing.

The first author worked with six nurse participants for five observation and conversation sequences with each. For the first sequence each participant was initially wary. In the acute care hospital system, where there are constraints such as protocols and audits as well as often-changing expectations on practice, non-compliance invokes censure. There is an inherent risk in allowing one's practice to be scrutinised by another. Latimer (2006) points out that Koch's (2006) critical reports of practice might have been

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more contextualised if her approach was ethnographic. Or as Bourdieu (1996) puts it: "it is solely to the extent that [the researcher] can objectivate herself (*sic*) that she is able [...] to understand that if she were in her shoes she would doubtless be and think just like her" (p. 34). A "field log" outlining the participant's activity during the observation, developed as a basis for each conversation, was useful in allaying participants' concerns about being watched.

The conversations, arranged for a time and place to suit each participant, took place up to a week later. Given the nature of nursing in the acute setting the observer (I) knew that participants would have trouble remembering what specifically happened so many days ago and hence wrote up a "field log" record. To encourage the conversations to remain "in the zone" of the research question, a comment about "what I think/thought I saw" in relation to accomplishing nursing was added to each log. For participants this was different to their thinking about the everyday. A frequent comment as they read through the logs was that they did not think they did so much.

Aiming for free flowing conversation that might illuminate nurses' habitus, I found that direct questions stifled discussion. Acknowledging the "infraconscious, infralinguistic" (Bourdieu, 1998, p. 79) complicity of habitus in the social world, I therefore chose to talk more as a nurse in the conversations so that the exchange mirrored the ward handover where nurses may speak freely (Wiltshire and Parker, 1996). Bourdieu (1996) points out that "various kinds of distortion are embedded in the very structure of the relationship" (p. 18) between researcher and respondent and that the researcher can begin to redress the power imbalance by sharing "with her what she is inducing the other to divulge" (p. 21). To attend to the "ellipses and lacunae of the language of familiarity" (Bourdieu, 1977, p. 18) in field logs and conversation transcripts a detailed field diary glossary was developed so that data relating to participants' words and activity remain primarily as they were recorded at the time.

A "minimally manipulated written account" (Humphreys and Watson, 2009, p. 42) of each observation was woven together from five main sources of data. These are the field notes of the observations, the transcript of the follow-on conversations with the nurses along with entries in the field diary relating to the observations and other aspects of nursing in that ward. Relevant hospital documentation data included clinical protocols and finally patients' case notes, which incorporate the entries of the multi-disciplinary team. In one such account of the fourth observation with one nurse participant, a small section describes the course of events over ten to 15 minutes as a patient with diabetes was preparing for breakfast. In this short period of time the nurse, Glenda, moved fluidly between intravenous antibiotics, insulin, breakfast, documentation, the doctors' round and wound care accomplishing multiple moments of nursing practice.

This paper explores the dialectic between habitus and field (Bourdieu, 1977, 1990, 1998) for these several moments and then contrasts this with an explication of the more usual ways of making meaning in nursing.

Multiple moments of nursing practice

The moments of nursing practice occurred in a ward that admitted both elective (planned) and acute (unplanned) adult patients for surgical treatments. However, in contemporary hospital organisation, some patients could be outliers of the medical acute care teams and be located in surgical wards because of lack of "medical" beds. Moreover, patients do not meet these arbitrary categories either, often having a complex mix of co-existing conditions that require either medical or surgical treatment. The ward had been built several decades ago when a long corridor-like layout was the

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vogue, so that the patient bed rooms were set out along one side of the "corridor", which also functioned as a thoroughfare; while utility rooms where provisions for the ward are situated such as the clean supplies (e.g. the treatment room for medications and dressings and the linen room), the clean-up rooms (e.g. the toilets, bathrooms and sluice room[1]) and the rooms for the administrative functions (e.g. patient case notes, paperwork, reception and computers) were on the opposite side. The ward office is midway on this side behind the reception area. This area functions as the message centre of the ward, and the office is where the nurses' handover between shifts takes place.

Nurses starting work on the morning shift at seven o'clock would listen to the recorded handover about the patients already on the ward from the night shift nurses, take note of further elective admissions due to arrive on the ward later in the shift after surgery, and "allocate" these patients to individual nurse's caseloads. The nurse with the "lightest" load would expect to "take" the first acute admission.

Having listened to the handover, the nurses then go to "do the Obs"[2] of each of the patients in their caseloads, and also check through each patient's drug chart for any medication that might be due or needed, such as analgesia (pain medication). An hour later at around eight o'clock, the rest of the ward day would get underway with breakfast for the patients who were eating and the doctors' rounds, when the majority of the patients would be seen by medical teams.

The ward was not particularly busy that morning and Glenda's caseload for the shift was only three patients, but one, Ross, was seen to need more nursing than many of the others. While another, a very frail 100-year old lady with a fractured hip, required full nursing care[3] including being fed. She was also due to be transferred by ambulance back to her rest home at 10 a.m. Glenda's third patient was a lady recovering from gynaecological surgery the day before. Therefore, also according to TrendCare[4] the computerised workload management programme, her workload was similar to that of the other nurses.

I had arrived at the start of the shift, listened to the handover with Glenda and then followed her as she went about working with her patients, doing their Obs and giving them their morning medications. Then she had gone to see Ross in Room Nine, a man with diabetes whose foot had become severely infected, and checked his blood sugar level before going to the treatment room to draw up the intravenous antibiotic[5] which was prescribed for him.

I wait outside Room Nine while Glenda takes the drug chart and the antibiotic into Ross' bedspace where the curtains are still drawn. I hear her say "sorry" and then she comes out again, telling me quietly "he's having a wee" […] she talks to Ross through the curtains, and then goes in again, pulling back the curtains and moving to the side of the bed. She checks that Ross is giving himself his insulin[6] and then she comes to the end of the bed and writes on the drug chart and the blood glucose chart before clipping them back onto the clip board.

The registrar [a trainee consultant], Humboldt [a junior doctor] and Emily [the ward physiotherapist] come to the bed side […] they talk to Ross and the registrar wonders if a Vac dressing[7] would be a good idea […] Ross says he is "not keen […]" "It would certainly heal it quicker […]" says the registrar. "Do you want to have a look at it" asks Glenda. They do and while they are still talking Glenda goes quickly into the bathroom[8] across the corridor, comes back with a "bluey"[9] and puts it on the bed beneath the bandaging on Ross' lower left leg. She pulls out her scissors and gently starts to work on the bandage, loosening it where possible and cutting it or the tape where it is stuck.

The registrar, Humboldt and Emily move on to the next patient in the room and spend a few minutes with him at the bed near the window, then they turn to leave the room, coming back past Ross' bed.

By now, Glenda has removed the crepe bandage, the layers of protective padding bandage underneath and is deftly peeling the soggy absorbent dressing from the cavities, using the padding so as to not touch it with her fingers. The dressing bits lie on the bluey and the wound is becoming visible. She looks up from her work as they come closer and catches the registrar's attention. They come back to the end of the bed and the doctors take a closer look at the wounds. "[…] don't think we'll get a Vac on there" says the registrar.

The registrar, Humboldt and Emily move down the corridor and stand outside Room Ten […] I can hear Humboldt say that Ross' blood sugar is now seventeen point five, and ask "would it be a good idea to restart the GIK[10] infusion?" "Better to ask someone who knows about these things", says the registrar. "I'll talk to the diabetes specialist" says Humboldt; "good idea" says the registrar.

Meantime Glenda has gone swiftly back along the ward corridor to the treatment room and now comes back with large combines[11] and crepe bandage. Passing the message centre of the ward twice, she returns without delay to Room Nine. "I'll put these on the foot to protect it" she tells me, "let him have breakfast first and then I can quietly sit and do it […]".

She goes into Room Nine with Ross, "[…] just put a makeshift bandage round here while you have breakfast". She peels open the sealed paper envelopes of the sterile combine dressings, and wraps them around his foot and the open wound and then secures them with the bandage, taping it to stay in place with the tape from her pocket. She uses the bluey on the bed to contain the mucky discarded dressings, folding the edges over and saying to Ross "[…] do the antibiotic after you've had your breakfast?"

She nips across to the bathroom again and gets another bluey which she puts on the floor beside the bed. Ross swings round so that he is sitting on the side of the bed and rests his foot on the bluey. Glenda moves the bedside table into place over his knees, being careful not to bump his foot, and then places the breakfast tray on it. Ross starts eating his breakfast.

Then she gathers up the rubbish bluey, holding the outside edges and corners together so that the mucky dressings are contained within the non-permeable cover, and takes it to the sluice room. I watch as she disposes of it in the yellow bag[12] in the corner of the room, and then does a proper hand wash[13] at the basin, also washing her scissors before putting them back in her pocket.

I pass on the conversation about the GIK infusion between the registrar and Humboldt to Glenda; she looks troubled "[…] they're trying to get him back to a more normal routine for him […]" she says.

We emerge from the sluice room. "Time to do TrendCare then feed my button in there[14] […]" says Glenda. We head to the ward office.

Making meaning from Bourdieu's point of view

When it came to write up these 15 minutes of the observation, there was much that needed explaining to someone unfamiliar with patient care in hospital. What was a Vac dressing and why was it important that the doctors saw the wound? What was a bluey and why did it matter that Glenda used two blueys and went to the treatment room (and back without stopping) for the dressings to cover the wound. Although the activity seemed to be about a wound dressing during the doctors' round, for Ross (and

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Glenda) it was also insulin time, breakfast time and antibiotic time. Plus what was a GIK infusion and why did Glenda look troubled when she was told that the junior doctor is thinking of restarting it; and why did the registrar say better to ask someone who knows about these things. How did Glenda's actions and words provide Ross with the nursing he needed? But also, in terms of the study, how best to answer Kunda's (2013) question: what was this (activity) an example of?

Bourdieu's theory of practice (Bourdieu, 1977, 1990) sees social space as a field of both forces and struggles (Bourdieu, 1998, p. 32), and elaborates that: a field is "a game devoid of inventor and more fluid and complex than any game one might design" (Bourdieu and Wacquant, 1992, p. 104). Hence the social space of the ward, apparently bounded by physical geography, is a field with a particular focus that is constituted within the larger fields of facility, local organisation and healthcare system. The overarching governmental authority of the healthcare system, manifested through health policies, funding models and practice legislation, is administered locally through health board governance and hospital management. Also situated at hospital level are clinical practice protocols and guidelines written by clinicians. These align to national expectations and are influenced by international "best" practices. These structuring structures, imbued with the dynamics of symbolic power (Bourdieu, 1989), establish the scope of healthcare delivery in the ward as a field where players with varied interests come together.

Players' interests as members of a social arena and social group are expressed through Bourdieu's notion of habitus as acquired dispositions (Bourdieu, 1998), which are both structured by the environment and by membership of the social group. In a rather simplified expression of the notion, a nurse incorporates a disposition to carry out practices in a social arena (in this case an acute care "surgical" ward) according to their life experience, i.e. upbringing, education and practice experience. However, the efficacy of these practices is affected by the nurse's position within the social arena and the weight given to this position by the social arena (and the other social agents in the arena) (Bourdieu, 1989). This constitutes nurses' symbolic capital in this arena.

Interest or *illusio* is inherent in habitus: "*Illusio* is the fact of being caught up in and by the game, of believing the game is 'worth the candle' or, more simply, that playing is worth the effort" (Bourdieu, 1998, pp. 76-77). This is not "an intellectual act of cognition […] [but an absorption in] the doing […] which is inscribed in the present of the game […] in an incorporated state: she (*sic*) embodies the game" (pp. 80-81).

Rules of the game, the doxa (Bourdieu, 1998, pp. 56-57) of the field, exist for all of the activities outlined in the observations above. These can be explicit rules written down, and/or covert rules existing in the ways things are done. In practice, rules can be followed to the letter, in spirit or not at all. They create entities to be worked with or around and this, mediated by *illusio* and the symbolic capital of the players, becomes the dialectic between habitus and field. Players other than nurses also invest in the field. One of them is Ross who is not only a patient but a person with his own desires and expectations. Two of the more obvious features of the structures in the observed data, the medical power of the doctors and the doxa of wound care, are the focus of this exploration and the way, under Glenda's *illusio*, and her "feel for the game" (Bourdieu, 1998, p. 98), these play out for Ross, a diabetic patient with a severely infected foot.

Medical power

Doctors are seen to hold the power in the hospital situation. Each patient is allocated to an "admitting consultant", a responsible specialist, an expert in specific medical treatment. The consultant functions as a member of a department, working with a registrar and

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junior doctors, forming a retinue of medically qualified personnel who practise medicine while learning from the consultant heading up the "team". The learning occurs through looking after patients, including regular "doctors" rounds' where the team discuss treatment needed at the patient's bedside, updating daily "orders". The consultant has the overall say, but the registrar is capable of carrying the delegated responsibility in their absence, with the backup of the consultant for anything untoward. Other specialists may be called upon for advice and input outside the admitting consultant's area of expertise if the patient's situation requires this. These rules are informal, performed by players to familiarise new players, conformed to by doctors, reinforced with letters between consultants in the breach.

Because the infection is destroying the bones in his foot, Ross has been admitted to orthopaedics. On the morning of the observation, the registrar is leading the doctors' round, with, as usual for orthopaedics, the physiotherapist in attendance. However, the junior doctor is new to the team, having started the orthopaedics "run" only that week.

The overt process of hospitalisation documented in the patient notes record that Ross has been in the ward for more than a week, receiving intravenous antibiotics to treat the infection. Intensive therapy, the GIK infusion, as set by the diabetic specialist, has been invoked to regain control of his blood sugar levels which are destabilised by the infection. This treatment is a bodyweight specific combination of glucose, insulin and potassium administered intravenously by nurses according to a junior doctor's prescription following guideline specifications. These require nurses to titrate the amount of the infusion according to Ross' blood sugar levels, which are monitored every hour. Two days before the observation the infected area was "debrided" (cleaned) under anaesthetic by the registrar and although the bandages remain undisturbed since then, the GIK infusion was discontinued.

Two suggestions arise from the doctors' review of Ross' treatment: one is to apply a Vac dressing, a mechanical device that seals a dressing to the wound bed by vacuum which is maintained for days at a time by a rechargeable pump; the other, to restart the GIK infusion, also requires an electronic pump. If these suggestions are implemented, the pumps would be attached by tubing to Ross' foot and arm, respectively, severely limiting his activity and extending his hospital stay. Each would require specialised, intensive nursing input. Glenda's practices of nursing accomplish a different result for Ross in both cases.

The doxa of wound care

Wound care in hospital follows a set of rules prescribing how a dressing should be done. These are partially unwritten with the remainder addressed by expectations and proscriptions located in different parts of the structure. The processes of "doing a dressing" are taught to nursing students pre-registration and do not exist as written rules in the hospital setting. These involve a dressing trolley, a sterile dressing pack and dressings and/or wound care products, a rubbish bag, careful handwashing and a linear process. This starts with setting up the new sterile work area, donning gloves and then removing the old dressing. Rules for application of different wound care products, which purport to promote wound healing, are available in the hospital and advertised through coloured pictorial wall charts in wards. But the other aims of the process, to protect the wound from further infection while at the same time protecting the environment from contamination with potentially infected material, reside in the written rules of infection control[15]. Three (of 26) infection control policies in this facility are most relevant to the moments of observation: hand hygiene, standard

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precautions (i.e. prevention of transmission of infection) and healthcare waste management.

During the observation Glenda followed these rules in the spirit rather than the letter. No dressing trolley or pack was involved and she did not wash her hands before removing the dressing. However, she ensured the environment was protected with the expeditious use of blueys and prevented transmitting infection from and to the wound through the careful way she handled different dressing components. She did this while removing the bandages and contaminated material from the wound and the patient's bed, and when applying the new sterile dressings. This latter also protected the wound (and the environment) for the duration of Ross' breakfast.

The "immanent tendencies of the game inscribed in [Glenda's] body" (Bourdieu, 1998, p. 81) ensured that the wound was available to the doctors' gaze (Foucault, 1995) while they were available and present "to gaze". They could see, as I could see from where I stood, that the wound was near Ross' toes, making it very difficult and/or unlikely for the vacuum to achieve a seal. Glenda's handling of the situation materialises the limits of the wound to the doctors countering further technological intervention.

Ross, Glenda and a "feel for the game"

Ross had resisted admission to hospital so that when he arrived in the ward the infection in his foot was entrenched. He remained reluctant to accept proposed treatments, even not accepting panadol to relieve his fever, resulting in nurses sometimes changing his linen two or three times per shift from sweating due to fever. Other difficulties were maintaining infection control standards because as a smoker, he often left the ward for a cigarette, trailing infected ooze from the bandages. While continuing to do what was needed, nurses' responses among themselves varied from moues of distaste to a comment that he was: "kind of cute in a Nimbin [hippy area of Australia with communes and other attributes] sort of way".

Glenda's relationship with Ross has evolved as she nursed him. She knows that he likes to sleep in, that he likes a "fraction" of sugar in his coffee and watching TV, and that turning things into a game meets his resistance halfway.

On the morning of the observation as we walk towards Room Nine Glenda tells me: "we got him off the GIK yesterday and then his blood sugar went to two point seven, so I gave him some sandwiches and milo, but it was fifteen point five overnight and they haven't given him anything" […] she looks behind the curtains […] "he's asleep, we'll come back for him […]".

Glenda's introductory comments put into words her present concerns about Ross' inconsistent blood sugar levels (the range is between four and ten) as she goes to do the first check of the day. Once again it is high and when we talk later she tells me "we have bets […] now, him and I have a bet, 'right, what's it going to be […]' " I laugh. Glenda says: "it's a game". I say "yeah, well, how old is he again?" Glenda tells me: "he's thirty five […] he's thirty five". I respond: "but he's quite young in himself isn't he […]" Glenda agrees: "yeah, he is […] yeah".

As the shift draws to an end after many other things have happened in her day, Glenda neatly tackles the issue of how best to manage Ross' variable blood sugar levels with the junior doctor.

In the notes' room Humboldt is writing in Ross' case notes and Glenda asks to have them next […] Humboldt tells her that the diabetes specialist won't be coming to see Ross; "[…] would you like me to ring the educator" asks Glenda […] Humboldt thinks this is a good idea "[…] very happy with that […]" Glenda uses the phone on the bench

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along from Humboldt […] waits a while and leaves a specific message about Ross: where he is and that "diabetic education" is needed.

Humboldt looks up from his writing and tells Glenda that the blood sugar monitoring is now only before meals and at bedtime; "[…] does he get supper? […]" asks Glenda. "[…] don't know […]" says Humboldt. "[…] should there be a blood sugar done over night?" Humboldt is "not worried […]"[16].

Humboldt's newness to how things are done in the ward had been commented on by the nurses at the morning handover, one saying that he "won't be told by a woman. He doesn't say that, but that's how he acts […]" When we talk later Glenda says: "[…] Humboldt or whatever his name is, he's yeah […] he can be a bit sort of slack in his approach and stuff and he really […] got to get him pushed around […]".

The everydayness of her series of questions and the audible request to the diabetic nurse educator might more properly be described as a nudge rather than "pushing him around". However, with these words Glenda has revealed to Humboldt an alternative to restarting the GIK infusion while the junior doctor has learnt something of the ramifications of treatment options within the field. Once again Glenda's feel for the game prevails and Ross' hospitalisation progresses towards discharge as she brings together the responses needed for this patient who has both medical (unstable diabetes) and surgical (care of an infected wound) treatment needs.

Having ensured that Ross' breakfast was not too delayed as he had had his insulin, Glenda continues meantime with other aspects of her day's workload before returning to administer the intravenous antibiotics. Later she tells that these are often late now that the infusion has stopped, as Ross is able to leave the ward again, but she quite likes looking after him.

In this account Glenda's feel for the game is not limited to the doctor nurse game (Stein, 1967); she also has the ability to engage with Ross' reluctance to accept treatment, as for instance when she connects with him in the "game" of the fluctuating blood sugar levels. Furthermore her actions to acquire the dressing materials that she needs speak of a player completely at home in her immediate environment. Also her activation of the diabetic nurse educator's input addresses Ross' need to transition to "what is normal for him", by ensuring that the educator, a player from the wider field that follow-up Ross in the community, understands his present situation.

Prioritisation or *illusio*?

The vocabulary that nurses use for the work they do comes from the everyday. In the research, nurse participants' explanation of what they did was commonly: I/we/you "just do it". Glenda's responses, like those of other participants, were to the point rather than reflections of deeper thinking. When we talk about the observation a few days later I say "[…] cos that looked like a quiet day with three patients, but it was pretty steady. There's the bit where you did his dressing and stuff at the same time as the doctors' round […]". Glenda replies "[…] I had to do that then because otherwise they wouldn't have come back […]" adding that the doctors must sometimes wonder about her. I prompt further, outlining the series of actions that I had observed (i.e. in relation to blood sugar levels, insulin, doctors' round, breakfast, antibiotics and wound dressing). Glenda acknowledges: "[…] yeah". She is laughing quietly, sharing the moment. I prompt again, showing a kind of amazed respect: "[…] so it was sort of like […]. whoooaaaoooaa […]". With a little laugh Glenda says only: "yeah, I know […] 'quick' […]" "Quick" is said lightly and crisply, as if reliving the moment; acknowledging my

recognition. But my next prompt brings no further elaboration of her own practices as Glenda talks some more about the junior doctor.

Sometimes the words nurses used can be traced to the nursing literature as with the only other thing I could prompt her to say about what happened. This was at the end of the conversation when I commented again saying "[…] you went through about four or five different things at once […]". Glenda responds "yeah […] yeah […] it's the old multitasking, prioritising […]". That was all.

Multitasking is an everyday word described in the Oxford dictionary as "(of a person) dealing with more than one task at the same time" (Pearsall, 2002, p. 1707), while prioritising may be found in the nursing clinical decision-making literature. This literature has evolved from the nursing process movement (Lake, 2005), where the nurse was supposed to follow a linear set of activities to assess and diagnose a patient's needs for care before implementing and evaluating each nursing care response (Yura and Walsh, 1973). Prioritise was later included as a fifth step between diagnose and implement (Yura and Walsh, 1988) in this problem-solving process, which still forms the basis of many nursing texts. All stages were to involve critical thinking.

Over time, acknowledging the limitations of this linear process, "critical thinking" and "clinical judgement" were deemed to be what nurses did or needed to do to provide patient care, with a further extension looking at "thinking-in-action" (Benner *et al.*, 1996) for critical care nurses in advanced practice. Tanner's (2006) review of the clinical decision-making literature in nursing presents a comprehensive model of clinical judgement that incorporates the language and concepts of the corpus. However, thinking-in-action and clinical judgement are still more about problem solving (to a degree of complexity) one thing for one patient at a time, rather than concurrent interactions with multiple facets of a patient's care as was observed that day. While concurrent interactions within and between multiple patients as per the usual daily acute care caseload, let alone the many other "within and betweens" (with other issues, other workers, and/or policies, protocols and what the patient has done) are not able to be addressed at all.

In daily nursing practice it is difficult to see how these models have meaning. Where, in those few minutes of observation, could one say that Glenda made a decision and what was it: to not give the intravenous antibiotics on time?, to take down the dressing before breakfast?, to catch the doctors before they moved on so that a decision could be made about the Vac?, to sidestep the mandated practices of wound care?, to give Ross his breakfast before the clinical imperatives of wound dressing and intravenous antibiotics? Her expressed reasoning was only that she "had to do that then because otherwise they wouldn't have come back". A meaning for this might be made from Rolfe's (1997) instance of moving beyond the problem-solving process norm to argue from abduction reasoning. He presents an example of a nurse surmising that providing an anxious patient with too much information prior to surgery could increase their anxiety and prove detrimental, and so she provides less. Glenda's "pushing" of the junior doctor also approaches this way of thinking, as, if the GIK infusion is restarted, this is a retrograde step in relation to Ross' progress towards his discharge. However, this does not cover the element of "bringing up to speed" that was also contained in Glenda's interaction with Humboldt.

Other scholars also explore beyond the usual paradigm. For instance, one study (dela Cruz, 1994) describes nurses' styles of assessment as surveying, skimming and sleuthing, but this also bears no relationship to what Glenda did, moving from one thing to another without appearing to assess the situation at all. A Canadian study

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(Boblin-Cummings *et al.*, 1999) reports that nurses make discretionary decisions about resources, including how much nursing time and nursing effort to put into a patient's need for care; here again, it is difficult to see Glenda's flowing in-the-moment actions as distinct decisions.

What is apparent is that attempting to fragment Glenda's actions into "decisions" limits the potential to make meaning of the interactions, effectively illustrating Bourdieu's (1977) contention that conceiving of practice objectively as mere execution "gives only very imperfect mastery" (p. 25) of what is actually happening. Breaking down the various aspects into discreet elements also obscures both the overall context and the complexity of the unfolding situation. To paraphrase Aristotle: the sum of the parts is (a lot) less than the whole.

Further studies describing concepts of embodied knowledge (Brykczynski, 1998) and practice wisdom (Benner, 2000) also attempt to move beyond the clinical reasoning paradigm to present nursing as having professional knowledge. Other nurse scholars (e.g. Johns, 1995; Rolfe, 2000) continue to build on Schön's (1983) work on professionals thinking-in-action through reflective practice. Tanner's (2006) model of "clinical judgement" incorporates the concepts of both reflection-in-action and reflection-on-action. But as examples of reflection-in-action, Glenda's comments during the observation are more narrative than reasoning as she tells (some of) what's in her thoughts as she works. And again, her "to the point" comments in the follow-on conversation are not reflection-on-action in the usual sense of the term.

Glenda's fluidity of movement and activity is mirrored in a small section of a study positing "knowledge as action *in* practice" (Purkis and Bjornsdottir, 2006, p. 247), where a nurse retrieves the situation for a patient with low blood sugar in the community. However, the positioning of the nurse as a "knowledge worker" (p. 255) activated by contextualised knowledge remains within a philosophy of consciousness (i.e. knowledge rather than reasoning). In this study, as with Parker's (1997) discussion of temporalities and ambiguous spaces as potential places for nurses to work the in-betweens, context is seen as central. But the internal dynamics of "the space where everything is happening at once" (p. 16) are adjunctive to nurses' practices in both approaches.

On the other hand Bourdieu's (1977, 1990) theory of practice is able to explain the relationship of the "structuring structures" (Bourdieu, 1989) of the field with the actions of the nurse and thus illuminates the intricacy of the "embodied knowledge" that was apparent to a knowledgeable observer of Glenda's actions for those few moments of practice. The following has resonance:

> The theory of action that I propose (with the notion of habitus) amounts to saying that most human actions have as a basis something quite different from intention, that is, acquired dispositions which make it so that an action can and should be interpreted as oriented toward one objective or another without anyone being able to claim that objective was a conscious design […] The best example of such a disposition is without doubt the feel for the game: the player, having internalised the regularities of a game, does what he must do at the moment it is necessary, without needing […] to know consciously what he does in order to do it […] (Bourdieu, 1998, pp. 97-98).

This last sentence in particular seems to be best able to encapsulate what was seen that morning in the hospital ward. Glenda's "acquired dispositions" work with, and around, the "regularities of the game" to produce the effects she (infraconsciously) desires. Knowing that Ross needs to progress towards what is "normal for him", and that the technology of hospitalisation should be gradually reduced, she presents the wound to

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the doctors, then later redirects the junior doctor's attention. However, her adaptation of the regularities of wound care works around (rather than with) the doxa of the field. This also remains beneath her "conscious design", with Glenda using only the word "quick" to describe the interaction. Bourdieu (1990) describes such *illusio* as a logic of practice observed in "the intentionless invention of regulated improvisation" (p. 57).

At the same time these acquired dispositions reproduce the field in that the symbolic power of the doctors and the doxa is not overtly challenged. Bourdieu (1977) makes the case that "through the habitus, the structure which has produced it governs practice" (p. 95), or as Thomson (2008) puts it: "In other words, *field* and *habitus* constitute a dialectic through which specific practices produce and reproduce the social world that at the same time is making them" (p. 75).

But also through Bourdieu's lens the notion of patient discharge as a/the structuring structure of the field begins to emerge from the data as a key concern of the game. This concern relates to "the economically driven demands for shorter length of stay and throughput of patients" (Parker, 1997, p. 16) of contemporary healthcare. It is particularly evident in Latimer's (2000) work where nurses are figured as conductors of care, and acknowledged as the "technologies of bed utilisation" in Rankin and Campbell's (2006) institutional ethnography approach.

In the observation all the various players (Ross, the doctors and the nurse) demonstrate differential investment in this key concern, which manifests according to the player's symbolic power in the field. Ross would rather not be in hospital and is likely to continue to have difficulties in the community. The doctors favour the high-technology treatment options, commonly arguing for up-to-date practice while contributing to higher costs. Meantime, as the/a nurse, Glenda is expected to practice in line with the written policies and protocols of the organisation, carry out the treatment orders and facilitate Ross' discharge in accordance with contemporary health care demands, doctors' plans, and Ross' abilities and expectations.

Conclusion

This paper presents a counter argument to usual explanations made in the nursing literature about how nurses practise through being a cognitive artiste who is adept at multi-skilled reasoning. While such cognitive expertise in decision making is based on clinical knowledge and skills, it remains isolated from the field in a bubble of thinking. Bourdieu's (1977, 1990, 1998) theory of practice allows a view that is embedded in the context of clinical practice, not only illuminating the practices of a/the nurse but also revealing how complex are the interactions of nurses' practices so that they obtain the required work within and between everyday patient care in acute care hospital wards.

Contrasting the approaches highlights not only the intricacy of nurses' practices, but also the dialectical nature of nursing practices in unfolding situations. Using the theory of practice (Bourdieu, 1977, 1990, 1998) these are shown to be both responsive to and adaptive within the expectations and constraints of the practice arena. This is not available in the more usual approaches to making meaning of nursing practice as clinical judgement, where attention to "expertise" discounts everydayness and the authority of the practice context. Although over the years scholars have developed increasingly complex explanations, the emphasis on the nurse as a skilled thinker tells only fragments of how nurses nurse patients. As Bourdieu (1998) neatly puts it: "There are quite paradoxical situations that a philosophy of consciousness precludes us from understanding" (p. 83).

This account of ten to 15 minutes observation with Glenda is still only an account of one nurse with one patient for a few moments of her day and makes no attempt to

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speak to the rest of her workload (except as she mentions what she will do next while Ross has his breakfast) or the rest of her workday. However, through Bourdieu's lens, it is an illustration of how nurses work with multiple aspects of patient care in the field – as a pivotal player of the game. In this framing Glenda's *illusio* works not only within and between Ross' needs for care but also within and between the players and the rules of the game of shorter hospital stays and the flow through of patients no matter how complex their issues. It is common to portray that doctors organise hospitals and patient care; through the lens of Bourdieu's (1977, 1990, 1998) theory of practice, this paper instances how nurses go about organising doctors, patients and the system in their everyday work.

Notes

1. The sluice room is the room where unclean and/or contaminated things and material are either cleaned, sent to be cleaned or otherwise disposed of.
2. Obs is the nurses' common word for observations. To "do the Obs" means to record the patient's vital signs (i.e. signs vital to life). These usually include temperature, heart rate, blood pressure, breathing rate, and blood oxygen levels.
3. Full nursing care means that the patient requires full assistance with all personal care such as eating and drinking as well as toileting and personal hygiene.
4. TrendCare is the proprietary name of the computer programme, widely used in Australasia for workforce planning and workload management, that records and monitors the amount of time a nurse spends with a patient using data entered by nurses.
5. The policy of this facility specifies that intravenous antibiotics are to be given at the prescribed time; the rationale is that this maintains blood levels, and therefore efficacy, of the antibiotic.
6. Insulin is given as a subcutaneous injection, enabling sustained release of the medication, which starts to take effect within half an hour of administration.
7. Vac dressing is the common name for a complicated type of wound care product where a specially absorbent padding is sealed against the wound bed and a vacuum applied with a portable suction pump.
8. The main supply of "blueys" is kept in the linen room, however, this is a door further down the corridor, while the bathroom stocks only a few but is closer.
9. A bluey is the nurses' name (at this facility) for the blue backed incontinence pad: impermeable on the blue side and absorbent on the other.
10. GIK, pronounced gick, is the acronym for Glucose/Insulin/Potassium (K is the chemical symbol for potassium). These are combined in an intravenous infusion for use with or the treatment of hospitalized patients with diabetes when the patient's diabetic state is unstable or likely to become unstable.
11. Combine refers to a gauze covered absorbent cotton dressing pad that comes in different sizes.
12. Yellow rubbish bags are used to dispose of all potentially infected material except sharp objects.
13. A "proper hand wash" is the phrase used in the study to describe a hand wash at a basin using anti-bacterial skin cleanser to wash and paper towels to dry, in contrast to the more common "dispenser hand wash" which applies only alcohol based bactericidal lotion.

14. To “do TrendCare” is to enter the patient data for the morning shift so far, while “my button” is Glenda’s affectionate allusion to the 100-year old patient.
15. Infection prevention and control is central to providing high-quality health care for patients and a safe working environment for those that work in healthcare settings […]. Healthcare-associated infection (HAI) is a potentially preventable adverse event rather than an unpredictable complication. It is possible to significantly reduce the rate of HAIs through effective infection prevention and control (National Health and Medical Research Council, 2010).
16. These latter two questions are what nurses work with after hours to maintain satisfactory blood sugar levels as a diabetic patient’s home routine is re-established, so Glenda is “checking” whether Humboldt has thought of these things.

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About the authors

Sarah Lake has practised as a Registered Nurse in the acute care hospital setting for more than 30 years. She has published in the clinical decision-making literature and is currently enroled as a PhD Candidate at the Sydney Nursing School. Sarah Lake is the corresponding author and can be contacted at: Slak9234@uni.sydney.edu.au

Dr Trudy Rudge is a Professor of Nursing with a Chair in the Social Sciences and Humanities at the Sydney Nursing School, The University of Sydney, and publishes in the organisation of nurses' work and workplaces.

Sandra West has practised as Registered Nurse in acute and critical care settings. As an Academic Researcher she is especially interested in social understandings of nurses' shift and night work and how the nursing workplace is constituted within current health care contexts.

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