Nothing Personal? Narrative Reconstruction of Registered Nurses' Experience in Healthcare Reform

by

Gail Margaret Lindsay

A thesis submitted in conformity with the requirements For the degree of Doctor of Philosophy Department of Curriculum, Teaching and Learning Ontario Institute for Studies in Education of the University of Toronto

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Doctor of Philosophy
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University of Toronto
2001
Abstract

My research is an inquiry into how it matters to explore Registered Nurses' experience in healthcare reform through narrative reconstruction autobiographically and biographically with other nurses. Narrative inquiry, a phenomenon and method that informs nursing praxis (being-becoming, knowing, and doing), is ontologically related to shaping nurses’ identity and is concerned with epistemology, nurses’ knowledge. A comparison and contrast to phenomenological research in nursing education reveals how narrative inquiry contributes through the inclusion of the researcher with co-participants in the construction of identity and knowledge in three dimensional space. Individual and social aspects of experience, temporality, and place are considered. Examination of plotlines in healthcare reform literature and research reveals only the negative effects of restructuring and includes top-down strategies. In contrast, seven co-participants in my inquiry illuminate the healthcare professional knowledge landscape through their stories of experience. The notion of liminal space, holding paradox in-between stories, is explored. Sasha, a co-participant in my inquiry, is a nurse in clinical practice who is also a student in a BScN program. How it matters to have a story to live by in healthcare environments undergoing many changes is shown through Sasha’s reflection on and reconstruction of experience through two years of conversations. Narrative inquiry offers nurses a way to think about their experiences, to reflect in relationship, and to discern future possibilities for reform that is inside-out, grounded in daily life. How my inquiry matters to nurse-teachers and to nursing education at the university is presented through conversation with three colleagues at a reading luncheon. My inquiry deepens and new questions emerge related to nursing education and nursing praxis embedded in the relationships between nurses and their social situations.
Acknowledgements

Bohdan and Paul Dubniak, sustaining on all planes of existence.
Krissty Lindsay, who reminds me that I am embodied too.
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Bev Brewer, dear friend who is still here at the end.
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My co-participants, my gratitude and appreciation is unbounded.
Moira Lynch, a scholarly sleuth.
Friends and colleagues at the Centre for Teacher Development, OISE/UT and at York University, School of Nursing who listened or read and entered into my inquiry to say how it matters, deeply appreciated communities.
My thesis committee, Professor Connelly, Professor Rogers, Professor Kilbourn.
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Jeanie Stewart and Dr. Rose Steele, who said “make it so” and my thesis was formatted and edited.
Professor Nehls and Professor Diekelmann, who offer me a home in nursing scholarship.
Foreword

A letter to my readers

January 21, 2000
Dear Nurse-Teacher Colleagues,

Thank you for being a reader of my research in which co-participants and I explore and reconstruct our experiences in healthcare reform. As colleagues, you are the audience in my mind as I write my thesis: You further my inquiry as your personal and professional experiences of being a nurse and choosing to stay in our profession intersect with co-participants' and my stories in a changing world. For as Dewey says, "all reflective thinking is a process of detecting relations" (1933/1998, p.77).

Beginning my thesis work in 1997, based in Connelly and Clandinin's (1999) narrative inquiry, I had few stories to tell myself to live by and to shape my identity as a nurse-teacher. My inquiry grew out of profound separation from my experience in the world. I questioned if I should stay in nursing and how I could teach nurses and nursing students without understanding the experience of nurses, including my own.

Because this is a narrative inquiry, puzzles or dilemmas are presented over time and through intermingling stories of experience. My purpose is to explore what is happening to specific nurses in their particular situations and to understand how this knowledge informs daily practices and nursing curriculum. What questions arise in you as our narratives touch? Have you lived in liminal space between stories? What resonance do these stories have in your life? And if reconstructed, what possibilities of reform from-the-inside-out is revealed?

Ultimately, Paley (1997) reminds us, it is the reader who interprets the writer. My hope is that my inquiry makes a difference to you in how you teach and learn which has consequences for nursing students and the people they care for. I would be delighted to hear from you and can be reached at the School of Nursing, Room 406, Atkinson Faculty of Liberal and Professional Studies, York University, 4700 Keele Street, Toronto, Ontario, Canada; M3J 1P3 or through email at (glindsay@yorku.ca). Yours in nursing,

Gail Margaret Lindsay R.N., B.Sc.N., M.S.N., PhD(c)
Assistant Professor
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<tr>
<td>AERA</td>
<td>American Educational Research Association</td>
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<tr>
<td>BScN</td>
<td>Bachelor of Science in Nursing</td>
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<tr>
<td>CNA</td>
<td>Canadian Nurses Association</td>
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<tr>
<td>CNO</td>
<td>College of Nurses of Ontario</td>
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<tr>
<td>FCC</td>
<td>Family-centred care</td>
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<tr>
<td>HBHC</td>
<td>Healthy Babies, Healthy Children</td>
</tr>
<tr>
<td>HBP</td>
<td>Healthiest Babies Possible</td>
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<tr>
<td>HN</td>
<td>Head Nurse</td>
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<tr>
<td>JPNC</td>
<td>Joint Provincial Nursing Committee</td>
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<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
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<tr>
<td>NP</td>
<td>Nurse Practitioner</td>
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<tr>
<td>NRU</td>
<td>Nursing Effectiveness, Utilization and Outcomes Research Unit</td>
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<tr>
<td>OISE</td>
<td>Ontario Institute for Studies in Education/University of Toronto</td>
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<tr>
<td>ONA</td>
<td>Ontario Nurses Association</td>
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<tr>
<td>PHN</td>
<td>Public Health Nurse</td>
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<tr>
<td>PLA</td>
<td>Prior Learning Assessment</td>
</tr>
<tr>
<td>Post-BScN</td>
<td>Completed university nursing education; eligible for RN exam</td>
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<tr>
<td>Post-RN</td>
<td>Completed diploma nursing education and RN exam</td>
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<tr>
<td>QNWRL</td>
<td>Quality of Nursing Worklife Research Unit</td>
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<tr>
<td>RHPA</td>
<td>Regulated Health Professions Act</td>
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<tr>
<td>RN</td>
<td>Registered Nurse</td>
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<td>RNAO</td>
<td>Registered Nurses Association of Ontario</td>
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<td>RNEC</td>
<td>Registered Nurse Extended Class</td>
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<tr>
<td>RPN</td>
<td>Registered Practical Nurse</td>
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<tr>
<td>RPNAO</td>
<td>Registered Practical Nurses Association of Ontario</td>
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<tr>
<td>RR</td>
<td>Recovery Room</td>
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Dedication

To my Mom
I hope life was enough;
You gave me a chance to say who I was.
Prologue

Change and Restructuring: Reconstruction and Reform

Bev, my thesis writing partner, and I went to the American Educational Research Association (AERA) conference in San Diego in April 1998. Midway through the week, I took a field trip by trolley, 13 stops from the downtown Convention Centre. Restless and vaguely distressed, I rode up into the hills, got off at a mall, walked around without shopping, and had lunch by myself. On the way back to an afternoon session, I wrote in my journal the following experience:

Feeling insecure as the landscape changed from downtown, manicured gardens to suburban industry, tire yards and homes with bars on the windows, I noticed people as they came into the trolley car. Looking through the window at one stop, I saw an elderly woman stooped over her walker and wearing wool leg warmers. As the wheelchair door of the trolley remained closed, she shuffled towards the open door with the stairs. I debated getting up to help her and wondered how long the driver would wait.

A young woman behind me reached over the stairs and lifted the walker into the trolley car. I thought the young woman was kind to do so and was glad the older woman had been helped without my involvement. Then the old woman began to talk loudly, shouting words rather than sentences, related to trolleys and time and where she was going. The young woman gently answered with monosyllables of acknowledgement. Sinking into my bench seat, I realized I did not want to engage with this old woman at all. I am so tired. (Journal, April 1998).

Happy to be alone and physically quiet while writing in my journal, I wondered what kind of nurse that made me? Equating my avoidance of this woman with my not wanting to be in the messiness of clinical practice, I wondered how I can be connected with the nursing students and Registered Nurse (RN) students in the university classrooms where I worked as a sessional teacher? What is my nursing practice? How is my practice expressed in my teaching/learning process? These questions are a tension alongside my dilemma about whether or not I am in a different world than my students.
Re-entering the conference too late for the session I had planned to attend, I joined another session that was nearing completion. The topic was the viability of the professions and the need for professionals to connect to larger social issues. I listened to a man who questioned how to get others into teaching so their issues can be part of policy-making and change. I interpreted that to mean that the professions cannot be inclusive or work for change until people with differences come into the professions. Those of us without issues, who are not different, can presumably continue as we are. Wanting to judge the man and yet recognizing his point of view, I thought about my afternoon on the trolley. If I am most comfortable with people like myself, how do I learn not to be afraid and to have relationships with people who are not like me? How does it matter that nurses make connections to larger social issues in their practice?

Thinking of these questions as I emerged from the session, I headed for the washroom. Coming out of the cubicle to wash my hands, I noticed an Hispanic woman in a black and white maid’s uniform as she wiped the sinks and counters. Idly wondering about her life and what she might be thinking about the conference participants, I watched as she emptied the garbage bin that was built into the wall under the towel dispenser. She leaned into the bin and, bare-handed, pulled garbage out in clumps and put it in a big garbage bag on a trolley. Turning off the water tap with a paper towel, I felt horrified by the health risks this woman was taking by virtue of her work, work which made things more pleasant for conference-goers. Wondering if I should say something to her about protecting herself, I headed to the next session. All the small meeting rooms in the area were being dismantled to recreate the ballroom for the presidential address. Black and Hispanic men, wearing t-shirts with the hotel insignia on the chest, stacked chairs, folded tables, and retracted walls. White men in red hotel blazers came to observe every so often, briefly said something to one of the working men, and left.

Watching these social relationships at play and my responses to them, I thought about my thesis that explores nurses’ experience in reform. I meant healthcare reform, which in my Ontario nursing experience was hospital restructuring. Connecting people, places, and events from that afternoon, I began to think about nurses and social reconstruction in contrast to organizational restructuring. The work of the woman in the washroom and the labour of the men in the meeting room are necessary for the
conference to proceed. Yet this work is not mentioned or celebrated with gratitude. The racial difference between the hotel staff and conference participants was sharply drawn. Becoming aware of these features of the afternoon underlined my thinking about social reconstruction. I was not thinking of activism or critical social theory as much as narratively linking my daily experience to questions of social significance. I was beginning to understand how my thesis inquiry about nurses’ lives, foregrounding experience and its reconstruction, was connected to a social world, a way of being, and to the construction of knowledge.

My thesis supervisor, Dr. Connelly, drew my attention to how the terms change and reform were at play in my thesis writing. Opening The Concise Oxford Dictionary (Thompson, 1995) on my return home from our early Tuesday morning meeting, I looked up change, restructure, reform, and reconstruct. ‘Change’ is to make or become different (p. 218); ‘restructure’ is to rebuild, rearrange, give new structure to (p. p. 1175); and, ‘reform’ is to make or become better by removing faults or abuses especially of moral or political kind, to form again (p. 1154-5). The meaning of ‘reconstruct’ is to form a mental or visual impression of past events by assembling the evidence for them, re-enact, reorganize, build, or form again (p. 1148). Given these distinctions, I see that what nurses call ‘healthcare reform’ to describe downsizing in healthcare institutions is really organizational restructuring involving many changes. My work is not in critical social theory, nor am I precommitted to emancipatory social action (Thorne & Hayes, 1997). My work resists theoretical overlay that predetermines how to interpret experience.

Reconstruction of Registered Nurses’ experience in healthcare restructuring explores how the emergent identity and knowledge construction is personal reform and how that is significant in terms of a nurse’s being-becoming, knowing, and doing—my definition of nursing praxis (1). Praxis as being-becoming, knowing, and doing is a theory-practice dialectic. My commitment is to my own and others’ learning to transform action and, in my view, to make a difference in the world.

Before concluding this prologue, I present scenes of changes in the healthcare system and nursing responses from the years 1988 to 2000 to set the stage for exploring the healthcare landscape. This will situate readers in the events and temporal cycles of restructuring that have happened in Ontario, although many of the initiatives are national.
and in some cases North American in scope. The time period begins in 1988 with studies of a nursing shortage and financial policy changes. Reform, as improvements in the healthcare system, are hinted at through policy statements, but are not realized by the year 2000. This prologue sets the stage for my inquiry about reform from-the-inside-out for Registered Nurses.

In 1988, the nursing union, professional association, and hospital council in Toronto all studied nurses’ working conditions and literature on nurses’ job satisfaction (Frisina, Murray, & Aird, 1988; Goldfarb, 1988; Meltz & Marzetti, 1988). These studies were in response to nurses leaving their workplaces for other occupations or electing to work only part-time in nursing. Dissatisfaction with worklife conditions and nurses’ perceptions of negative impacts on patient care were consistently documented. Recommendations from these reports to ameliorate nurses’ concerns were: improve salary levels and grids, premium wages for specialty care, self-scheduling, job-sharing, and health human resource planning. Research and pilot projects on nurses’ contact with patients, tasks performed, scheduling models, educational support, and nurses’ input into decision-making were also encouraged.

The Advisory Committee on Nursing Manpower tabled a report with the Ministry of Health in 1988 as well. Twenty-four recommendations covered funding, education, inclusion of nurses on decision-making committees, development of health human resource planning, examination of nursing roles and recruitment and retention strategies. In response to these studies, The Honourable Elinor Caplan, Minister of Health, made an announcement to the Legislature in October 1989 acknowledging that quality of nursing worklife needed to be improved. The Minister allocated $15 million over five years for six major initiatives: a nursing innovation fund, educational bursaries with return of service provisions, a nursing co-ordinator position at the Ministry, broadened membership of the Advisory Committee on Nursing Manpower, development of a nursing human resources data centre, and nursing research funding into quality of nursing worklife. All of these were implemented and Pat Bethune R.N., past-president of the Ontario Nurses Association, was named as the first Nursing Co-ordinator.

The Quality of Nursing Worklife Research Unit (QNWRU) was established between the Faculty of Nursing at the University of Toronto and the School of Nursing at
McMaster University in Hamilton (O’Brien-Pallas & Baumann, 1992). The framework for the research was stated as a “theoretical model (which) attempts to explore and establish links between the level of the individual nurses’ experience, the institutional context of work, and features of the broader health care system” (p. 12). The content of nurses’ work, women’s issues, the impact of the media and intra/interprofessional relations on that work constituted the experience being investigated. Recruitment and retention of nurses and the means to enhance both were the foci of this research unit.

The nursing shortage also affected physician practice. “Almost every physician has been affected by the declining availability of nurses because the decline translates into closed operating rooms and fewer intensive care beds and unacceptable delays for our patients” said Dr. Newman (1990, p. 127), a specialist from a downtown Toronto teaching hospital. He proposed that nurses are leaving their profession due to disrespectful treatment by nursing administrators. Dr. Newman’s final point in his letter to his professional association journal was that “nurses are nurses because they want to nurse. However, this relatively simple statement seems beyond the grasp of the profession’s leaders—perhaps they became leaders because they didn’t want to nurse” (p. 128). At the same time that Dr. Newman worried about a nursing shortage, funding policy changes were announced that would further restructure his practice environment.

“In 1988/89, total health spending absorbed 8.79% of G.D.P. (Gross Domestic Product) compared to 7.3% in 1970….Additional expenditures on health care will not necessarily result in improved health status….combined with government debt levels that have not been seen since the early 1950s, provincial government strategies call for restructuring of our healthcare system” (Roch, 1992, p. 8).

In 1990, the Canadian government passed the Expenditures Restraint Act (Bill C67) to reduce federal transfer payments to the provinces for health, education, and welfare programs (2). The Canada Health Act (1984), with its provisions for accessibility, comprehensiveness, universality, portability, and public administration, had been enforced by central government funding and the new schedule of multi-year reduced payments lessened the pressure on provinces to consistently implement Medicare. Change was afoot in the early 1990s that would rearrange the healthcare system.
Bill C67 had a cascading effect over the decade. Partly in response to reduced federal health dollars, the Ontario government downloaded 100% of the costs of public health to the municipalities (while still mandating services) through Bill 152: An Act to Improve Services, Increase Efficiency, and Benefit Taxpayers by Eliminating Duplication and Reallocating Responsibilities Between Provincial and Municipal Governments in Various Areas and to Implement Other Aspects of Government’s “Who Does What” Agenda (Armstrong & Armstrong, 1999). For reasons not totally clear, in January 1999 the Ontario government reinstated 50-50 cost-sharing with municipalities for public health. This instability of funding policy in all sectors of healthcare affects people who need care and those who work in the system. The impact of decreased and unstable funding in healthcare does not create something better, something that could be called reform.

One earlier attempt at healthcare reform in Ontario was the establishment of the Premier’s Council on Health Strategy. In 1991, the Healthy Public Policy Committee of the Premier’s Council created a discussion paper on the determinants of health called Nurturing Health. Recommending action on healthy child development, adult and labour market adjustment, and environmental policies, this report linked individual health to social and physical environments. “The research is described in a framework that recognizes the dynamic interplay of many factors and extends our understanding of health beyond a traditional focus on the health care system” (p. 20). Given the values of inclusivity and connectedness in this work, I see the groundwork for reforming the traditional healthcare system. Making the system better would require downsizing the acute care sector while integrating it with and expanding the community-based healthcare system.

Unfortunately, as Rachlis said, there is “not a lot of evidence that real health policy reform is occurring in Ontario. We are certainly seeing cuts in the illness treatment sector but we’re not seeing the reallocation of funding from treatment to the promotion of health and disease prevention. We are also not seeing structural reorganization of the delivery system” (Rachlis in Bannerman, 1993. p. 17).

In the first third of the 1990s, it was clear that health dollars were decreasing. What was less clear was how a focus on population health, at regional and local levels, based on the
determinants of health, might reallocate resources. The Nursing Roundtable (1994), advisory to the Minister of Health, recommended several strategies to deal with the impact of hospital downsizing, including development of a health human resource plan, labour adjustment strategies, public education, and appointment of nurses within the Ministry of Health. While understandable that the Roundtable would be concerned with nurses who were being redeployed, there is no evidence of reform recommendations.

How were nurse-teachers and nurses in practice, largely in hospitals, preparing themselves for a restructured and, perhaps reformed, healthcare system? Alice Baumgart, at the College of Nurses of Ontario (CNO) Annual Meeting in 1994, commented that “health care in Canada is really being re-invented” with “three separate but related streams of development in regard to nursing work” (p. 27): the (primary care) nurse practitioner role, the advanced practice Nurse Practitioner role which is consolidated with Clinical Nurse Specialist education at the Masters level, and a rapid proliferation of specialty units and clinics in hospital settings. Two of the three streams for nursing discussed by Dr. Baumgart are expanded roles and specialty practice, largely situated in hospitals. How is nursing development congruent with the direction that the healthcare system is moving? How are changes in nursing education and practice changing the system?

After years of lobbying government, good news for some nurses came in February 1998 when the Expanded Nursing Services for Patients Act, 1977 (Bill 127) was proclaimed by the provincial government in Ontario. This legislation amends the Nursing Act to recognize the expanded role of primary care nurse practitioners through the creation of an Extended Class Registered Nurse. The primary care Nurse Practitioner is educated at the baccalaureate level with an integrated Bachelor of Science in Nursing/Nurse Practitioner (BScN/NP) program or with a Post-BScN Nurse Practitioner certificate. Nurse Practitioners have three new controlled acts: communicating a diagnosis, ordering diagnostic ultrasound, and prescribing drugs listed in the regulations. Action is still needed, however, on funding and employment opportunities for Nurse Practitioners (N. Cross, Coordinator NP Program, personal communication, July, 2000).

By the middle of the last decade of the twentieth century, fundamental changes in healthcare delivery was occurring in tandem with organizational restructuring in acute care
institutions. Between 1990 and 1995, hospital stays in Metropolitan Toronto had decreased by 20%,
day surgery increased from 53 to 70%, and 3500 acute care hospital beds had closed. This meant
that scarce dollars were being spent on overhead and infrastructure of 44 health facilities that were
not functioning at capacity (MTDHC, 1995).

The Metro Toronto District Health Council (1995) recommended changes to the
healthcare system in Toronto such that 32 health facilities and 3 ambulatory care centres
would remain open. Consolidation and clinical integration of teaching hospitals (three
adult and one pediatric), expanded rehabilitation services, reduced emergency
departments and continuing care beds, with a concomitant increase in long-term care
facilities, and expanded respite and palliative care services were specifically suggested to
the Ministry of Health. This report estimated that 23% of the hospital workforce would
need to be redeployed during the transition.

By January 1996, the Ontario government passed the Savings and Restructuring
Act which created the Hospital Services Restructuring Commission to oversee healthcare
reform. This arm’s length agency was accountable to the Minister of Health and worked
with local District Health Councils to implement their hospital restructuring reports.

In the end, 35 hospitals—about one in six across the province—were
ordered closed. The mergers and closures have had major consequences
for services such as home care and long-term care. Although the
Commission’s orders were based on the assumption that such other
services would be in place, the Commission lacked the power to ensure
these other services would be available before the hospitals disappeared

The Restructuring Commission, upon completion of its work, advised the
Minister of Health that:

An effective primary healthcare system does not exist in Ontario
today....Although there are many dedicated primary care providers who
serve the population, healthcare is fragmented, unstructured, and not part
of an integrated and coordinated healthcare system...much of the activity
to date aimed at improving the healthcare system has related to hospital
services (HSRC, 1999, p. ii).

Reform, in terms of making the healthcare system better, has not yet occurred.

Concurrent with a surplus of experienced nurses created by hospital restructuring,
the funding for the Quality of Nursing Worklife Research Unit ended in 1996. The final
report did not distinguish between organizational restructuring and healthcare system reform. Reform was defined as "innovative programs, restructuring hospital/community interface, re-engineering of hospital systems, and care management" (QNWRU, 1996, p. 2). No studies were done on how nurses’ experience and knowledge might contribute to healthcare restructuring, reform, and/or recruitment and retention of nurses in the five years 1991 - 1996. Studies were done on and about nurses, but not with nurses as co-inquirers or knowledge-makers. The co-investigators of the QNWRU proposed a renamed Nursing Effectiveness, Utilization and Outcomes Research Unit (NRU) to the provincial government. Funded by the Ontario Ministry of Health from 1996 – 2001 for $1.75 million, research is underway that focuses on the design, management, utilization, outcomes and provision of nursing (NRU, 1998). The NRU (1998) fact sheet reflects an 11.2% decrease of RNs in hospitals, with a further 10% decrease predicted. Only half of the RNs were in full-time work (55%) in 1997, as compared to two thirds (63.7%) in 1985. The concern about nurses shifted from defining healthy workplaces to justifying RN employment through efficiency and outcome measures.

The Canadian Nurses Association (CNA)(1998a,b) stated there is a ‘quiet crisis’ in healthcare because the public and government do not seem to know of the nursing shortage created by healthcare restructuring. This claim seems refuted by the federal Minister of Health, the Honourable Allan Rock’s speech in June 1998 at the CNA convention:

Let me begin by acknowledging some hard facts. I think it is best to be blunt. No professional group has borne the brunt of healthcare restructuring more than have Canada’s nurses. You have seen widespread lay-offs. Those who remain face increased workloads. Too many have had to cobble together a series of part-time assignments just to forge a career, to support themselves and their families. And just as sad as the loss of job security, has been the diminished job satisfaction as it becomes harder and harder to feel like a valued member of the team when your work does not seem valued and when your teams have been disbanded (C.N.A., 1998a, p. 2)

At the same meeting, the Honourable Monique Begin, the former Minister of Health who introduced the Canada Health Act, said:

The first observation is that the restructuring of the health care system in our provinces was done—and is still done—on the backs of nurses. In the last years, it is mainly—almost only—nurses who have lost full-time
employment and income and worse in my opinion, who are witnessing the
deprofessionalization of their occupation....Nurses are overworked,
stressed and burnt out; as employees, there is no way they can be
committed to several employers the way full-time employees are to one
employer; and not just quality of care but safety of care becomes an
issue.....If care is fragmented, it is lost, for the very notion of caring is
about the whole person, both from the patient and from the provider
viewpoints, and the relationship between them. Quality care requires both
time and continuity (C.N.A., 1998a, p. 3).

The analysis by C.N.A. continues:

In human terms, the cost of restructuring the health care system has been
high, both for nurses and their patients. At the moment, the prospects for a
secure and rewarding career in nursing appear dim. Many experienced
nurses are leaving their profession and many newly trained nurses are
leaving Canada. Those who do stay are often demoralized and
“casualized” (C.N.A., 1998a, p. 3).

Recommendations from the C.N.A. on behalf of the nurses of Canada and their patients
include: implementation of recruitment and retention strategies, research on patient care,
quality of life and human resources, and establishment of evidence-based nursing
knowledge networks.

The Honourable Elizabeth Witmer, Ontario’s Minister of Health, announced in
September 1998 that a provincial task force would be established:

to examine nursing services in Ontario with a view to identifying how
changes in the profession have affected patient care and how the health
system can be improved...this announcement builds on the Harris
government’s ongoing commitment to nursing, which to-date includes the
creation of more than 7,000 new nursing positions, more than $300
million in direct reinvestments in specialized acute-care hospital
programs, and proclamation of legislation recognizing nurse practitioners.

No mention was made of the government policies and funding decisions that had created
the situation. The announcement also positions nursing services as the source of
healthcare changes.

By January 1999, the Nursing Task Force released its report “Good Nursing,
Good Health: An investment for the 21st Century.” The short-term (six months or less)
recommendations asked for:

- $375 million dollars to create new full-time, front line nursing positions across
  the healthcare system, including nurse practitioners

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participation of RNs and Registered Practical Nurses (RPNs) in corporate and operational decision-making about patient care, including a senior management level nurse accountable for professional nursing resources

$1 million annually for research for a nursing resource database to address skill mix and client outcomes

employers to create pilot projects to test alternative models of nursing care in relation to client outcomes and the working environment

home nursing services' remuneration inequities be addressed, and

the creation of a comprehensive marketing and communication plan to encourage young people to choose a career in nursing.

Medium-term strategies (6 to 18 months) included:

- development of a comprehensive method of funding nursing services which is responsive to the changing needs of healthcare consumers, based on performance standards for quality outcomes, and based on health information systems
- include healthcare consumer status, nursing interventions and client outcomes in information systems
- make the BScN the entry to practice level of education in the year 2005
- lengthen the RPN program to four semesters of college education
- remove barriers and create incentives for partnering between universities and colleges for nursing education, and
- monitor the implementation of these recommendations through the Joint Provincial Nursing Committee (JPNC)

I notice how similar the short-term recommendations are to the ones made in the late 1980s in response to nurses leaving the healthcare system. The medium-term strategies relate to the evidence-based thrust of most of the research done by the Nursing Research Unit at the University of Toronto and McMaster University, and to nursing education. Nurses are still asking to be part of the policy environment, even after all the system went through in the 1990s in response to fiscal policies and organizational restructuring.
"The work environment in 1998 is different than that observed in 1988" (O'Brien-Pallas & Baumann, 1999, p. 13). In 1988, nurses chose to work part-time in response to worklife issues and hospitals were working towards a higher skill level in staffing. In 1998, "there are a large proportion of young nurses working part-time or casual and this is not by choice. Employers, in response to financial restraint, are terminating employees and offering part-time and casual appointments to save the cost of benefits" (p. 13). The imbalance in correcting the situation again has hospitals as the primary worksite for nurses while most patients are in and out quickly and needing care in their homes and communities. Clearly, there is no integrated policy direction for healthcare reform and for human resource planning.

In March 1999, the Honourable Elizabeth Witmer undertook a series of announcements that responded to the Nursing Task Force (Witmer, 1999a, b,c). The provincial government would give money to fund Nurse Practitioners, community, and long-term care nurses, establish a skills update (educational) fund, require employers to have senior nursing positions in their management structures, and implement the BScN entry to practice requirement for the year 2005. These are situational interventions in existing facilities. Nurses got what they asked for, but where is the reform? How is the system better if the community care sector is not enhanced?

The Registered Nurses Association of Ontario (RNAO) (1999) responded to the Minister's announcements with an analysis that found the government's increased funding investments on a continuum from excellent (for Nurse Practitioners) to insufficient (given demand for nursing services). The Ontario Nurses Association (ONA), the nursing union, responded to the Minister by issuing their own daily press releases (ONA, 1999a, b,c,d). ONA said the government figures do not add up to the new dollars needed, that action on front-line positions is needed immediately and not over the promised two years.

ONA questions the wisdom of a government that has spent approximately $400 million to downsize thousands of front-line care providers and is now trying to bring them back....Where is the Harris government’s plan for health care? These latest Ministry of Health announcements are not enough to address problems in a healthcare system that has driven thousands of nurses out of the profession (1999a).

An Environics poll prepared for RNAO in November 1999 revealed:
three quarters of Ontarians think nurses have more influence than doctors or hospital administrators on the quality of daily hospital care... An overwhelming majority of 84% of Ontarians agree with the statement that nurses are overworked... The survey results confirm there is a strong link in the public's mind between the funding of nursing services and the quality of healthcare that is available... the survey continues to find virtually unanimous support for the suggestion that a certain amount of government funding be earmarked expressly for the promotion of the quality and availability of nursing services (Environics Research Group, 1999, p. 7,9).

The nursing association, the public, and the pollsters are working in the paradigm of hospital based care and illness treatment as central to the healthcare system.

RNAO, in collaboration with the Registered Practical Nurses Association of Ontario (RPNAO), responded to the Nursing Task Force recommendations about recruitment and retention (RNAO & RPNAO, 2000). In order to recruit 60 to 90,000 people by the year 2011 into nursing and to retain nurses in Ontario:

We must establish the policy framework and address the structural constraints that impact on recruitment and retention. The best recruitment strategies for nurses are those that influence the image of nursing and the career choices of young people. The best retention strategies are those that are specific to the health-care organization and are based on extensive staff involvement as a critical source of recruitment and retention information within the organization (p. 9).

The method suggested in this report for consulting with RNs is through nurse role satisfaction questionnaires and exit interviews in health care organizations.

The RNAO/RPNAO recommendations on nursing recruitment and retention acknowledge the embeddedness of nurses in social situations (RNAO & RPNAO, 2000). It is important to recognize that other concerns, besides a shortage of nurses, shape the current healthcare system, a system whose expenditures represent 34% of the total provincial budget. The Chief Operating Officer of a major urban hospital lists the following issues facing the healthcare system: aging of the public, many of whom live with chronic conditions, consumer activism, aging of caregivers, shortages of therapists in rehabilitation and oncology, biotechnical revolutions (pharmacological, genetic, equipment), and information technology infrastructure needs (Guerriere, 1999). To illustrate just one of these issues and its complexity, Dr. R. Filler, a surgeon at The Hospital for Sick Children, documents five components to an information technology
system called Telehealth (Filler, 1999). He names this as “medicine at a distance” that involves real-time videoconferencing with patients and caregivers, or internet-based information transfer such as health databases, community health information networks, telephone triage, and tele-education (p. 68). These issues and developments are part of the same world in which nurses define their identities, knowledge, and actions.

I wonder what nurses working in the healthcare system think of all of this—how they understand what is going on and how they stay working in the system as it undergoes restructuring instead of reform? How would it matter to ask nurses to reconstruct their experience in healthcare restructuring? Based on the reports cited here, and 12 years after the 1988 studies, nursing organizations are still concerned with nursing’s image and shortages. The research is largely quantitative and nurses are consulted mainly through questionnaires. After all these changes and cycles, through all the acute care organizational restructuring, how would it matter to ask nurses what stories they tell themselves to live by?

These questions are addressed in my research. As illustrated in the San Diego story that begins this prologue and echoing Dr. Newman’s letter, I wonder about myself and other nurses who are not in clinical practice or who choose not to work in healthcare institutions currently being restructured. My thesis gleans information from the particularities of nurses’ lives, specifically those of my co-participants and me. Based in the assumption that where people are in a situation, what they do, with whom, and how, matters to their construction of identity, knowledge, and subsequent action in the social world, I study experience through narrative inquiry. My San Diego story illustrates the personal dilemma of how to be a nurse competing with social tensions that call forth caring and involvement. My research looks deeply into the apparent contradictions of restructuring and reform, to discern through reconstruction, the connections between a person who is a nurse and the social world. What reform from-the-inside-out might occur with narrative reconstruction of experience? And, how would this matter to people and healthcare systems?

I invite you into my inquiry.
1. Nursing praxis is defined in the School of Nursing, York University Accreditation Candidacy Report (March 2000) as 'being-knowing-doing'. Thinking narratively, I add 'becoming' to this definition because this term includes temporality—it intimates forward movement and growth, which is education.

2. On September 11, 2000 the First Ministers' meeting between provincial and national political leaders resulted in an announcement that the federal government would reinvest in health renewal and early childhood development. ($23.4 billion of new federal investments over five years). Similar to the nursing shortage-surplus-shortage cycles, government's investments in health and education follow patterns of reduced payments, targeted payments for troubled areas, across the board increases, and then the cycle begins again.
Chapter One

Nothing Personal? Coming to Inquiry

My narrative inquiry is called Nothing Personal? Narrative Reconstruction of Registered Nurses’ Experience in Healthcare Reform. I inquire into how it matters to explore RNs’ experience in healthcare reform through narrative reconstruction autobiographically, and biographically with other nurses (1). Seven co-participants illuminate the health care landscape through their stories of experience. Sasha, my co-participant who is a nurse in clinical practice and a BScN student, shows how it matters to nursing praxis to have a story to live by in environments undergoing many changes. The phrase “nothing personal” came to me on a bus ride home from graduate school in 1997. It can be said matter-of-factly, ironically, or in sorrow. It speaks of my own disconnection within nursing and health care and of my assumption that other nurses feel this way. My frame of reference and despair were reinforced in the university classrooms where I taught in the first half of the 1990s. Post-RN BScN students talked about their practice settings where what nurses called ‘healthcare reform’ was enacted through layoffs and casualization of the nursing workforce. Nurses working full-time in hospitals were laid off and rehired on a casual basis with no benefits or certainty of consistent hours or settings (CNA, 2000) Increasingly, community-based nurses told similar stories—layoffs, replacement of RNs with less educated workers, and diminishing amounts of available, casual work. These conversations affirmed my fears that the options were for nurses to comply with the health care system changes, while hoping for the best, or to leave for another career.

To show the complexity of health care restructuring and nurses’ place in it, one of my chapters could be a play on an Oliver Sacks (1985) book title, The Media That Mistook a Nurse for a Bed. Health care system problems are portrayed in the media as ‘not enough beds’ and, therefore, we have a back-up of patients in hospital emergency departments, surgical procedure waiting lists, and transportation of patients to other jurisdictions for care (Tranquada, 2000, Valpy, 1999). In fact, the beds are there—steel frames and mattresses waiting in closed units. There are no nurses to care for patients who could fill those beds. And why are there not enough nurses? Because the last decade has seen an economic approach to health care that played out as physical plant
amalgamations or unit closings in acute care and staff downsizing. A concomitant increase in community-based services, explored by previous and current governments, has not yet materialized.

When I was in the last year of my undergraduate nursing program in 1974/75, health was redefined in national policy documents as an asset that individuals have a part in creating (Lalonde, 1974). Government documents heralded the movement of health care to the community as the next and best innovation. This is still being explored in health policy in the 1990s while the community sector remains fragmented and underfunded. Acute care downsizing has been achieved, which is part of the proposed reforms. The promise of transfer of monies to community agencies has not been fulfilled.

Relationships that nurses have with their employers, the institution, a unit, colleagues, and particular patients are disturbed or disappear in the face of organizational restructuring that includes downsizing, lay-offs, and transfers. A nursing leader in Ontario, Dr. Gail Donner, calls these realities situational responses to health care reform. She defines reform as a broader phenomenon that involves a “change from institution-based care and a provider-driven system to a more publicly motivated, consumer driven, community-based system” (Peereboom & Wyse, 1996, p.1). This is reform, as in making the healthcare system better, by removing barriers and becoming patient-centred.

In contrast to Donner’s ‘consumer-friendly’ view of reform (Peereboom & Wyse, 1996), an American nursing consultant describes the potential health care system of the future as patients being monitored, regulated, educated, examined, and injected by technology (Christman, 1999). In this scenario, nurses who have embodied relationships and nursing knowledge have disappeared. How would this matter? And more chilling than that, what if we are coming to that point now? As nurses go in and out of hospital rooms and homes, how are they influencing and being influenced in healthcare environments towards possible futures?

Registered Nurses’ Experience in Restructuring: Plotlines in the Literature

Nursing research on healthcare reform uses the term ‘reform’ to mean what I call ‘system restructuring.’ To minimize confusion, I present the author’s definition of reform for each study under consideration in this chapter. Approaching the studies narratively, we see how each one tells a story of what is happening in the healthcare system and how
nurses intersect socially, through their practices, with people and events in 'reform.' Narratively conceptualized, each study shares a plotline for nurses to guide their practice. I hope for a sense of how it is for other nurses in terms of identity and knowledge; and for ideas about future possibilities that could guide our actions. I share plotlines from selected studies in order to see how they might help us to understand nurses' experience with healthcare changes and to discern the unique contribution of my research.

In American nursing literature, nurses are recognized as one of the most important resources for delivering high quality care, contributing to cost savings and maintaining a competitive edge (Kovner & Gergen, 1998). Prescott documents that the level of nurse staffing is “inversely related to mortality rates and length of stay for patients so that downward substitution among nursing personnel undermines the hospital’s competitive edge” (1993, p. 192). So, while nurses are not described in the literature as agents of reform, they are defined as important in terms of making a difference to people’s health and well-being (Aiken, Smith, & Lake, 1994; Knaus, Draper, Wagner, & Zimmerman, 1986).

Benner, Hooper-Kyriakidis, and Stannard (1999) have studied clinical settings in the United States. They suggest that the health care system is so destabilized by extreme workload and by systems designed for cost control and profit that for nurses “the pervasive and anonymous forces of cost-cutting, downsizing, and sense of threat became the foreground” (p. 465). The researchers see nurses’ resultant detachment from patient and family suffering as a means of self-protection; “as a consequence of having lost the ability to meet the other and to identify with their suffering” (p. 18). How nurses respond goes beyond individual clients and families as “the nurse accepts the untenable premise that she must let the system fail” (p. 481).

There is discomfort for me in that plotline for nurses. How and by whom are nurses charged with keeping the system together? Where does that belief and practice come from? I want to understand how individual nurses construct that knowledge from their lives and their environments. My response wells up; I want nurses to protest and to act on behalf of patients and themselves. I want nurses to leave these situations, but then I am stopped by the thought that keeps nurses in place—who will take care of the patients who cannot choose their situation?
Another plotline in the nursing literature on reform reveals nurses as powerless and absent as architects of health care reform or as not consulted in health and social policy circles (Murphy, 1992). Cohen asks whether nurses “have the tools to participate effectively in the search for solutions to the problems that face nursing and society” (1992, p.113). Typically, nurses are seen as implementers of restructuring strategies and as complicit in system maintenance. Senior and middle management nurses are often the key personnel responsible for implementing sweeping system changes that impact others’ worklives as well as their own.

How are clinical and management nurses talking with one another about expectations and what is possible? Nurses are everywhere in the system, so they are part of constructing situations for caregivers and patients as well as being shaped by the larger context. Do nurses implementing change by virtue of their job title and function also disengage? If I do things to keep my job that feel wrong or painful, how do I keep coming to work each day and what happens to my relationships? Are nurses shutting down emotionally at all levels of the system and is their work only a job, a series of tasks to be completed? Are there nurses who feel they can make positive changes?

In Ontario, many studies in the first half of the 1990s documented factors affecting the quality of nursing worklife because of concerns with nurses leaving health care (QNWRU, 1994, 1995, 1996). The concern shifted in the mid-1990s with institutional downsizing, layoffs of nurses, or their relocation within the workplace through union-ruled ‘bumping’ out of more junior nurses. These restructuring strategies created a surplus of experienced nurses and acknowledgement that nurses bear the brunt of reform restructuring (Church & Noseworthy, 1999). From 1995 – 1998, more than 5800 nurses did not renew their registration with the College of Nurses and over 7700 reported working in other jurisdictions (Sulzenko-Laurie & Milburn, 1999). Many of the undergraduate nurses at the university where I was a sessional teacher either moved upon graduation to other jurisdictions to find work or they did not practice in nursing.

In 1997, Ryten used demographic data from the last 30 years to analyze Canada’s need for nurses (Sibbald, 1998). The supply/demand cycle has moved forward as we are now experiencing a national shortage of nurses that is predicted to worsen “due to an aging workforce, inadequate retention and declining enrolment” (Sibbald, 1998, p. 22).
Concern with the education and retention of nurses is widely felt. Nurses' experience with healthcare restructuring over the last two decades is illustrated in several significant studies. Sharing these studies in some detail will allow me to draw the contrast and significance of my inquiry.

Armstrong-Stassen, Cameron, and Horsburgh (1996) studied job satisfaction of full-time and part-time nurses in three Ontario hospitals. The authors measured nurses' job satisfaction in 1991, the same year that ONA "raised the maximum salary of nurses by 29% over a two year period" (p. 21) and that hospitals were experiencing a nursing shortage. Job satisfaction was again measured in 1992 "following a hospital restructuring involving the closing of beds, the relocation of nurses to other units, and the layoff of some nursing staff" (p. 9-10). This downsizing of nursing staff continued as the authors analyzed their data. Between 1993 and 1996, "five thousand nurses across Ontario (were) laid off due to restructuring and rationalizing efforts" (p. 9) and "two of the four community hospitals (in this research were) closed" (p. 26).

This research examines the impact of downsizing on 258 RNs and 87 RPNs job satisfaction (Armstrong-Stassen et al., 1996). Two thirds of the nurses worked full-time and the remainder were employed part-time. The participants were 97% female. 74% married, with an average age of 40 years and an average of 12 years work experience. A 20 item Minnesota Satisfaction Questionnaire was distributed at the three hospitals for the nurses to complete and mail back to the researchers. Quantitative analysis of the data revealed "no significant differences on any of the job satisfaction measures for work status.....There were, however, significant time effects for satisfaction with supervision, hospital identification, co-workers, financial rewards and career future" (Armstrong-Stassen et al., 1996, p. 16). All the significant effects, except financial rewards due to the ONA settlement, were reported as less satisfying.

Armstrong-Stassen et al. (1996) recognize that "most hospital administrators have found themselves in uncharted waters—they have had little experience in dealing with organizational restructuring of the magnitude necessitated by current budget constraints" (p. 22). Strategies for administrators to ameliorate nurses' job dissatisfaction include continuous communication about what is happening in the organization, establishment of survivor programs, and training managers to deal with nurses' concerns. The authors
recognize that nurse managers are a "particularly vulnerable group with higher rates of layoff and displacement than their staff nurse colleagues" (p. 24). Finally, the researchers recommend that employers renegotiate the traditional psychological contract with nurses that rewarded hard work and loyalty with job security. The plotline I discern here is that nurses are in situations where their sense of belonging to a place, their peers, supervisor, and profession, is interrupted. The expectation is raised in me that this study, or its next stage, will shed light on the meaning and consequences for nurses of not belonging. How are different levels of nurses, both in crisis, helping each other?

Corey-Lisle, Tarzian, Cohen, and Trinkoff (1999) define health care reform in the United States as "the expansion of managed care into an increased number of individuals covered by contracts, fewer hospital beds and job redesign for nursing staff" (p. 30) Quality of care and the cost of providing care must be balanced by organizations, according to the authors, as individual health care workers must balance personal and professional roles. Seventy-eight percent of 6000 eligible RNs completed an eight page anonymous questionnaire in this study. Most participants were female (96%) with a mean age of 41 years. Ninety percent were employed and 47% had a post-diploma degree.

On the last page of the questionnaire, nurses were invited to comment on topics in the survey. Twenty-five percent of the participants chose to do so. Content analysis of these 'narrative comments' revealed significant themes related to nurses' experience of health care reform. The themes included: reduced reimbursement to institutions leading to a cost-cutting focus with reduced staffing, multiple changes in job status and security for nurses, increased paperwork, and decreased morale. "Although some of the individuals reacted to health care reform changes with frustration, reduced job satisfaction and job changes, others perceived opportunities for individual growth and the growth of the profession" (Corey-Lisle et al., 1999, p. 35). This is the first time I have found the doom and gloom of reform reframed in the literature. The authors link their observations to stress theories and suggest administrators can promote healthy coping mechanisms of nurses by fostering participation in work reorganization and showing respect and valuing of staff. "Policies encouraging these outcomes should have beneficial economic and patient care outcomes" is how the article ends (p. 36). Noting the top-down, psychological strategies and the primacy of economic outcomes, I wonder if the
authors' understanding of the situation for nurses and, therefore, their sense of what can be done and by whom has been enlarged by this research? I am intrigued by the idea that some nurses see reform as an opportunity. That has not been my experience and I want to know more about what makes interpretation of the same situation so different.

As a reader, I see consistency between this study and others in terms of issue identification. But something vital is missing. The sense of experience emerging from a particular life where there is meaning and significance attached to relationships cannot be discerned. The assumption that administrators will fix the nurses so they can better deal with their situation is reified. On what basis do nurse researchers and participants comply with this plotline for nurses?

Woodward and colleagues (1999) undertook a longitudinal study of staff undergoing organizational reengineering while working at two campuses of an Ontario teaching hospital. This study involved almost 900 staff from across the hospital, including nurses. The findings confirm that the "emotional distress felt by staff at work began spilling over into their home lives and vice versa" (p. 563). They also suggest that "combined with the costs of increased illness and absenteeism among staff...the impact of these changes may cost the health care system and society more than the savings initially anticipated by instituting changes" (p. 565). There are high stakes at play in restructuring; people's lives as patients, families, and caregivers, and enormous amounts of money. This study acknowledges the interplay between work and personal life in that the consequences of reengineering are implicated in individuals' lives in a way that cuts across professional personal boundaries. It also hints at how staff react to (resist?) these changes in embodied ways through increased absenteeism. The authors ask if the costs of corporate restructuring point to its futility as healthcare reform.

Reform is consistently defined in these studies as corporate restructuring and reengineering of work design. Nurses report similar concerns for patient care and for themselves across North America. The studies use quantitative analysis of written questionnaires to generate themes and issues for nurses related to working in rapidly changing environments. Qualitative data are less often requested from nurses. Two further studies that include qualitative approaches are worth examining in some detail to
Further explore literature plotlines about how nurses are experiencing health care restructuring.

First is an American longitudinal study that examines organizational redesign and delivery of care from patient, nurse, and administrative perspectives (Geddes, Salyer, & Mark, 1999). The authors depict worklife experience of nurses affected by individual and organizational uncertainty as situational “turbulence, related to workload, loss of workplace identity and the changes resulting from reengineering” (p. 47). Uncertainty is defined by the authors as “unanticipated variations in an organization’s information and resource domain and the individual’s perception that critical information about the environment is unavailable and results in the inability to accurately predict changes” (p. 41). Interaction between a person and her/his environment is stated as an underlying assumption, but how nurses influence the social world is not demonstrated. This report did not define the reengineering strategies beyond general categories of mergers, acquisitions, and closings.

The researchers incorporated “narrative information which enriches and enlivens” into the quantitative data in their study (Geddes, Salyer & Mark, 1999, p. 47). The use of the term narrative in this study means work-related observations and speculations recorded in written journals. The narrative information is based on monthly open-ended reports kept by ‘key informants’ who were site coordinators at 53 acute care hospitals. Site coordinators were asked to format their journals with the following content headings: critical incident and implications. The narratives were to be contextualized within “circumstances in their hospitals that would inform researchers about changes occurring in the internal and external health care environment and the impact of changes on the worklives of nurses working in these hospitals” (p. 42).

Given the directions and the format of the journals, parameters were placed on what key informants could write and on what researchers would find. The anecdotal evidence quoted from the nurses’ journal entries is spare in detail and reads as if disembodied: “med-surg nurses have floated to units where they have little or no experience” (Geddes et al., 1999, p. 43); “our unit was closed and the staff were dispersed throughout the hospital to vacant positions” (p. 44); and, “our hospital is knee deep in process design and the staff is in great turmoil” (p. 45).
The group of researchers thematically analyzed the journal data that were collected over 6 to 12 months. Nurses' concerns with workload, workplace identity, and the impact of re-engineering were revealed. While workload concerns may sound self-interested about too much work, the journals reveal a concern with the safety of patient care. Typically, a nurse works on one unit and is knowledgeable in general to a certain extent and has expertise related to persons who are living with conditions commonly found on that unit. Workload concerns relate to nurses caring for different patients without educational preparation, the number of patients to be cared for, reassignment to unfamiliar units, and working with part-time and/or agency nursing staff. Nurses reported that all of these issues impact negatively on the consistency and quality of patient care.

The nurses in the study were concerned with a loss of identity as they were separated from the stability of place and people in their work situations. Loss of workplace identity was reported by the nurses as a result of organizational mergers and unit closings. Technological changes in patient care and documentation increased the environmental turbulence. As peer groups and supervisors were frequently changing, there was less workplace support available to one another. Lower paid and less educated workers, brought in to do tasks under the supervision of a nurse or to replace a nurse, resulted in fewer RNs for patient care. This demographic, which makes invisible the knowledge and experience of nurses, has also been documented in Canada by McGillis Hall (1997, 1998). Finally, Geddes et al. (1999) suggest that there is a need to increase an individual's and organization's capacity to deal with uncertainty. Given change is a feature of life, I wonder how temporality is implicated in nurses' responses to uncertainty. Actual strategies for increasing capacity related to uncertainty were limited in this report.

The method of qualitative research used in Geddes et al. (1999) study yields interesting themes for consideration of nurses undergoing system restructuring. However, understanding the meaning of the changes in the health care system to individual nurses is lacking. The data does not include detail and contextual information that would move a reader beyond generalizations. Given that health care situations are portrayed consistently as rapidly changing and negative, how does a nurse make sense of and continue to do her/his work? Geddes et al. (1999) do not address whether restructuring activities have
value or not; nor do they address differential impact between caregivers and patients.
Instead, these issues are portrayed as events in the social environment to which nurses react. How do nurses think about the part they play in designing and implementing restructuring or reform?

A recent Canadian nursing education study explores “the chaos in the everyday experience” of 38 female Registered Nurses who live and work in Nova Scotia, Canada (Keddy, Gregor, Foster, & Denney, 1999, p.59). The authors identified themselves as nurse teachers and researchers. Positioning their study as feminist within research on women and work, the authors believe:

that the occupation of nursing is a microcosm of the larger social context of women’s work where reproductive labour in the home and in other personal arenas (is) affected by the disruptive chaotic productive labour in the workplace….if the providers are themselves in crisis, it is a reflection of the system itself in disarray (p. 59).

The age range of participants in this study was 21 – 55 years and none had full-time employment with security.

Reform in this study is referred to as government policy about “community-based care in lieu of long-term hospital stays” which has not been implemented (Keddy et al., 1999, p. 58). What the participants in the study respond to are disruptions in care, disparities in resources, and loss of jobs for nurses, the largest group of healthcare workers. The specifics of these system changes are not detailed by the authors. The replacement of full-time work with part-time, casual, or no work is the phenomenon under investigation. The authors, conducting face to face or telephone interviews, called the data “stories told to us in narrative form” (p. 60). The quoted excerpts from participants describe always being on-call to the workplace, “sometimes with only fifteen minutes notice to go in and work the night shift” (p. 60). Emotional reactions to living this way were also described including anger “at being treated this way” and hopelessness because “it does make you feel like you don’t matter, you don’t count, you’re replaceable and nobody really cares” (p. 60). Describing the link between professional work and work in the home, nurses in the study reported living day by day with uncertainty, anger, and hopelessness. Technology such as beepers and telephones ruled the nurses’ lives. They waited for calls to come in for casual and part-time work
and at times felt "almost harassed by the hospital to fill these positions" (p. 60). The authors of this study identify the government policies about health care reform as a social construction that positions reform as a good thing; as delivering seamless, efficient, appropriate care to the community where people work, live, and learn. This is not the experience of Registered Nurses in Nova Scotia. Reform is defined by them as "cutting and slashing existing services without community resources and supports for patients" (p.62).

In the analysis and theorizing, the authors refer to national government and health association reports to make links between the nurses' reported experience and earlier findings about work status and health. Noting that "none of these nurses resisted or revolted; most were too exhausted or stressed to do much else but keep going from day to day" (Keddy et al., 1999, p. 63), the authors did not ask each woman, "How do you understand what is happening in your situation?" 'How do you stay?' This study reports nurses' experience as described by them, but does not suggest or use an interpretive framework that makes sense of it.

The authors note that "there were few substantial differences amongst the thirty-eight participants" (Keddy et al., 1999, p.60), acknowledging they did remove the two male nurses because the purpose of the current report is "to discuss specifically how job disruption impacts upon the personal lives of women" (p. 59). This study explores nurses' tensions about working conditions using thematic analysis as if there is a homogenous group of participants. Thus, no connections are made with particular nurses between their narrative histories and their social world. By this I mean the analysis of the data creates categories in which similarities between people are named and differences disappear. How could a participant find herself in this study and be facilitated to learn and grow? I also do not know from reading this study how the nurse educators and their curriculum were changed by this research.

Reform in these two studies (Geddes et al., 1999; Keddy et al., 1999), as organizational restructuring and re-engineering, is a mis-educative experience for Registered Nurses. Also, the research method utilized in these studies, while nominally narrative and about experience as lived, removes the consequences of the inquiry from
the lives that gave up the ‘data’. It leaves me wondering how the nurses, both researchers and participants, were changed by the inquiry.

These studies shed some light on broad issues and attributes of health care systems undergoing change and the generally negative consequences for nurses, but do not illuminate how nurses live within social environments as people with histories and bodies, hopes, dreams, and choices. Having read the research on health care reform and nurses, I am not enlightened as to how to contribute or make the situation better for myself or others. Reading about what administrators and health care organizations should do, I miss a sense of how other nurses in clinical practice, education, and research are knowledge-makers who shape and are shaped by their healthcare situations. I want to know how the participants and researchers were changed by the research and if their understandings and their choices were enlarged.

**Registered Nurses' Experience in Restructuring: My Inquiry**

Beginning my inquiry, I was convinced nursing would not exist in the new millennium. My experience as a nurse administrator in the 1980s and as a teacher in the 1990’s, showed me how nurses were being treated in health care organizations, and I couldn’t imagine why they would stay in the profession. In 1973, Ashley observed that many nurses feel powerless or feel the power they do have is unimportant and she wondered why. Further, Ashley pointed out that nursing literature predicts that “unless nursing does this or that, it will become obsolete, replaced by something else, or cease to exist” (p.637). Is this true now, a quarter of a century later? Do nurses feel powerless and doomed at the end of the 20th century?

Nurse teachers predict that nursing will change to meet the needs of individuals and society based on examining current trends and doing environmental scans (Korniewicz & Palmer,1997), or on defining future scenarios and back-casting to know how to achieve the preferred version (Rogers,1997). These authors assume our profession can transform in tandem with social changes so that nurses will be available in the future to work with people to achieve health. Watson (1999) worries about the survival of nursing as “it either matures into its own sacred healing practices, or remains in a technical, dependent position in an industrial, material framework” (88-9, 102). Moore, Clarke. Regan, and Steele (1999) cite the effects of economic policies in British
Columbia's healthcare system as similar to Ontario with reduced middle management and educators, layoffs, and decreased full-time work for front line nurses. "At the same time, the pressure to achieve the goals of reform has provided opportunities for some nurses to practice to their full scope. It has also resulted in consumers managing their health to a greater degree—an innovation that has the potential to reduce demand for health services" (Moore et al., p. 25). The Comox Valley Nursing Centre, RN First Call system in emergency departments, and Telehealth systems are described as nursing-run, nursing services that meet public needs for information and primary health care.

The Institute for Alternative Futures (1998) suggests that by 2010 alternative practitioners and health care professionals trained to do alternative practices will overwhelm traditionally educated, conventional providers. This scenario could result in a surplus of physicians, pharmacists, and nurses. As health care knowledge is decentralized to members of the public, professional education and roles will change. This view of the future directly contrasts with the nursing shortage statistics which underpin the nursing profession’s current attempts to economically and organizationally rectify the impact of healthcare restructuring. How else can nurses imagine a future?

Widely divergent points of view about nurses’ experience in healthcare over the past two decades and the consequences are available to readers through choosing different literature/research plotlines. I am curious how nurses conceptualize ‘reform’ to themselves and with colleagues. Do they see themselves cooperating with administrators and governments plans for the system? Do they see themselves as “being critics of social relations or social reconstructionists who were engaged in dynamic social experiments designed to restructure society?” (Crocco, Munro, & Weiler, 1999, p.36). How do nurses understand being part of the social world of healthcare restructuring and, potentially, reform?

I locate my inquiry in the gap between defining healthcare reform as organizational restructuring, portrayed as externally derived and negative for nurses, and the not-as-yet realized social improvements of genuine reform. My research inquires into how it matters to explore RNs’ experience in healthcare restructuring through narrative reconstruction to explore how individual nurses create identities and knowledge from reform that is from-the-inside-out. Exploring how it matters to individuals and to society
that nurses turn inward as well as outward, my inquiry also includes nurses’ past-present-future and place in the world. Clandinin and Connelly (2000) name this way of considering experience as three-dimensional narrative space. Consideration of each dimension informs my narrative inquiry with nursing co-participants.

My inquiry, as a narrative space, includes autobiographical exploration of my experience. Learning by reconstructing my life experience involves exploration of relationships in the past and present which creates possibilities for a future. My research also illuminates the social world of nurses through stories of seven participants who are diversely situated. Finally, my inquiry explores how reconstruction of experience to create meaning and knowledge matters to my co-participant Sasha who is a nurse in clinical practice and a BScN student. My research differs in important ways from the studies presented in this chapter. In narrative inquiry, researcher and participants are co-inquirers. As my co-participants and I conversed about reform in health care, stories were called up in each of us. We moved into the past as we shared family stories and early career stories to show the plotline of our lives as we currently understood it. The temporality of our relationships and events informed our understandings. Specific nurses in particular situations shared their lives with me, as I shared with them, through conversations, transcripts, and construction of composite conversations. We reconstructed meaning as the research proceeded and it was for us to situate new knowledge in our present experience. Staying with each of us as persons and not generating categories shows how nursing identity and knowledge are constructed. Within new understandings, my co-participants and I saw choices for our futures we had not previously discerned. The relationship of researcher and participant and the narrative conceptualization of life experience offer a unique contribution to nursing education research.

Reconstruction of experience, according to Dewey (1916/1966, 1920/1957), leads to change that is social as well as personal. In these relationship terms, reform is social reconstruction rather than being limited to corporate restructuring. The meaning of the term reform as social reconstruction necessarily includes a nurse as a person in a daily life in the social changes. Dewey’s work underpins Connelly and Clandinin’s (2000) line of inquiry in narrative and is foundational to my work on reconstruction of nurses’
experience. Exploration of nurses’ reconstruction of personal experience and how that matters to the capacity to act in social situations is my phenomenon of concern.

Exploring ‘nothing personal?’ informs the ‘so what?’ and ‘what else?’ questions arising later in my inquiry. I propose that nurses can awaken to mutually shape their situation through reconstruction of experience which enhances forward movement and education. This is a powerful notion for me personally. When multiplied by a quarter of a million Registered Nurses working in Canada, this idea is of social significance.

**Nothing Personal: Separation Between Person and World**

Beginning my inquiry into nurses’ experience of reform in 1997, I assumed that education and practice were two separate worlds. My students told me that their personal lives and work lives were separate and my education told me that theory defines practice. My understanding of life was full of certainty and divided into compartments. My thesis title, ‘Nothing Personal?’, comes out of my struggle with being a nurse, with what that means, and with how I should practice nursing. I assumed that other nurses were suffering the same tensions. Through health care restructuring in the 1990s, nurses have been disaffirmed as our work is broken into tasks, delegated to less educated, cheaper workers, and we are moved like chess pieces across organizations (Nagle, 1999).

Administrators feel that nurses should be grateful they still have jobs even though they have lost their work team and their clinical specialty (Baumann et al., 1995). The messages from society to nurses say: Nothing personal, but you are not going to give the care you are educated to offer. Nothing personal, but you cannot contribute to your potential, just go where you are directed. Nothing personal, but who you are doesn’t matter—just do what you are told.

Are the nurses who care for people at the bedside or in homes the most vulnerable in the health care system? The nurses who have the privileges of educational credentials, time flexibility, offices, and better salaries are mostly out of the public eye in research, administration, and teaching. How are they experiencing restructuring and, perhaps, questioning their identities and knowledge? These separations in my experience of nursing have dire consequences for supporting one another and working together. Yet, I would not want to work in a hospital as a staff nurse at this point in health care’s history or in my history. This is a paradox because if real nursing is front-line, hands-on care and
I don’t want to do it, can I still be a nurse? What constitutes a real nurse—a role, the setting, a person’s identity? The message that other kinds of nursing are not real is emotionally true in me even though I know intellectually that there are many ways to be a nurse. To be accurate, it’s not that I don’t want to do hands-on nursing—it’s that I don’t want to work in the organizations and under the conditions where clinical care is delivered. Yet, I work in education with people who are nurses or who want to be nurses and take care of others. Nurses and the people they care for may not have similar choices to withdraw from the acute care health system. As I began my research, the competing tensions seemed unresolvable.

My earlier writing accurately shows how I lived and understood myself as not in relation to a world. As an example of what I mean, here is an excerpt from a column written when my son was three months old:

It is also a myth that mothering comes naturally to women. That’s not a glow, that’s the sweat of anxiety! The combination of responsibility a child’s unknowingness in the world can create feelings of inadequacy and incompetence, even in sterling experienced parents. Day by day there is a learning process as the child experiences his world and his parents learn what works best with their infant (Lindsay, 1985, p.30).

A woman with whom I worked at the time suggested sending my thoughts to a parenting magazine with the results of publication and a cheque for $150.00. The circumstances that gave rise to my writing were not obvious to the reader, because I did not contextualize it at all. The morning that I wrote the short article, my husband, son, and I had spent a very anxious time over brunch with a group of colleagues who were meeting our three-month old for the first time. In the course of our time together on a humid July day, our son was passed hand to hand by admiring women. He reacted to the situation by screaming for about an hour. My husband and I took turns taking him outside for a walk while I was also flooded by feelings of imperfection and embarrassment. When we got home, my husband took my son for a cool bath and I wrote out my feelings and thoughts in the only way I knew how. To look at my experience of that morning, to deal with feelings of embarrassment and uncertainty, I wrote dispassionately and from a distance.

Continuing in that way of thinking was not challenged over the following decade (or I was not aware of any challenge?) until I returned to school. Professor Connelly
talked about Dewey's individual/social dialectic in the fall of 1996 in our Foundations of Curriculum course. He said the individual person exists embedded in a social world, not separately. always in context. The idea that I am shaped by and shaping my social world as it is shaping and being shaped by me was stiff and unwieldy; difficult to put beside my experience as a nurse. Connelly and Clandinin (1999) elaborate on a metaphor from Geertz about life as a parade that we cannot watch because we are in the parade. We are in a social world of relationships, events, and places all the time. I tried this theory on like a new dress, pivoting before a mirror to see how it looked and felt from all angles. Some of what I hope to reveal in my research is how it matters for a nurse to awaken to being in the parade, in contrast to passively watching and waiting for events to happen on a social plane.

Helgesen describes our social world as the zone beyond the walls where our lives include “the simultaneity of contemporary social changes and the myriad results of their interactions” (1999, p. 50). This tapestry of relationships between people, events, and places over time constitutes stories regarding people and their social situations which Clandinin and Connelly (1995) name the professional knowledge landscape. Exploration of relationships is a way to understand the personal-social connection that is foundational to learning from our experience. Landscapes are a matrix of storied influence where people's biographies, histories of places and social positioning intersect. Thinking narratively is one way to reflect on our lives as people in social situations which brings together person and world. We learn from our experiences through reconstruction and discern stories to tell ourselves to live by. This process of narrative discernment shapes a professional identity that is contextualized in practice landscapes (Connelly & Clandinin, 1999). In curriculum studies, Connelly and Clandinin view teacher knowledge as constructed by “teachers living stories, telling stories, retelling with changed possibilities and reliving the changed stories—teachers are characters in their own stories of teaching which they author” (1995, p. 12).

**Narrative Space and Liminality**

Reflecting on the studies presented earlier in this chapter, and on my compartmentalizing of life experiences, I think about how the researchers seem to think so little of nurses and worse yet, leave them without the means to change their situations.
Addressing this conceptual gap is another hope that I bring to my inquiry. The puzzle for exploration is: How does it matter that Registered Nurses, as persons in a daily life, narratively reconstruct their experience in healthcare reform?

Asking questions about narrative inquiry and its potential for nursing education research, I attended a lecture series at the University of Toronto in 1997, where Heilbrun talked about liminality as a threshold condition. In the 1999 text based on her lectures, she defines liminality as “being poised upon uncertain ground, to be leaving one condition or country or self and entering upon another, while at the same time lacking clarity about where one belongs and wants to be doing” (Heilbrun, p. 3). Liminal space seems to me to be like my great-grandmother's family homestead in rural Manitoba, the boarding house where immigrants and travelers stayed, always on their way somewhere else. As someone who did not have a sense of myself as a nurse with a place to be or what nursing work I could be doing that would feel satisfying, liminality is where I am positioned in my thesis writing.

Continuing with Heilbrun’s notion of liminality, the essence of which “is revealed in women's experiences once they are willing to move from convention to another form of self-expression” (1999, p. 38), my thesis writing is deepening my connection to the women/nurses who write their thinking. Nursing theorists, Watson (1999) and Newman (1994) identify this time in nursing knowledge development as between cosmologies; where nursing is reconstructing from particulate-deterministic and integrative-interactive paradigms to unitary-transformative perspectives. How nurses are thinking about who we are and the consequences of our actions informs our professional identity. Perhaps as each nurse reconstructs her experience and grows, the profession will find itself viable and evolving.

Thinking historically, I revisit Nightingale's concern that “social conditions, not only among the poor but in ‘good society’ are responsible for many stifled souls and wasted lives” (Nightingale as cited in Stewart, 1939, p. 219). Nightingale was concerned that upper class women with intelligence and talents, like herself, were kept from meaningful work by Victorian social conventions. As a young woman, desperate to work, she was perhaps in the liminal space between desire and acting. Moving beyond convention and living with unknowing is liminal space, the three-dimensional narrative
space of my inquiry. What possibilities, yet unknown, for being a nurse can be found by narratively exploring and reconstructing nurses’ experience in times of change, in liminal spaces? Thinking about identity and knowledge and returning to the definition of reconstruction as ‘forming a mental or visual impression of past events by assembling evidence for them,’ I start with my own history.

*Family History as Reconstructed so far*

My mother always said I should be a teacher. I did not think so. Perhaps Mom’s thinking about me as a teacher relates to family stories more than to what was “teacherly” about me. Mom’s father’s father, my great-grandfather, John Wallace Stirling Duncan (born March 11, 1888) was a teacher. In 1908, John was a law student at a college in Winnipeg who spent his summers teaching in farming communities like Ardal, now called Arborg in Manitoba. Johanna Kristin (Stina) Gudrundottir Gudmundson (born March 14, 1891), my Icelandic great-grandmother lived in Ardal. Her family ran the boarding house that was a temporary home for many people as they crossed the prairies. In those days, the mail was delivered everyday and so John and Stina communicated their daily lives and arrangements to meet through the mail. In the fall of 1908, John wrote to Stina:

Well, Stina min. I hope those mumps have completely left you. I was very sorry to leave you on Tuesday morning, but of course it had to be and both you and I had to make the best of it. You’re a dear brave girl Stina. I know it was very hard for you to see me going away but I think all the more of you Stina for the way in which you controlled yourself. But dearie, don’t think of me too much. You must be your cheery self again now, for I know you were not as happy the last week I was with you as you usually were. But you can always think of me as one of your dearest friends and I shall always think of you as one of the best girls I have ever known. Now we won’t say any more about that. Your true friend, J. W. Stirling Duncan (Manitoba College, Winnipeg, October 9, 1908).

I wonder what was affecting Stina’s happiness in the fall of 1908? A hint of what it could have been is revealed in John’s letter to Stina on January 16, 1909 as he wrote, “we both know by this time that you are about to be a mother.” Advising her to stay at
home in Ardal “before your trouble becomes very noticeable” his words foreshadow her struggles ahead:

Now when you go home of course you will have to face a lot of trouble. I know you have promised me that you will say nothing to anybody about what happened between you and I. Your father or mother no doubt will be angry and want to know all about it. Well if you tell him he can make me marry you. I suppose you know that. Well as I told you before Stina, it is impossible for me to do that now. After this year it will be different. But if you absolutely refuse to say who it was, why your father or anybody else can do nothing. Besides you will not help yourself any by saying anything about it. If you did tell anybody why I should have to leave college and Winnipeg and go I don’t know where.

Pregnant and apparently unmarried, a walking scandal, Stina went home to her parents and John went back to the city to his study of the law. On June 23, 1909, 20 days after his son was born. John wrote to Stina from Alberta:

I should like to see you and him for awhile but that can’t be for sometime yet. What did you want to know my father’s name for? There are a lot of people with our name down home (Prince Edward Island). It is just like Gudmundson or Johnson in Ardal. As for the baby’s name, call him any pretty name you like only don’t call him Stirling. I don’t like that name very much. Well I am having a rather lonesome time here. There is nothing doing. It is far worse than Ardal but I shall have to teach for some months anyway. I hope you are getting strong and well again. I shall send you the ring as soon as possible.

John continued to teach during the summers in the provinces west of Manitoba and never did meet his son or live with Stina. When my grandfather was three years old, the Winnipeg Telegram reported on August 11, 1912 from Edmonton that J.W.S. Duncan had drowned by “the swamping of the canoe” while fishing with a friend on Lake Wabamum.

In February 1996, I visited my maternal grandparents, Amma and Afi, in Winnipeg. Afi, my grandfather, gave me the letters from his father that his mother had
kept. Also included in this package were a lock of John’s hair, pictures of a handsome, serious young man wearing wire-rimmed glasses, and a postcard from the Winnipeg Law College. There are pages in Stina’s picture album where she copied and recopied his obituary from the paper. I wonder who wrote the obituary and if this is how she learned of his death. Given how much he was away from her when he was alive, I imagine she was trying to comprehend his final absence. Afi said he never has read his father’s letters. He also said that his earliest memory is a picture of his mother scrubbing plank floors on her hands and knees, getting wood splinters in her fingers. He has given me books and pictures of our Icelandic heritage, as well as the letters. Afi still speaks, writes, and reads Icelandic. I learned he is half-Icelandic when I was 43 years old. Up to this point in my life, Afi’s real father had never been discussed (2).

From Afi’s research in his adult life, he uncovered his parents’ marriage certificate, dated January 26, 1909, and his birth certificate dated the same year in June. I interpret this to mean that legitimacy was important to him. What remains unexplored is any links to his father’s family and heritage. Through my grandfather’s journals, written in his eighty-ninth and ninetieth years, I also learned more about our family. He has written and mailed to me eight scribblers full of his autobiography in which he recounts his early life at Ardal, his move to Winnipeg as a teenager during the Depression, and his subsequent family and work life. Despite the offer of a scholarship, my grandfather had to leave school to work on the farm as a teenager, and this was a cause of suffering for him because he loved learning and wanted to be an artist. Afi writes that his mother’s father was a book-learning doctor who helped people with toothaches and illnesses. In the flu epidemic after WWI, he helped people with his remedy of molasses, sulphur, cod liver oil, and epsom salts. He made his own tools for dentistry and used coal oil as a disinfectant and sedative. My great-great-grandfather’s wife was a midwife who helped the local ladies give birth. To my surprise, I find teaching, medicine, and healing are part of my family history as are secrets and struggles to construct an identity of one’s own. Recording our family history may be assisting my grandfather to come to terms with his life experience and reading that history is a gift for me.

Writing about my family members and our shared history, I wonder at their power for me now. As he gave me his father’s letters, grief and anger were evident on Afi’s
face. He denied having read the letters and I remember feeling cautious. Aware of my own judgement and anger at his father's actions, I did not know how to proceed. When Afi refused my offer to tell him some of what I had read, I took that to mean he did not want to talk about it further. Whether or not that is true, I do not know. But, I marvel that having lived nine-tenths of a century, what happened before Afi was born and in his childhood still grips him with strong feelings. This example from our lives shows me that experience which is accumulated but not reflected on and reconstructed with a benevolent witness is "an undigested burden unless it is understood" (Dewey, 1933/1998, p. 78). In this state, full of unreconstructed experience, which I recognize from my own life, everything happens as if it is ground zero, as if there is no history, or context, or previous learning to build upon. Living a daily life that is not narratively grounded can be profoundly unsettling. As I reflect on my grandfather's experience, I wonder how reconstructing and reliving his story might have changed his life and my own? Liminal space is how I conceptualize this time and events where movement to an as yet to be defined future is occurring.

**Career Choices by Default**

Told through the generations, these family stories have resonance in my life. Some of the same issues of relationship and vocation are at play in my dilemma of how to locate myself in a world as a nurse. My nursing career started in high school when I accepted the guidance counselor's opinion that girls are not veterinarians, which was the choice close to my heart. So, based on my best friend Lora applying to hospital Schools of Nursing, I considered nursing programs at our local university with several hospital applications as back-up. What was clear to me was that I did not want my mother's life of domestic detail and economic dependence. I saw my father's corporate, social, and recreational life as more exciting and autonomous. I remember how I felt when a post office clerk treated my mother with scorn when she did not have a social insurance number to use as identification to cash a cheque. Ironically, it now occurs to me that I was entering my mother's domestic sphere by falling into nursing, but I would be paid for the work (as if that would make all the difference).

By our final year of studying for a BScN at the University of Toronto in 1974/75, I remember standing in the hallway of the Faculty of Nursing, talking with a professor I
liked. I struggled to put into acceptable words how I felt about our nursing education. Every evening as we walked to our apartment, my best friend Judy and I would analyze another day of classes and wonder why we felt so constrained and resentful. From these conversations, I realized that I felt shaped by nursing education, like an object being packaged. I saw the teachers as pretty much all the same—wearing A-line skirts, blouses with Peter Pan collars, and flat black shoes; teaching with overhead projectors and transparencies that I copied into my notebook—and I felt they expected us to be like them. The role of the University of Toronto BScN was interpreted to us as primarily being a change agent. We were expected to be able to enter any situation, to use the nursing process for problem solving, and to fix everything for others. I interpreted this to mean it was our responsibility to make things right for our patients and to fix the world. My understanding of situations was based on book learning theory. At that time, I was sure I had so much to offer because of my perfect, middle-class, suburban childhood. The social mandate from our professors manifested itself in my desire to be in leadership and supervisory positions early in my nursing career. I did not see the value in being a staff nurse. Thinking that change could only be made from hierarchical heights with positional power, I did not understand that my history and social context were also in the situation. Laughing, my professor asked me if I felt they were winding us up like mechanical toys and sending us out into the world. I answered yes. Although this was a very important conversation from my point of view, it ended there. I might privately complain, but accepted that teachers are powerful in shaping students' sense of themselves and that my only option was to fit in. This memory mirrors my experience with the guidance counselor whose advice I did not challenge. What was clear to me by the fourth year of my nursing program, however, was that I wanted to work in Child and Family Psychiatry.

Picture Perfect?

In the winter of 1975, I went to have my graduation picture taken. I wore my white, short-sleeved, student nurse uniform and a white, black-banded, traditional nurses' cap. My hair was up in a small bun above my collar with curls over my ears. I held a single red rose with my left hand toward the camera so that my engagement ring would show. Being engaged symbolized adulthood and reassured me that I didn't have to face the future alone. There were so many life choices to be made at graduation and marriage.
foreclosed thinking about some of them. As I gaze at this picture in my home office and write out this image, I notice my expression of smiling sweetness and wonder if that was real or part of the costume? The photographer sent a series of the prints to each nursing student and I eagerly looked for mine. I really loved how I looked in that picture—a nurse, an angel, a person with a purpose. But, what was hanging from my right ear? It is green and lacey; it is a piece of the floral arrangement, hanging in the curls above my shoulder. As I write this, over a quarter of a century later, my body squirms with humiliation and laughter. That picture was supposed to embody Gail the nurse and it seems to parody that identity. Amma, my maternal grandmother in Winnipeg, still has that picture in her living room. She relates to me as a real nurse, even with ivy in my hair, because of the uniform and cap.

At this same time, my parents gave me a school ring for a graduation present. The ring was gold with the University of Toronto shield and with the Faculty of Nursing, 1975 written on it. I wore the ring on my little finger of my right hand as soon as it was delivered. At that time, because of my plan to work in children’s mental health where we wore street clothes. I assumed that I would never wear a uniform with a pin or cap. The ring became my symbol of professionhood. It set me apart from other university graduates in that I had a profession; it set me apart from my nursing student colleagues who wanted mainstream, medical-surgical nursing positions; and, it represented my identity of specialization in child psychiatry in health care.

The photographer gave me a second sitting, this time without ivy in my hair, in the spring of 1975. By then I had cut my hair short and wore a black university gown with a blue, gold, and white hood. The picture shows me from the shoulders up. Had my hands been revealed, you would see that I no longer wore an engagement ring. At that time, my fiancé planned to move to the Maritimes for a media job and I only wanted to work in Toronto at the Hospital for Sick Children in Child and Family Psychiatry. Church and reception hall bookings notwithstanding, if the choice was marriage and moving or the only nursing job I wanted in the world, he got to move to the Maritimes alone.

Sixty years after my great-grandmother moved home with her parents, secretly married and visibly pregnant, I had the privilege of a different plotline and life choices,
largely because of my education and advances in birth control. This is one way to look at the connections between Stina's life and my own. I also wonder about her capacity to choose her heart's desire in spite of strong social disapproval and how this could be instructive for my own life. This thought raises a question for me about how it matters that nurses' experience, including my own, is the basis of identity and knowledge in contrast to expectation and convention.

To celebrate our graduation in May 1975, my sister Carol and I went to Florida with four of my nursing friends. As I walked on the beach one morning, while smoothing suntan lotion on my arms and hands, my school ring fell off into the water at my feet. Leaning down to retrieve it, I watched in horror as a wave carried my ring away from me towards the open ocean. I never saw that ring again. I do not remember if I told my parents about this or not, but I remember getting a replacement School ring. Where it is now, in the year 2000, I do not know.

A nurse teacher colleague, Alix, wrote to me after reading this chapter in an earlier version:

For me the disconnection was immediate too. My uniform collar rubbed, scratched and confined. I felt trapped, trapped because my mother wanted me to become a nurse and trapped because I wondered "what else can I do?" I had been shaped and reshaped all my life at home towards this end. At nursing school. I consented to be further and further shaped away from my real self. The image of the perfect nurse, the perfect human being is what I sought. That image, that dream, that vision is so flawed.

I had a teacher at my hospital nursing school who would come into a patient's room and stand silently behind students. I came to FEEL her eerie, frightening presence which was magnified by a stern, pinched face, standing with her hands clenched behind her back and a persistent rocking back and forth. I was not alone in my terror of her. I think I almost hated her and blamed her for my self-doubt in myself as a person and a nurse. I felt little sadness when I learned of her suicide after several medical leaves of absence. For me, as I became a nurse teacher, I worked so hard at modeling the opposite way of being. Thankfully, we had many other more
grounded and kindly teachers who helped me to find my way. Is the picture ever perfect? Of course not, yet somehow I fell into a trapped way of thinking/believing that it should/could be. (McGregor, email, February 8th, 2000).

Perhaps other nurses feel this way about being a nurse—that it is complex and autobiographically meaningful. My research explores that possibility. For me, the connections between the picture with the ivy in my hair and losing my nursing ring remain unmade even today. What does it mean that a profession I entered by default was not to be symbolized in my life by costume or jewelry? Should I have entered nursing, left early in my career or was there a deeper meaning for me? The search is still on.

Who am I in Nursing?

Full-time work as a nurse after my 1975 graduation, and over the next decade and a half, included child and family psychiatry and public health as a staff nurse; in pediatric cardiology and oncology as a Clinical Nurse Specialist; and in hospital administration as a Director of Nursing. For reasons that will be explicated later on, I left full-time hospital nursing in 1989. Constructing a multiple part-time workstyle for myself in the 1990s, I worked in health policy, educational consulting, and sessional teaching at a university.

In 1995, exactly 20 years after graduating with a BScN, I began my doctorate in curriculum studies and teacher development. It was out of the question for me to do my doctorate in nursing. Rebelling at the idea of re-entering the local academic nursing environment and despite my years of service, I began my doctoral studies resisting and rejecting a nurse identity. During introductions in classes, I mentioned being a nurse at the end of sharing about myself even though I was working part-time in nursing education. I felt uncertain about staying in nursing and even contemplated letting my professional registration lapse. I felt very judgmental towards women nursing colleagues in my classes and distant from their descriptions of nursing practice. An accurate way to describe my stance at that point is righteous isolation and, paradoxically, suffering from a lack of connection or belonging.

In preparation for my comprehensive examinations and for writing my proposal, I attended a Works-in-Progress course sponsored by my supervisor, Dr. Connelly, in the winter of 1997. One of the other students participating in this session was a male nurse.
He told his stories of education and practice and my embodied response was hot rage. Immediately, I moved into a gender story about how men move ahead in nursing and about how I resent them being in nursing. Silently I asked, “They have so much of the world already, can’t women have nursing?” His sense of freedom to move, to say what he thinks, and to negotiate with administrators and physicians is in sharp contrast to the constrictions I feel about my behaviour and choices. Noticing my emotional response with surprise, I wondered if I feel this strongly, then perhaps being a nurse does matter to me. Since the Works-in-Progress seminar and the ensuing discussion that ruffled my own notions of distance from nursing, I have asked: How does it matter that I am a nurse and how I am involved in the world of health care? At that time, as a sessional nursing teacher, I also wondered how understanding more about nurses’ experience in reform mattered to the BScN curriculum at the university.

Unlike Alix who grew up with a mother who was a nurse, I had no role model beyond my childhood books about nurses, such as Cherry Ames (Wells, 1943, 1944, 1946). My own stereotypes and assumptions about how nurses are regarded socially create tensions underlying my sense of nursing as a profession. Images of nursing are “loaded with inherited meanings” (Brandt, 1996, p. 34) which suggests to me that nursing is a role with costumes and scripted dialogue. Nursing can be a metaphor (Diers, 1986) in that nurses can be interpreted to represent mother, religious sister, conscience, intimacy or dependency (Fagin & Diers, 1983). Handmaiden holding a bedpan or wife to a doctor are other common nursing images.

As I shared with Mary, a Director colleague, when we worked in hospital administration in the late 1980s, I felt like an abused wife who had left her husband, only to find out that her boyfriend was an alcoholic. I identified the physicians with the abusive husband and the hospital administrators with the alcoholic boyfriend. Mary commented that she imagined being the mother of the physicians and dealt with them within that role to create distance and safety for herself. This family imagery of hospital administration played out in my experience. Given that nursing administrators are the mothers and doctors and senior administrators are the fathers, then staff are in the role of children. Lovell (1981) illustrates how the hospital is an extension of the physician’s home territory. Nurses are medical wives organizing the physician’s work with patients.
(who are predominantly female), while cleaning up after him. This view of nursing recognizes tasks and dependent relationships without acknowledging what nurses know or the necessary interdependence of their relationships in a social world.

A medical sociologist, Oakley (1986), comments on her 15 years of work with patients and doctors with "nurses around somewhere in these scenarios" (p. 182) Upon reflection, Oakley sees doctors and nurses as parents with patients as children. Her own awakening to "seriously notice" nurses was as a patient on a cancer ward. Could this lack of notice be about a lack of relationship between nurses and patients? Watson (1999) argues that contemporary health care restructuring tinkers with an already broken model. Explaining that nurses' relationships to physicians and institutions have overshadowed a direct connection to people who are patients, she urges nurses to redress this imbalance. If family stories at least partially determine nurses' connections with others, what meaning and significance will be illuminated through reconstruction of personal experience? I take direction for my inquiry from this question in subsequent chapters.

Bev, my writing partner, described her picture of a nurse from a public school experience when we were at the American Educational Research Association meeting in Montreal in April 1999. According to Bev, a nurse is a tall, lean, imposing, thin-lipped woman with sucked in nostrils who looks down at you and makes you feel your concerns are too small for her attention. While anxiously reviewing which of those characteristics I might have, I want to disown it all. I'm not like that, I think, and I don't want to be associated with someone like that. This is a brief example of how I am influenced by how others see nursing. Instead of trying to understand with Bev how her experience mattered narratively to her, I take the vignette into my story of nursing. I implicitly agree that nurses are like that description and, therefore, I too must be like that if I am a nurse. My sense of nursing identity has been static, one-dimensional, and context-free. Now that I am working with the idea that person and profession are inextricably connected in nursing, I wonder how to understand myself as a nurse, spatially and temporally positioned. And, I wonder how this narrative positioning matters to other nurses, nursing students, and patients.

Watson (1999) calls for nursing as a metaphor symbolizing deep, healing, feminine energies with human caring as the core of nursing. She is dismayed that
mainstream discourse about health care reform has not identified nursing as one of the primary solutions. Just as Woodman and Dickson (1996) and Chernin (1987) have, Watson theorizes that balance between feminine and masculine energy is necessary for men and women in the new millennium. This requires recognition and respect for feminine energy that has been subordinated and repressed. Can I take Watson’s thinking seriously and value my experience as a woman? What does it mean to value feminine attributes and act on those values? It is frightening to align myself with other women. My models so far have been abandoned single mothers, humiliated housewives, and strict, disapproving nurses. How does it make a difference if, instead of externally defined images and metaphors, I had a story to tell myself to live by—an identity—arising from inside my experience of life? How does it matter if who I am as a person is who I am as a nurse? Asking these questions, what could we learn from other nurses?

McMahon (1991) dared to ask these questions of her life in a film that was part of her Masters thesis, entitled Nursing History. She was “too embarrassed to admit that the theories were not making my life fall in order, feeling like a failure, not smart enough, not a good enough feminist—unable in the end, as I’d been told all along, to GET IT RIGHT” (p. 25). She intuited that her strong feelings of exclusion led to her conventional way of approaching social situations. She was a nurse who left nursing in 1982 and completed an undergraduate degree in cinema studies. McMahon recognized that “school had provided me with the analytical tools to conceptualize my experiences in a way that helped explain why I felt the way I did in circumstances of regulation and subordination” (p. 26). She returned to nursing for a year before leaving again, “apparently with more success because this time I haven’t been back. I say ‘apparently’ because although I have left the field, the urge to care for others as my major pre/occupation has never left” (p. 26). She did not understand the personal specificity of her response to situations where subordinate-caring behaviour is called up in her. Making the film, using images and family home movies, “the feeling of not being who I was told I should be” and “analyzing my efforts to be who I was not” (p. 27), McMahon explored why she couldn’t stop caring. “I had expected that the trauma of oppression would simply go away now that I had a theory to explain it. Well, it didn’t. The secret memories I had about how I learned not to speak, to be passive, to service others, threatened to overwhelm the
present...If only I could be satisfied nursing” (p. 30). McMahon was aware of the tension between longing to know another story and the pressure to identify with and dutifully repeat the family story. “The tension acted as an emotional barrier preventing me from crossing over to discover something that I was not prepared to know. What I was not prepared to know made me vulnerable to conformity” (p. 30).

What McMahon (1991) revisioned through her inquiry was a daily event in her childhood—physical abuse by her father. She reframed her caring as “an identity through which I came to ensure my safety as a child in a violent household” (p. 32). Nursing was how she was paid “for doing what I had taught myself to do—make other people’s spoken and unspoken needs direct my actions and thus form the basis of my sense of what was real in the world at large” (p. 32). She came, through her reconstruction of experience, to see how her history, identity, and professional work were connected and had meaning. She uncovered the knowledge that informed her actions. She called this scholarly activity “housekeeping of the heart...because without our stories recovered, the past haunts the present and hopelessly claims the future. The possibility of living here and now is lost to the compulsive need to deny through repetition the past as we live it” (p. 33).

Connecting to McMahon’s (1991) research, I see a nurse who is reconstructing her experience and changing how she is in the world. She needed to see the relationship between theory and practice as emergent from life experience before she could change her behaviour. This is what is missing in health care reform literature about nurses and nursing. People are not conceptualized as embedded in a daily life with plotlines and narrative tensions informing their actions. This is another gap my inquiry addresses.

McMahon’s (1991) autobiographical, she called it historical, recovery of her experience and reconstruction of meaning shows how the intermingling inward, outward, temporality, and place construct knowledge and identity. Given Watson’s (1999) and others’ call to transform nursing practice in concert with others, I start with the assumption that it matters to explore how nurses shape and are shaped by their life situations which include personal and professional experiences. My assumption is grounded in the unitary nature of life, reframing dualities such as theory/practice, mind/body, personal/professional into dialectics. This transformation in thinking
uncovers the deeper connections of apparent contradictions. What I hope to reveal is how it matters that nurses’ narratively reconstruct their experience, which incorporates our new experiences, and informs praxis, teaching/learning relationships, and curriculum.

Moving Forward in Inquiry

Chapter one begins a narrative reconstruction of RNs’ experience in healthcare restructuring. The separations and despair I experienced in entering nursing by default and being externally shaped are mirrored in the reform literature presented. Quantitative studies document health care system characteristics and nurses’ job satisfaction or dissatisfaction within corporate restructuring. Qualitative studies use narratives or story as a description of current circumstances, but do not explore nurses lives’ inwardly and temporally. The literature posits conflicting views of what is the future of nursing and does not locate such discernments in individual nurses. Expectations that nurses keep the system running within administrative or business/economic paradigms dominates the literature. Strategies for coping with restructuring are organizationally top-down and psychological. Narrative inquiry, based on Dewey (1938), Clandinin and Connelly’s (1995, 2000), and Connelly and Clandinin’s (1999) line of research, offers social reconstruction and exploration of life experience as a means to construct identities and knowledge.

The first chapter outlines how in narrative space, between convention and self-expression, education as learning from reconstruction of life experience is possible. Family stories, relevant research, and literature are threaded throughout my inquiry. The puzzle for me is how reconstruction of our experiences matters to nurses’ sense of themselves and their actions in the world. The call for transforming nursing can be implemented in individual nurse’s lives, offering undreamed of future possibilities. A hoped-for consequence of my research is sharing a process for nurses to explore their personal capacity for learning, caring, and healing.

The second chapter elaborates on how narrative reconstruction of everyday, personal experience matters to identity, knowledge construction, and action in the world. Dailliness writing is linked to the phenomenon and method of narrative inquiry. One of the features of writing narratively is that by the time I came to record my inquiry, ideas that I did not know about when I began my research have been revealed. The
phenomenon that was such a puzzle to me initially has transformed and deepened. It is now possible to write and share some of this movement that underpins my thesis.

One of the connections that will be elaborated in chapter two is how narrative inquiry of Clandinin and Connelly (2000) in curriculum studies and interpretive phenomenology and narrative pedagogy of Diekelmann (1993, 2001) in nursing research and education touch, allowing me to cross over into nursing theory and practice. The basis of narrative inquiry and my research is Dewey’s (1938) philosophical pragmatism and theory of experience. Narrative pedagogy in nursing education research embraces diverse philosophies, including phenomenology, pragmatism, feminism, postmodern, and critical social theory (Nehls. 1995).

Chapter three shows how I had no story of myself as a nurse when I began my inquiry other than as a failure and as someone who had withdrawn from the perceived chaos of the health care system into the separate world of education. I left full-time administrative work in hospitals in 1989 and, in some important ways, what happened prior to that felt like frozen experience. It was so difficult to take in and reflect on my experience that I could not make sense of it, nor learn from it. The reconstruction of family-centred care stories from that time are the core autobiographical exploration that I will share in the third chapter.

Dr. Martha Rogers, at my spring 1998 proposal and ethics committee meetings, suggested that I interview administrators to avoid characterizing them unidimensionally. This idea grew to include seven new participants. As I transcribed our conversations, the intersections of stories between people across a health care and education landscape became apparent. This mingling of stories in chapter four co-creates a liminal space within which we can wonder how else you and I, or any nurse, can live. The composite conversations I created from our conversation transcripts include you as reader and myself as researcher in the role of listener.

Initially, I conceptualized having three co-participants as representatives of different worlds—administration, clinical practice, and education. It became evident to me as I transcribed tapes of our conversations in chapter four that there is a social world that can be viewed from many different perspectives, but it is a whole world. Additionally, I learned that there are many different ways to be a nurse, incorporating
several roles or functions at once, so my distinctions were artificial and not helpful to understand individual specificity in a context. When participants are known intimately as people, not merely as categorical representatives, categories fragment (Clandinin & Connelly, 2000). Understanding this resulted in only one more co-participant being included in my thesis. I met for over two years with Sasha, a nurse in clinical practice and concurrently in a Post-RN BScN program. To show the meaning and significance of reconstructing of experience, my co-participant Sasha tells and retells her stories in chapter five which also reveals links to her BScN curriculum.

Chapter six explores how reconstruction of experience and revealing the thinking of Registered Nurses matters to nurse-teachers and their practice and, therefore, to society. In conversation with nurse educators who are my research audience, we share responses that uncovers the ‘so-what’ of my research. One of the consequences of appreciating nurses as knowledge-makers is an interruption in the idea of nurses as passive, as only taking direction, as being interchangeable cogs in institutional wheels. This notion calls us to acknowledge the awareness a nurse needs to practice, for personal responsibility, for seeing possibilities to act in ways that are caring and healing and to resist practices that undermine the humanity of people in their care and of themselves. In this conceptualization of my inquiry, life experience as narrative is foregrounded. To paraphrase Clandinin’s (1986) inquiry, my study explores how nurses’ identity and knowledge is narratively composed, embodied, and expressed in nursing praxis through reconstruction of experience in healthcare reform.

As you read on, please think about what difference it makes if nurses construct identity and knowledge from their experiences, and enact that learning capacity in health care and other life situations. This is where I will stop my introductory chapter. I am interested in the intersections and resonances my experience and questions have for you, dear reader. In the next chapter, we will explore thinking narratively and how narrative inquiry contributes to our understanding of nurses’ experience in healthcare reform.
Chapter One Endnotes

1. In my research, ‘nurse’ means Registered Nurse. The term nurse is legally defined in the Regulated Health Professions Act (1991) (RHPA), which came into effect in 1993. RHPA is provincial legislation in Ontario that defines the twenty-four self-regulated health professions. All disciplines share a mandated College structure and activities such as Quality Assurance Committees. Each profession also has its own Act which defines the scope and practice of practitioners. The Nurses Act defines three kinds of nurses, Registered Nurses, Registered Practical Nurses, and Christian Science Nurses (*). Christian Science Nurses only work within their religious parameters. Registered Practical Nurses (RPNs) are educated in community colleges (one to two years) and receive a diploma. They are regulated by the College of Nurses of Ontario and have their own Standards of Practice. RPNs are accountable for their own practice which is sometimes supervised by Registered Nurses. Registered Nurses (RNs) are educated in community colleges and universities. By the year 2001, nursing students can only be in degree-granting programs, as by 2005 no nurse may enter practice without a BScN (or equivalent). The RHPA/Nurses Act legally defines both RNs and RPNs as nurses. However, my co-participants and myself are all RNs so for the purposes of my inquiry, only Registered Nurses are included in the term ‘nurses’.

(*) As of 1998. Nurse Practitioners are included through the Expanded Nursing Services for Patients Act as Extended Class Registered Nurses (RNECs).

2. On September 30, 2000 at my sister’s home in Waterloo, Ontario, my family celebrated my maternal grandparents’ 70th wedding anniversary, which actually falls on October 18. My grandfather wore his wedding shoes, brown lace-up Florsheims, that have been his dancing and party shoes over the years. I waited for a moment in a weekend of visits and dinners to show AfI how he was included in my thesis. With his agreement, including acknowledgement that he would hear some of his father’s words, I read the three and a half pages of this chapter that start ‘Family history as reconstructed so far.’ Tears slipped down his cheeks and he nodded often, hearing the words that came from his father’s letters and from his own autobiographical writings. He shared some new details and said it was important to include them in my writing. The first story, already
alluded to in my writing, is about Afi completing grade 10 with honours and getting a scholarship to a new school for grade 11. He could not take the scholarship because his family could not afford the 35 cents a day train fare for his transportation to school. Instead, he went to work for neighbouring farmers, cutting cordwood in the forest for 75 cents a day. This leads to the second story. One day, after cutting and stacking wood in the forest, Afi came home and his step-father asked him to clean the cow’s barn. Afi asked why his younger brother couldn’t have done that work as Lorne was home during the day. Afi said his step-father responded with his fists, so at the first opportunity, 16 years old, Afi left Ardal for Winnipeg to work as the night manager in the Leland Hotel. Afi said “that’s when my life changed direction from what it could have been—it was the dividing line of my life.” My grandmother, he said, was his friend in those years when he could have gone so wrong with the contact every night with drinking, fighting, and women who wanted to rent a room only briefly. Margaret was the one person he knew from home with whom he could talk.

In response to my words about his legitimacy being important to him, Afi also told me that his mother’s parents took her to Winnipeg in the new year of 1909 and got John Wallace at the law college. They stood with the young couple in front of a minister which is how the marriage took place six months before Afi was born. So, Stina’s parents did find out who the father was. Did Stina tell easily? Did she want them to help her convince John of the need for a wedding? Or did she try to protect him and only told under parental pressure? I like having this additional detail and interpret it to mean that my great-grandmother had some family and social support, despite John’s wishes that her daily life be lived as a secret.
Chapter Two

A Conversation Between Narrative Inquiry and Heideggarian

Phenomenology about Daily Life Experience

Thinking Narratively

In the first chapter, the purpose of my inquiry and the gaps in nursing research and literature were introduced. My research into nurses’ experience in healthcare reform goes beyond external, negative events that are imposed on nurses to address issues of identity and knowledge making through narrative inquiry. Exploring how (1) nurses understand being in a professional knowledge landscape requires a method/process of research that will reveal how becoming a nurse is autobiographically meaningful and socially significant.

In this second chapter, I introduce narrative inquiry as a phenomenon and method that contributes to nursing education research. Readers will see how narrative inquiry relates to the phenomenological nursing literature in terms of storying experience. Before having that methodological conversation, I turn to dailiness writing to make a distinction between story as a description of life experience and narrative reconstruction of daily life. In my inquiry, nurses are co-inquirers and knowledge-makers, mutually shaping life situations through reconstruction of experience and living in new ways. To inquire narratively is to begin with daily life and so we return to Stina, John, my grandfather, and me.

A little girl of eight and nine, visiting my great grandmother Stina by myself, I remember how she would get on her hands and knees and pull a locked brown suitcase from beneath her white iron bed frame. Each time, we would pore over black and white photographs, square in shape instead of the rectangle that I was used to, because they were taken with her old box camera. Two stories, retold in the quiet of her bed-sitting room, were thrilling and frightening. One was about her nine-year old son, a twin, who had died of pneumonia. Seeing him as photographed, in his coffin, and touching locks of his hair that she had saved, I felt chilled by the impossibility of a child my age dying. The other story was about an item in a crumpled newspaper that documented the drowning of a young man. She did not share many details about him, but I felt these were the loves
and tragedies of her life—losing this man and her son. In my child’s understanding, my
great-grandmother’s real life stopped with these two losses, her grief seemed so fresh. I
did not know how such events could be part of a life that went on to new happenings, a
fabric that continued to be woven, and that holes made by loss could be rethreaded with
new colours and textures.

My great-grandfather came into the daily life of my great-grandmother and her
family on their Manitoba homestead, a world that had a continuity of past-present-future,
and the interaction of people and events. The boarding house homestead had ongoing
stories, as did the people who lived there either full-time or just passing through. John
was on his way somewhere else and interrupted his work and studies to have a
relationship with Stina. Did she imagine leaving her family boarding house to be the wife
of a lawyer? Pregnant and believing that he would return, did she dream of creating a
new family story? When I was a teenager in the 1960s, I could imagine no fate worse
than unmarried pregnancy and Stina faced that stigma 50 years before. John writes that
he will send the ring, presumably by mail, as there is nothing in his letters to her to
indicate that he would be returning to Ardal. And what about John, what was his story?
He moved from Prince Edward Island to Manitoba to go to law school. Was he the son of
a lawyer? Why did he go to school so far from home? Was Stina a dalliance, pleasant but
not enough to stay for? What did he feel for his son?

My great-grandmother, Stina, moved beyond convention to have a relationship
with John and lived in liminal, in-between space, with risk and unknowing keeping her
company. While I do not know what sense my great-grandparents made of their
circumstances, Stina did keep her lover’s letters and decades later gave them to their son.
He did not read them, but kept them safe from harm and passed them to me, his
daughter’s eldest daughter. Stina lived the contents of the letters and we can only guess
what she hoped her son would glean from reading his father’s letters. Based on my
grandfather’s reaction to the letters as he passed them to me, I wonder what they mean to
him and how the circumstances they represent shape his life and relationships? I know
that in the last decade of her life. Af visited Stina everyday in the nursing home to feed
her lunch and to keep her company. This story grips me because I interpret that my
grandfather lived his life in love and duty. I theorize that my grandfather felt responsible
for the conditions of his mother’s life, including the absence of his father. My great-grandfather shaped my grandfather’s life, in his absence and even from the grave. The letters were a chance for my grandfather to know his father, on John’s terms, to see the young man who loved and apparently chose school and career over family. I do not know my grandfather’s perspective on his parents’ story. Wanting to be harsh with John about his choices. I admit to having made what feels like a similar decision related to my education and career.

Out of this story of my family, I see how thinking narratively matters to my research. By entering the story, I see how the past comes into the present and shapes the future. I am intrigued by what we cannot know about my great-grandparents’ points of view—the stories they told themselves to live by. Thinking narratively reveals what I can claim to know about a situation and what I have assumed to know, the latter being my own perspective ascribed to others. This distinction about knowledge brings me up short—how much of what I ‘know’ is only a mirror of what I already hold to be true? If the story can be told from each person’s perspective, what new information will be revealed? Alternate plotlines can be constructed, depending on how the ‘facts’ are interpreted. The sense of ongoing stories within a situation is illustrated—the intersection of narratives truly creates a tapestry of relationships. This dwelling with my great-grandparents enlarges my perspective beyond seeing life only through my own interpretation of what is happening. If my story is the only lens, so much detail is missed that could enhance understanding. Noting how taking multiple perspectives on experience reduces my sense of judgement about John and opens me to want to know him better. I wonder how it would matter to inquire in this way, through narrative reconstruction, with nurses? What possibilities for living might emerge through exploring life experience in a narrative inquiry?

From Nothing Personal to Narrative Inquiry

In 1978, I completed a thesis towards my Masters of Science in Nursing (Lindsay, 1978). I quantitatively measured the knowledge of different groups of parents about children’s growth and development. One parent group was from a local daycare and the other from a social service program for parents at risk to abuse or neglect their children. I collected no contextual information, except simple demographic data, and simply had the
parents complete a card sort of children's abilities into envelopes marked with ages and developmental stages. The results showed there was no quantifiable difference in the parents' knowledge about children's growth and development. This disputed the literature claim that ignorance of children's growth and development norms is a cause of child abuse and neglect. From my informal conversations with parents at the social service centre, I began to appreciate how they perceived their children. I did not have similar discussions with parents at the daycare centre. At that time in my life, I did not have an understanding of how these conversations mattered or might have made a difference to the children and their parents. Lacking also was a sense of how nursing theories about persons, health, environment, and nursing might illuminate my study. Nor was I aware or thoughtful about how the topic, participants, and/or method related to my life experience and nursing practice. It was nothing personal.

Also during graduate studies, I was introduced to theories of nursing practice. As a nurse in a child and family psychiatry clinical nurse specialist stream, I was drawn to Peplau's (1952) framework of interpersonal relations. Peplau assumes that nursing and nursing education involve "the fullest development of the nurse as a person who is aware of how she functions in a situation" (p. xii). This awareness makes understanding "recurring difficulties of everyday living" (p. xiii) possible between patient and nurse. Nursing as lifework, in Peplau's and my terms, is inextricably connected to who a nurse is as a person. What happens in a nurse's relationship with a patient and what both learn in daily situations requires exploration of personal knowledge. My understanding of the meaning of Peplau's work to my own practice as a nurse remained unexplored in graduate school. Nor did I have the means to "look at the learning experiences that helped lay down patterns of present behaviour" (p. xvi).

Two decades later, immersed in narrative curriculum studies and teacher development as a doctoral student and narrative inquirer, I am also a nurse-teacher exploring nursing practice theories and nursing education research related to narrative pedagogy. The method/process of my inquiry and the intersection of nursing with curriculum studies informs my actions as a nurse-teacher. Curriculum encompasses a person's life experience (Connelly & Clandinin, 1988) which is lived, told, reconstructed, and relived. My research explores narrative as a phenomenon (story) and as a method
(narrative inquiry) (Clandinin & Connelly, 1994). Narrative inquiry is one way to approach understanding the daily happenings that make up a life. Reconstruction of life’s dailiness and seeing connections that were previously unknown suggests anew what an experience might mean. This fresh understanding can interrupt how the identity ‘nurse’ “structures social interactions,” encouraging people to see nurses as persons (Lawler, 1993, p. 217). Looking at life in this way invites the questions, “how does it matter to construct a nursing identity based on life experience, and how does the resultant knowledge inform teaching/learning relationships and curriculum in a nursing classroom?”

How can these questions be approached? Starting with ourselves, embedded in a daily life, with identities that change in different situations and roles, readers will see how narrative inquiry is a research process for learning from our experiences. Pratt suggests that:

we start with ourselves; we stand at the beginning of the maze, in our own bodies, our own lives, and begin to unwind all from there....to include all of our identities, our multiple selves, the one who has been hurt, the one who has worked hurt on another, the one who has despised, the one who has gloried in another and in her self” (1991, p. 219).

Narrative inquiry is an established research method emerging from over 20 years of studying the thinking of teachers by Connelly and Clandinin (1999). Clandinin was Connelly’s student as Connelly was Schwab’s student and Schwab studied with Dewey. This research lineage is grounded in Dewey’s (1938) theory that experience and education are inextricably linked. Connelly and Clandinin explore their “epistemological interest in the personal and practical nature of education” (p. 1) and, “see teacher knowledge in terms of narrative life history, as storied life compositions....both personal—reflecting a person’s life history—and social—reflecting the milieu, the contexts in which teachers live” (p. 2). Connelly and Clandinin also embrace relevant research writing on story and narrative in social sciences and humanities by authors such as, Bateson (1990) and Geertz (1995) in anthropology, Coles (1989) in psychiatry, Johnson (1987) in philosophy, and MacIntyre (1981) on narrative unity. Being Connelly’s student in a professional knowledge landscape, I am contributing to nursing education research by crossing discipline boundaries with narrative inquiry. Writing my
research text, I also see the possibilities of extending narrative inquiry in nursing to include issues of ontology (being-becoming), as well as epistemology (knowing) and its consequences (actions in the world).

Narrative inquiry is a way of doing research and understanding experience that is a departure from how I grew up to understand notions of the ‘real’ world. For a long time, I ascribed to the notion that there are separate worlds, such as practice and education or the personal and social. This thinking allowed me to compartmentalize my life which led to feeling contextless and atomistic in my daily life—wondering about the purpose and meaning of my life, the opposite of ‘wide-awake’ with energy. After leaving full-time hospital work in 1989 and beginning as a university sessional teacher, I worried that my ‘real’ experience in nursing practice as a clinician was becoming dated. My sense of nursing matched the students’ images in Kiger’s research that describe a “scene in an adult medical or surgical Nightingale-style open ward” (1993, p.310). The ‘good’ nurse was characterized by cheerfulness and caring, “needing to get involved with patients and relatives in order to be truly caring despite the fact that this could be at great cost to herself and she should not show her feelings” (p.311). My research interrupts the idea that nursing-as-epistemology is in conflict with its ontology by exploring how identity and knowledge construction are experientially based and interconnected.

How could I have an identity with integrity as a nurse-teacher if I felt increasingly irrelevant and confused about what constituted my current nursing practice? My notions of identity were externally derived—place, other people, and roles defined me as a nurse. Wanting to be relevant, to be in a meaningful relationship with nursing students, I come to narrative inquiry as a way of thinking that includes who I am as a person. Jardine and Clandinin (1987) elaborate on this sense of knowledge-making by suggesting that emergent meaning occurs when teachers and students intermingle narratively. Thinking narratively involves consideration of temporality and continuity in people’s lives and in social situations. In this way of knowing, separations between being a nurse and becoming a teacher fall away to reveal becoming a nurse-teacher. And my confusion about separate worlds is decreased by understanding that experience is “contextualized by a professional knowledge landscape which is composed of relationships among people, places, and things” (Clandinin & Connelly, 1995, p.5). For nurses, professional
knowledge landscapes include people and events in places, such as community-based and institutional health care agencies, schools, and other health-related organizations. People and landscapes each have narrative histories that can be explored through telling and reconstructing stories of experience for identity and knowledge-making.

A Nurse-Teacher’s Story

Thinking narratively about our lives as nurses is one way to learn from our experiences. Discerning stories to tell ourselves to live by, from our experience, is shaping a professional identity according to Connelly and Clandinin (1999) and is contextualized in practice landscapes. As you probably can already see, that sense of ongoing personal and social stories in my professional life was missing as I thought that I could be an observer without participating.

In Connelly and Clandinin’s (1999) book about how a professional identity is shaped, there is a story of a nurse-teacher. When I read Nancy’s story of teaching in her professional knowledge landscape at a community college, I connected with her despair about nursing and dislike of her own nursing education (Quan, Phillon, & He, 1999). Nancy was influenced by teachers who did not value what she was drawn to in nursing and who discredited her diploma education and experience. She loved nursing, but hated the working conditions of clinical practice. The discrepancies between Nancy’s identity and role result in “her despair at professional incompatibilities” (Connelly & Clandinin, 1999, p. 85). She left nursing several times and finally landed in nursing education as a place where she could feel satisfied as a nurse. Nancy made a point of being a nursing teacher who taught differently from what she experienced in her own education. She uses her personal stories of practice and students’ life experiences to shape her classroom actions. The social environment has remained chaotic and uncertain throughout her working life; what has changed is her sense of how to be a nurse. Nancy’s identity as a nurse-teacher is illustrated through the stories she tells herself to live by and through her actions in a social world. Her identity of nurse in clinical practice has shifted over time to nurse-teacher.

In the curriculum studies literature, teachers’ knowledge was conceptualized as ‘practical’ by Elbaz (1981). She interviewed a teacher, Sarah, and wrote a case study that highlighted the relationship between practice and knowledge. Elaborating on this work,
Connelly and Clandinin (1988) define personal practical knowledge, which is found in our bodies, including our minds, and in our practices, as "a particular way of reconstructing the past and the intentions for the future to deal with the exigencies of a present situation" (p. 25). Personal practical knowledge emerges from experience in the same way that Schwab indicated that theory must be embedded in "the concrete enquiry which gave birth to it" (1971, p. 512). Connelly and Clandinin further identify personal practical knowledge as "embodied, narrative, relational knowledge carried autobiographically and by virtue of their formal education by teachers" (1995, p. 3). Nancy's personal practical knowledge is revealed in conversations and practices with students and colleagues.

Clandinin and Connelly (1995) suggest that being a professional, such as a nurse or a teacher, has educational qualities that occur through three human desires: to tell stories, to be in relationship, and to reflect on experience. These authors distinguish between education that is cultivation and education that awakens and transforms. If the same story is told about a person, event, or place such that social expectations are taught (habits, manners, values), this is education as cultivation. If a story is reconstructed and retold with new understanding, this is education as awakening. When a person relives her/his experience by acting in a changed manner, this is education as transformation.

In thinking about Nancy's story and my own, I wonder about the place for nurses to express their desires—for storytelling, relationships, and reflection to achieve awakening and transformation? I would like my thesis and my classroom to be a place of safety for me and for my colleagues to share our experiences. My inquiry shows how a teacher's identity and personal practical knowledge informs curriculum and influences people as they become nurses. Students' conceptualization of becoming a nurse and their retention in the healthcare system partially depends on the meaning-making expressed in their knowledge and identity. My study explores how a Registered Nurses' personal practical knowledge informs identity and actions in social situations.

Nothing Personal in Nursing Education

A perspective which respects nurses' daily experience and assumes all nursing students have a life to draw their education from is not commonplace in nursing education. A university faculty member in a 1998 university paper was quoted as saying:
“It is exciting to work with students at the undergraduate level who know nothing and then watch them grow. It is an opportunity for me to engender the passion into people eager to become nurses” (Robson, p. 3).

At a curriculum meeting referred to in later chapters, community college faculty conceded that narrative approaches to nursing education would be possible in the second year of the program, but not in the first year because that’s when faculty have to tell students what they need to know. In the early 1990s, when teaching a senior level degree course to nurses, a faculty member said I should discourage students from discussing their clinical experiences or the whole class could go by spent on nothing; we should focus on the readings. When I ask Post-RN students if they understand themselves to be the same or different when they are at work in clinical situations, inevitably several students are vehement that they are separate people at home and at work. Very recently at a curriculum meeting, a faculty member told me that my idea “who you are as a person is who you are as a nurse” was too big for students to handle. Separation between daily life experience and theory-based curriculum is structured into nursing education. As I work through inquiry and writing, to transform my own separateness into awareness and relationships, my passion grows for nurses to understand how it matters to include yourself as a creator of meaning and as a knowledge-maker in a professional landscape. It matters to counter the belief that “whenever thinking is done higher up, wherever external authority reigns, thinking (by those lower down) is suspect and obnoxious” (Dewey, 1920/1957, p. 139). It matters to me as a nurse-teacher who wants to go beyond cultivation as education, in the sense of giving received knowledge as curriculum. Tanner (1990a) calls for nursing faculty development to deal with a fundamental conflict “as we attempt to ‘prepare’ nurses for the marketplace where the jobs are, and to ‘educate’ nurses for a practice that might be more responsive to health care needs” (p. 71). For me, responsiveness assumes awareness and relationship which is possible only when people apprehend themselves as part of a situation. “When external control is rejected, the problem becomes that of finding the factors of control that are inherent within experience” (Dewey, 1938, p. 21). Seeking for learning and education through exploration of our experience is necessary for students and teachers of nursing.
The principle that ‘who I am as a person is who I am as a nurse’ seems true in my experience, yet it cannot be stated as a context-free belief. I worry that this principle could be used as a way to categorize people, to mould them into the perfect nurse, another externally mandated identity. Or, it could be understood to mean that becoming a nurse is developing a set of characteristics, as presented to a class of graduating nurses in 1904 by Mary Agnes Snively, Toronto General Hospital’s Superintendent of Training:

What will be accomplished in this new century will depend quite as much upon what nurses are individually as upon what they do (p. 836)…I ask the question, what manner of women ought nurses to be? Because it seems to me the great question of the moment; because the longer I remain with nurses. I realize with ever-deepening conviction that it is the woman herself that is the all-important factor in the making of the nurse (p. 837)…To the superficial observer you have only been engaged in making beds, bearing the numberless annoyances which sickness entails, and attending to the hundreds of petty duties which go to make up the thrice three hundred and sixty-five days allotted to your training. Nevertheless, consciously or otherwise, you have been engaged in a much grander, nobler and more lasting work, viz., that of the formation of character. That you are more kind, considerate, intelligent, capable to-day than you were three years ago proves this, and this result dates back to that hour in your life when the decision. “I will be a nurse” was reached (p. 838).

In my terms, reconstructing daily life experience to create a story to live by defines who the nurse is becoming and constructs knowledge in specific social situations. The person who is a nurse is situationally and relationally embedded in a particular life and time. This is inside-out work that reveals meaning and knowledge construction and can be done by each nurse. As opposed to wearing a costume and assuming a role, becoming a nurse is autobiographically meaningful and expressed as a unique social contribution. Clarifying this principle is important to me so that readers will understand I do not mean to conflate person and nurse into another external definition of how to be a nurse that determines, reduces, or categorizes people.

**Stories and Narrative Terms**

It is one thing to describe a happenstance as if simply telling it as a story is all there is to know. Description of events and players in a situation is one way to build up the muscles of noticing—what happened, to whom, how did it feel, what did you see, what was said, is there a sensation in your body that belies what is being told? Full and
textured recounting of events and relationships can stand alone. But the “passive accumulation of experiences...is like the ant who busily runs about and collects and piles up heaps of raw materials” (Dewey, 1920/1957, p. 32). There are deeper levels of inquiry.

Inquiring into the narrative plotline related to each person’s life, the history of the setting, and how these stories intermingle sets up the situation as a puzzle to be reflected upon. Creating a narrative account that includes temporality, motivations, context, and other considerations shows a point of view that is constructed knowledge. Based on how the narrator or audience connect with this telling and are drawn into their own experience so they further reconstruct the experience to make more meaning, the story is changed and so is the person which influences her/his situation, and so it goes. Dewey likens reconstruction to the work of the bee who also collects raw materials but “modifies the collected stuff in order to make it yield its hidden treasure” (1920/1957, p. 32).

Stories of personal experience of patients, nurses, nursing students, and their teachers are pervasive in nursing education literature. Some stories are told at the end of shift report to communicate what is going on with specific patients or to exemplify a concern. Some stories of profound contact with patients may be told but remain undocumented—secret practices of connection (Krejci, 1995). Written stories reflect conflict and ethical concerns when nurses attempt to challenge institutional policies and practices (Parker, 1990). Such stories can go underground so a nurse can “maintain personal integrity or to avoid further devaluation” (Parker, p. 39).

Nursing education research literature encourages reflection on immediate experience through story-telling (Geanellos, 1995; Krystl, 1991; Sandelowski, 1991). Boykin and Schoenhofer (1991) suggest that “nursing stories reflect the lived experience of a nursing situation involving nurse and client” and illuminate nursing knowledge because these “stories naturally serve as an exquisite resource for understanding the content of nursing” (p. 246). Building on Carper’s (1975, 1978) nursing research on the four fundamental patterns of knowing (personal, empirical, ethical, and aesthetic), other nursing authors show how multiple ways of knowing, expressed in practice stories, build a unique epistemological base for nursing and conceptualize the nurse as knowledge maker (Antrobus, 1997; Johns, 1995). Story is utilized in Boykin and Schoenhofer’s
work as a method to recreate a nursing situation. An example from my experience follows:

In 1980/81, I was a Clinical Nurse Specialist working with children who had cancer and their families. While I explained the system, tests, and treatments to the families, they taught me about living each day with the experience of cancer. I learned that when a child died, the family ached to talk to someone who would say the child’s name without fearing the emotions evoked, so they welcomed phone calls from the nurses. Mothers said they caught themselves setting a place at the table for an absent child and sometimes heard their child’s voice coming in from school. Reflecting on these stories from parents, I theorize about how they experience life after their child’s death. Parents came to understand that their fear of becoming crazy or of sensing the presence of their dead child is normal grieving, as they shared their daily experiences with me. I conceptualized my role with parents as co-learners, participating in situations that were new to us and hopefully assisting them to make sense of their experience.

In this example, my growth is related to understanding more about the parents’ experience. I was not questioning my experience or awakened to connection with my own life events. This reflection on a storied nursing situation shows how narrative and personal knowing are meant in nursing literature. Boykin and Schoenhofer (1991) conceptualize ‘story’ as a way to interpret phenomenological description. They state that:

Personal knowing is essential to “being” in a nursing situation. Nursing cannot occur from the exterior. It only occurs through entering the world of the person(s) being cared for, understanding that world and the calls emerging from it, and responding to them. Any approach short of this cannot be identified as nursing. In order to know and appreciate the world of another, it is necessary to first know self (p. 247).

These authors claim that story is a method of inquiry that grounds epistemology (knowing) in the ontology (being) of nursing as lived in scholarship and practice. The missing piece for me in this approach to storying is how the nurse is in the experience—how she/he knows self.

Sandelowski (1994) conceives of nursing intervention in narrative terms in that healing is “constructing stories that patients can live by and with” (p. 28). Vezeau
(1994b) goes further to suggest that the value of story and narrative ameliorates nurses' disengagement in practice as a response to the difficult work of nursing. "Creative narrative allows practicing nurses to walk around in a singular event, fully involved" (Vezeau, 1994b, p. 72). Story-telling about persons' lived experience as inquiry is accepted within qualitative nursing education research in the last decade (Dzurec, 1991; Sandelowski, 1996). A researcher telling a story about participants within an immediate situation, without reconstruction, is how the term narrative is generally used in the nursing literature. The researcher generally does not self-disclose or only shares professional stories. The relationship between researcher and participant may be enacted in a way that includes the researcher's personal awareness, but this is seldom evident in the writing. The puzzle for me is how to encourage nursing teachers and educational researchers to include themselves explicitly in their work with students and patients.

Dailiness Writing

Positioned to begin a conversation with my readers about narrative inquiry in curriculum studies and interpretive phenomenology in nursing education research, I notice that both 'methods' value everyday experience as a place of inquiry. Coming to terms with everyday experience by reading of others' lives and choices is the mirror image of writing and thinking narratively. My home office shelves are filled with books that show how autobiographical exploration of daily experience, relationships, and events matters to living a life that is grounded in connection and wide-awakeness. "We encounter each other in everyday life by means of roles and patterns of behaviour that are habitualized, consciously or unconsciously learned. But what is everyday life? It is important to recall that it constitutes an interpreted reality" (Greene, 1978, p. 213).

Being drawn to a style of writing that shows how a life is created, my curiosity is always about how choices are made, especially if it means acknowledging secrets or parts of a self that feel unacceptable. Practicing and imagining the form of one's own writing by paying attention to what is read is a suggestion that Clandinin and Connelly (2000) offer to their students and readers of their book on narrative inquiry. This is one way to see the end in the beginning, which Dewey suggests is a guide to "know in what direction the present experience is moving" (1902/1990, p. 191).
Dailiness writing "makes clear and coherent the meaning of daily detail" (Dewey, 1920/1957, p. 212) and foregrounds everyday life, "the situatedness of human experience" (Grumet, 1991a, p. 81). Men and women speak and write autobiographically to come to terms with their life experiences and perhaps to offer themselves as examples of success or of overcoming hardship. Monette (1992) characterizes himself as "being a man with no story at all" (p. 1) and Styron (1990) describes his "reluctance to accept the reality that my mind was dissolving" (p. 13). Moore (1991), a physician, explains his devastating car accident from both sides of the doctor-patient relationship and Morrison (1993) explains how he last saw his father. These writers present a defining moment or a defining relationship to illustrate who they are or are becoming.

Most of the dailiness books that call to me are written by women. These books tend to share a conversation and events in a day in a way that evokes a coffeepot, a comfortable chair, and a friend. Aptheker (1989) invites us to imagine putting women at the centre of our thinking, as if we mattered. She suggests that this way of viewing our daily lives acknowledges a way of knowing that comes from the patterns women create and the meanings women invent in learning from each other. This way of thinking intrigues me. My usual way of knowing is shown in the struggle to articulate my thesis topic. In 1997, after a meeting with my supervisor, I wrote:

He accepted being my thesis chair and reminds me that such an intense journey is open to either of us changing our directions. I asked if that is a qualified acceptance and he said no, it is a fair issue to point out as the thesis journey is like a marriage and people change as they grow. I asked about working with my body voice and within a topic of body knowledge and he said it is something that could be explored. The challenge, he said, is that there are no handholds for such an activity and that some of what he does now he could not have done as a thesis. I instantly resolved to do my body voice work only in my journal and to find an acceptable topic that I can bring to my supervisor (personal journal, January 17, 1997)

Reading this, it is clear to me that I interpreted my supervisor's words to say that I could not do a thesis on body knowledge. When I reflected on this at the time with my friend Regina, she challenged me that again I was looking outside for direction and
approval. As she talked, and she could give me other examples, I felt so resistant to her message. I knew she was right and I resented it. Couldn’t she see that if I pleased my supervisor and gave him what he wanted, I could earn the space to do my work? Now I wonder what narrative pattern is being enacted; wanting the man’s approval enough to defer what matters to me and resisting the woman who points this out to me. Aptheker’s (1989) challenge to put woman and self at the centre of thinking bears further investigation.

This issue plays out for me across the years. Dr. Connelly and I talked about it in February 2000 at our weekly meeting. He recognized how students from another country seem to hear his advice and suggestions as orders. My response is that many of us do that, meaning I do that too. Noticing how I follow his suggestions even if they take me away from my intended work. I decided not to meet with him weekly until I felt grounded in my work. This struggle, mirrored in his questions about the clarity of my thesis topic, deepened my work until I could write and discuss it in my own terms. For the first time, following this meeting, I invited nursing colleagues to read my written work. Wondering how nurses would relate to my research, I felt affirmed by their responses and had more courage to proceed. It is, of course, an intersection of narratives when my supervisor and I, or my colleagues and my writing, meet. My thesis is like the writing that I am drawn to—women’s writing about the choices and consequences that construct their daily lives—moving beyond description towards interpretation, education, and social change.

Steedman (1986) writes of the difficulty of being excluded in the interpretations of motherhood available to her as a scholar and her need to document her growing up in the face of her mother’s longing for the middle class life. Steedman’s experience of growing up, working class and unwanted by a mother who made the burdens of her life all too clear to her daughters, was the subject of her research. She shows us how she and her mother “got to be the women they became” (p. 18) and how “the process by which we come to step into the landscape, and see ourselves” (p. 24) is autobiographical exploration of her family, contextualized in social situations that change over time.

Nancy Mairs, a woman I met through Kathryn Church’s thesis-turned-book, Forbidden Narratives (1995), has a body of dailiness writing that draws me. Nancy writes
about her experience as she goes about a life that includes growing up, getting married, having two babies, and being a writer (1986, 1989, 1993, 1994, 1996). Adultery, multiple sclerosis, depression, suicide attempts, her husband’s melanoma are also woven through her texts. As a writer of her life, Nancy says “learning line by line as the words compose me….in order to know anything at all, I have to write a book” (1993, p. 1). She calls her process of finding out how to live best, moral inquiry; a search of how one woman lives day after day. She composes narratives that make experience “comprehensible, bearable, pleasurable out of a welter of data so raw that even time doesn’t exist” (1993, p. 100). Mairs continually makes up her specific “I,” a construction from “whatever materials come to hand” (1994, p. 7).

Before the recent period that has seen a burgeoning of autobiography as a way to learn and know, Koller (1981) took herself to Nantucket for three months with her new puppy, Logos. She finished her doctorate at Harvard University in the late 1950s and watched the men in her year move into academic positions while she took part-time work in teaching. She had no husband, no home, no work, “I didn’t have a life: I’m just using up a number of days somehow” (p1). She decided to remove herself from familiar urban environments and to spend her days writing her thinking, reading, and walking the beaches. Knowing what she felt or what she wanted was a mystery, so Koller decided to reflect on her experiences. She wanted to get beyond her skills at fitting in and pleasing others to get what she thought she needed. Her words were published 14 years after she wrote them because early attempts to interest a publisher were thwarted by a perceived lack of audience for such personal exploration.

In 1990, Koller reflected on her first book and wrote a reconstruction of what happened during her three months on Nantucket with Logos (Koller, 1990). She claims an identity as a philosopher who studies her own mind and asks what it is to be a person. She learned to understand by writing her thinking. “I have become that third gender: a human person, the being one creates of oneself (p. 23)...I am teaching, not by telling, but by displaying the process” (p. 67). By the end of her sojourn, immersed in the natural world of sea, sand, and air, accompanied by her beloved Logos, she had learned many things about her motivations and experiences. These new understandings underpinned her construction of a future including where she would live, how she would work, and how
she could be in relationships without turning them into a replay of her need for her mother’s love and approval.

How women find their own story and their life’s work, according to Heilbrun (1988), is by telling each other the truth of our experience. She herself has a literary life as mystery writer Amanda Cross that allows her more possibilities for action than her conventional life. She felt that lives do not serve as models—stories do. We are “without a text and must discover one” (p. 44), which women do only after an awakening. And that “awakening is identifiable only in hindsight” (p. 118). How do we awaken? Writing is one way to penetrate a life, to turn the organic details of experience into a resource for living (Goldberg, 1986, p. 3). Entering into a story with a reader instead of telling or writing “about” means having a relationship with experience, other writers, and readers. Writing and life interpenetrate as “rereading our writing awakens us to the life we are living” (p. 162).

Mary Catherine Bateson (1989) published her research about five women, including herself, showing how life is a composition and improvisation. Bateson reflects on how “there are echoes from one life to another” (p.16) as odds and ends are put together in new ways, so that an already defined vision and standard arrangements no longer fit:

Women today read and write biographies to gain perspective on their own lives. Each reading provokes a dialogue of comparison and recognition, a process of memory and articulation that makes one’s own experience available as a lens of empathy (p.5).

Bateson “reinvents herself” after each uprooting in her life by writing, by seeking reconstruction and learning from her life’s discontinuities.

Women educators in Stories Lives Tell (Witherell & Noddings, 1991) share the narratives of their lives as a way to reflect on and reconstruct experience. The editors wish to show readers that narrative and autobiography have emerged as ways of knowledge construction that enable us to become authors of our own lives. In her chapter, Grumet (1991b) allows that “we are, at least partially, constituted by the stories we tell to others and to ourselves about experience” (p. 69). The purpose of this work is to understand that there are multiple points of view, no one story to live by, and that this inclusivity and diversity is desired in education. As teachers we are “not an agent of the
state peering into what is hidden from public view” (Grumet, p. 71). Witherell echoes this concern. She explores the nature of the self out of “the conviction that neither teaching nor counseling (designed to change human lives) can be considered an ethically neutral activity” (1991, p. 84). She encourages us to question how we understand person and community to avoid generalizing, reducing, or categorizing experiences.

Neumann and Peterson (1997) remind us that we bring all of our intellectual, personal, and professional identities to our work as teachers. They wonder what it might mean for a woman to bring her self in this way to research, to teaching, to scholarship, and to intellectual leadership? “Research may return personal learning to the life from which it grows; turning from the given reality through remembrances and reconstruction to an everyday space that is meaningful and socially connected” (1997, p. 239). In her own chapter that tells of her mother’s life as a Holocaust survivor, Neumann explores how “people live their stories as much as they tell them in words” (p. 107). She wonders about untold stories and their significance as she tells and retells her story of her mother three times: from the vantage point of a child, as an adult tape recording an interview and in the written text her mother prepares to win reparation payments from the German government. I wonder if lives woven around a silence are like a grain of sand that becomes a pearl, a cocoon for a butterfly, or an abscess? I wonder which of these my grandfather would say matches his experience? Neumann feels that an untold story, or one that is told unconventionally without words, relates to the teller’s continuing struggle to live. Not telling our stories, having them “caught in our throat” reduces our ability to participate in the world (O’Reilley, 1998).

Now positioned as a constructed knower, I ascribe to the principles that all knowledge is constructed; the knower is an intimate part of the known and theory approximates experience (Belenky, Clinchy, Goldberger, & Tarule, 1986). For me now, theory and practice are a dialectic, mutually informing and changing both the person and the social situation. Knowledge is not an end in itself; it enhances relationships, enlarges my understanding of nursing curriculum, and changes my teaching/learning practices. “Principles are by themselves abstract. They become concrete only in the consequences which result from their application” (Dewey, 1938, p. 20). Having an experience and
reflecting on my reconstruction of it is both necessary and inseparable if I am to consciously apprehend my world and to make meaning which determines my actions.

It is possible to have experience and act outside of reflective awareness. This can be dangerous, and potentially unethical, because unawareness puts our actions outside of relationship in the social milieu and outside of feelings which allow empathetic connection. Krall (1988) suggests that “we move forward into mature adulthood by accepting responsibility for our part in our circumstances, but more so for accepting the social consequences of our autonomous acts” (p. 468). In order to see our part in a situation and to discern the consequences, in narrative inquiry we reconstruct our experiences. Our emergent knowledge is both personal and practical, constructed in awareness of social connections. For nurses, meaning-making becomes an expression of personhood and the basis of concern for others. Dailyness writing offers nurses a way of understanding their experiences and including themselves in identity and knowledge construction. Dewey (1920/1957) suggests our choices in life are to do whatever we want, to do what we are told or to consider our acts and their consequences in the context of our relationships with self, others and the world. I choose the third option which we do by reconstructing specific situations to show how to achieve a sense of self and social usefulness. As Dewey says, “we are not ready-made” (1920/1957, p. 194).

To show how to achieve a sense of transparency in thinking about actions and consequences and in the relationship between writer and reader, I turn to a maternal narratives study undertaken in 1989 by Martens (1993). She explored the childbirth experience of 39 women in a Mennonite community in Manitoba through audio-taped conversations. She describes the interviewing process “as an intensely personal exchange” where her motives, what she calls the ‘politics’ of the exchange, “are central to the narrative itself” (p. 138). She defines the relationship between participants and herself as “an act of community performed between speaker and listener” (p. 139). Her role is to “assist in bringing forth stories out of women’s experiences in their own voices. She is not the ‘expert’, but a listener, a receiver.....her (written) document is conversation” (p. 140-1). Once the study is formed as written text, the conversation between Martens and her participants moves to conversation between text and reader.
Martens shows how she is in her inquiry, in relationship with participants and awake to her role as researcher.

Aware of the honesty of writing vulnerably and including herself in research accounts, Behar (1996), an anthropologist, asks, "What is the responsibility of the writer to those who are moved by the writing?" (p. 16). She examined her own experience to see that there are multiple ways of knowing and that we, as researchers, are part of the situation we inquire into. These principles led to her claim that "autobiography has emerged, for better or worse, as the key form of storytelling in our time" (p. 26). Jill Kerr Conway (1998), a noted autobiographer and scholar agrees and says that:

The need to examine our inherited scripts is just beneath the surface of consciousness, so that while we think we are reading a gripping story, what really grips us is the inner reflection on our own lives the autobiographer sets in motion (p. 17)...It is important to acknowledge our agency in terms of personal power to act because if we acquiesce in concealing our agency from ourselves, we've lost our moral moorings (p. 178-9).

Likewise, I imagine readers of my research are invited to come into my co-participant stories and respond with their own daily experiences and thoughtfulness. When readers feel moved into reflection on their own lives, narrative exploration is fruitful for more than the co-participants in the research. This requires awareness in readers and an engagement that mirrors a narrative way of inquiry and thinking.

What is emerging from my consideration of women's dailiness writing is a growing awareness of how a life is constructed and that our narrative plotlines informs all that we are and all that we do. I can visit different places on the landscape, but cannot make separations between who I am and what I know in teaching, research, and home life. Thinking narratively and reading women's dailiness writing informs how I understand myself temporally in the world. Nurses may find, like Neilsen (1998), "how the personal and professional contexts conflate to create the researcher herself" (p. 23). Her inquiry, what she calls the 'Academy of the Kitchen Table,' is embedded in daily life and in each situation, she asks, "What is going on here?" She acknowledges that her readers have probably figured out that she is more like her informants than she would care to admit and asks if her "work is called inquiry or is it simply called life?" (p. 118). Neilsen identifies an issue that is central for me in my inquiry—how are we as educators
awakening ourselves, honing, promoting, and celebrating our own multiple ways of knowing the world and of making sense? She further challenges us by asking, "What do we do as professionals to resist institutional practices which stifle our (and our students') growth?" (p. 185). I would add, how do we understand our institutions as also storied and in a temporal flow? Reconceptualizing ourselves as part of our social situations and as in relationship with others speaks to a nurse being a person, instead of being a role or social metaphor. Nurses are human beings with a sense of shared humanity with other persons (Taylor, 1992). I situate my narrative inquiry within women's dailiness writing as a way to create a nursing identity and construct knowledge from the inside-out instead of being determined only externally through social roles and functions.

**Narrative Pedagogy and the Curriculum Revolution in Nursing**

Within the last decade, nursing education research has come to include narrative dialogue which Diekelmann (1993) claims is the new pedagogy for nursing in the twenty-first century. "Narrative Pedagogy as sharing and interpreting contemporary narratives is a call for students, teachers and clinicians to gather and attend to community practices in ways that hold everything open and problematic" (Diekelmann, 2001, p. 55). She describes her development as a graduate student and novice teacher as a metaphor for nursing education moving from behavioural Tylerian curriculum approaches to interpretive phenomenology and emancipatory curriculum (Diekelmann, 1990). Narrative pedagogy, revealed through interpretive phenomenology, is Diekelmann's contribution to the curriculum revolution in nursing, defined by Bevis and Watson (1989) as the interaction between teachers and learners.

Moccia (1990) calls for nursing education as "egalitarian, cooperative communities with the abilities to critique and transform the health care system" (p. 308). Nursing education, in the curriculum revolution, embraces feminist and critical social theories as the bases for connecting private experience and public issues. Experience is valued as a source of theory and the social environment is connected to education. Tanner (1990b) defines the curriculum revolution as "alternative conceptions of the educational process, reflective of major social changes, particularly the crisis in health care and directed towards new ends" (p. 296). Those new ends include the centrality of caring, an
interpretive stance, theoretical pluralism, and nursing in relation to socially constructed determinants of health.

For Diekelmann (1997), the curriculum revolution in nursing is not moving from one ‘ism’ to another, it is characterized by “an explication of how we think...about common, everyday problems that confront us” (p. 47) and as transforming healthcare through dialogue between students, teachers, and clinicians (Diekelmann, 1990). Diekelmann (1990) calls this dialogue ‘converging conversations’ between all pedagogies in nursing curriculum. She includes her own and participants’ stories of practice experience in her research as a way to show the practical knowledge of teaching in nursing. In July 2000, Nadine, my friend and a Heideggerian nursing scholar, and I attended Diekelmann’s (2000) keynote address at the Chicago Institute for Nursing Education. Diekelmann explained that narrative pedagogy is from nursing research, for nursing education. She embodied her approach to nursing education research by sharing the podium with Associate Professor Margaret Douglas and graduate nursing student, Ms LeTonya Cannon.

Dr. Douglas shared her experience of teaching a graduate course in nursing theory wherein she acknowledged in the classroom her lack of understanding about the everyday practice of the public health nurses. The public health nurses admitted to their dreams about school and their fears about succeeding. The theory course was taught in the nurses’ workplace and was their first graduate school course. Noticing the absence of community experience in nursing theory literature, Dr. Douglas invited the students to write stories of their practice. These stories were shared in class and phenomenologically interpreted to create knowledge with students. Interpretation across student narratives allowed the students to identify shared meanings and common practices, creating a language that made their work visible in a world of market approaches to healthcare.

Ms Cannon told of a Chicago snowstorm, so severe the power went out. She was part of a team that went door to door in an apartment complex to survey the needs of people living without heat and light. One woman who opened her door told Ms Cannon she had just gotten off her knees from praying because her grandchildren were with her and she had no food or money. Ms Cannon told us of her response and actions that enabled this woman to take care of the children and herself, and ultimately to change her
relationship with her daughter and gain employment. Dr. Douglas explained that one of the themes of public health nursing practice, for clients and nurses, that emerged from cross-story interpretive analysis is *knocking on doors and not knowing what is on the other side*. Dr. Diekelmann joined the class, as part of her narrative pedagogy research project, and further interpreted the shared stories. *Living in uncertainty to create a future of new possibilities and to safeguard practices of caring* emerged as some of the practical knowledge of public health nursing realized through communal practices of reading, writing, thinking, and dialogue. In this story of nursing education, the teacher calls forth learning rather than offering teaching. The emphasis on storytelling is not the conventional story as illustration. Instead, the emphasis is on description and interpretation of stories of experience for meaning and significance. In her hermeneutic phenomenological work, Diekelmann (1990) identifies the pattern of teachers-as-learners that guides classroom relationships and practices. Interpretive phenomenology, grounded in Heidegger’s work (1962, 1975), is the basis of a 12-year research project in nursing education undertaken by Diekelmann.

Diekelmann (1988) asks two curricular questions for consideration by nurses. First, how should the subject matter that nurses need to enter nursing practice safely be selected and sequenced, and second, what is the role of experience in nursing education? She suggests that the dialogue between students, teachers, and nurse clinicians about these questions creates the curriculum needed in each educational situation. She also proposes that clinical knowing can only be experienced as lived. “Curriculum is the lived experience of students, teachers and clinicians as they work together in an attempt to understand how best to introduce students into the practice of nursing” (1988, p. 144).

Diekelmann (1990) links three central conversations between nurses-as-learners to healthcare transformation: caring, dialogue and practice. Caring refers to how “we see and learn the context from which the other speaks” (1990, p. 301) in order to create inclusive communities. Caring communities include nurses with patients, students, research participants, and with each other. Dialogue means “conversation as mirrors that reflect and call one another forth” (1990, p. 301), making our own stories visible and bearing witness to each other in order to understand our lived experience. Practice, as in the practice of teaching, views teachers-as-learners “in the world through their continual
rebirth of the struggle to understand” (1990, p. 303) in the context of teaching-learning situations.

Baker and Diekelmann (1994) propose that “just as our lives tell a story, so too do our stories tell about our lives....by listening to the stories of others we can gain an inside-out view of their practice, a privileged place where meanings can come together to shape, and be shaped by, our shared experience” (p. 68). In a 1993 study, Diekelmann interviewed 21 teachers and 21 students about their day-to-day lived experiences in baccalaureate nursing education. At each 90 minute interview, participants were asked to tell the researcher a story “about a time, one you’ll never forget, that stands out for you because it taught you what it means to be a student or teacher in nursing” (Diekelmann, p. 246). The interviews were taped, transcribed, and analyzed hermeneutically in seven stages by three researchers using Heideggerian phenomenology. Each text was explored for themes and practices that related to one another. The results of this study point to ways of thinking about how our views of ‘successful’ learning—“learning as cognitive gain” have come to dominate nursing education. “Learning as cognitive gain is the constitutive pattern with two themes: applying content as thinking and content as neutral, unproblematic, and consensual” (Diekelmann, p. 246).

These findings express what is problematic in more traditional teaching-learning approaches in nursing education. Having identified the pattern and themes, Diekelmann (1993) cites examples from the transcripts to show how the interpretations are explicated by stories from participants. She claims that dialogue about the kinds of experiences to be included in curriculum, told in situated narratives, will transform nursing education.

It may be in the familiar, the reflecting on what we currently do successfully, that innovation in our current practice will arise. To think of innovation as something new from an outside source rules out the possibility that innovation resides and arises from our experience (Diekelmann, 1991, p. 56).

At the Chicago Institute for Nursing Education, Nadine and I talked off and on all week about her work in phenomenology and mine in narrative inquiry. With two other colleagues, we met with Dr. Diekelmann and talked for three hours about nursing education and research. Aware that I was not in the same philosophical camp as Dr. Diekelmann and Nadine, I participated in the conversation as a nurse-teacher and as a
narrative inquirer—in-between two ways of being in the world. As we talked about ideas, our experiences, and potential collaborations in nursing education research, I noticed feeling my work should stay a secret if I wanted to remain included. In response to this silent bargain that trades fitting in and self-betrayal for acceptance, I spoke of my work and saw we could work together. As we concluded our conversation with plans for future meetings, Dr. Nehls briefly joined our group. I acknowledged her inclusion of Connelly and Clandinin’s (Nehls, 1995) work in her writing and how it pleased me to see others crossing discipline boundaries with narrative. Staying in the situation by including myself, by ‘being there,’ made a difference to possibilities for future research and for present relationships.

Given such rich resources in nursing in support of narrative and using interpretive phenomenology, why am I based in educational curriculum studies, particularly in the narrative inquiry of Clandinin and Connelly (2000)? The fact is I didn’t know these resources existed in nursing prior to embarking on doctoral studies. I knew about nursing theory and disliked how healthcare and educational institutions in the 1980s enforced one model on their employees and students. It seemed to me that telling nurses to think in a single and prescribed way was intellectually and morally bankrupt. Because of my resistance to the implementation and use of nursing theories, I kept my distance. Upon reflection, I would also admit to giving more credence at that time to medical and administrative literature than to nursing. I was chagrined and delighted in the mid-1990s to find nursing literature and research that spoke to my experience and interests. Nursing education research that embraces narrative pedagogy, which includes pragmatism, is where I cross over into nursing with my inquiry. Assuming that my readers may wonder why I am not using one of the other qualitative research methods in nursing education, I next undertake an exploration of interpretive phenomenology in the Heideggerian tradition from Diekelmann’s work in relation to Dewey and Connelly and Clandinin’s narrative inquiry.

**Narrative Inquiry and Interpretive Phenomenology**

What difference does it make to reflect on our experience phenomenologically as Diekelmann (1993) does or narratively, as in my inquiry? To illustrate this comparison of two lines of inquiry—phenomenology in the Heideggerian tradition in Diekelmann’s

The ideas and language within the two lines of inquiry contain similarities and differences. In dialogue with Dr. Roger Cheng, an educational philosopher from the Faculty of Education at The Chinese University of Hong Kong and a guest at OISE, he suggested to me that both Heidegger and Dewey grasp experience holistically and perceive it as open (personal communication, July 19 & 27, 2000). Dewey and Heidegger are both concerned with individuals in social situations, inseparable from their contexts. However, it is in the differences that the contribution of narrative inquiry to nursing education research is revealed. I am indebted to my friends and nursing colleagues Professor Nadine Cross and Dr. Beryl Pilkington, who are scholars in the phenomenological traditions, for their support and critique of my novice understanding of phenomenology (2).

To illuminate the comparison between phenomenology and narrative inquiry, I draw on Herron’s (1971) “commonplaces of scientific enquiry: subject matter, agent(s), method, data and outcomes/knowledge” (p. 179). Herron calls construction of a comparison “mosaic-making,” in which researchers use the same set, but not necessarily all, of the pieces” (p. 178) to analyze accounts of scientific enquiry. My understanding of Herron’s commonplaces was enhanced by Dr. Connelly’s recommendation that I read Enns’ (1982) dissertation Crisis research in curriculum policy making: A conceptualization. Enns was the research officer of a Curriculum Task Force in 1977-78, under the leadership of Dr. Connelly, which addressed declining enrollments in Ontario. Given the lack of policy-oriented research on the curriculum effects of declining enrollments. Enns proposed to “conceptualize the experience of the Curriculum Task Force research” (p. 9).

In order to proceed with his thesis, Enns (1982) began with Aristotle’s topics, common (discourse on any subject) and proper (discourse on a specific subject), using dialectical reasoning and rhetorical persuasion. According to Aristotle, “perfect
possession of the way to proceed in dialectical reasoning is when we are in a position...to
do that which we choose with the materials that are available” (1982, p. 26). Thus, the
subject matter for which dialectical reasoning and rhetorical persuasion are appropriate is
things which ‘can be otherwise,’ that ‘belongs to no definite science.’ This is the
character of the subject matter of human experience. It is subject to interpretation and re-
interpretation. “No single absolute view exists of its nature, nor of its meaning” (p. 27).

Enns (1982) links Aristotle’s proper topics to Herron’s (1971) commonplaces by
creating a conceptual matrix wherein each of Aristotle’s predicates, attributes of subjects
such as accident, genus, property, and definition, were applied to the Task Force
experience. Herron’s commonplaces became Enns’ framework which he ‘filled’ with
Task Force experience as content. He then analyzed each set of information with
Aristotle’s four predicates. Importantly, “in the process of applying the framework to its
subject matter, it takes on the character of that subject matter” (Enns, p. 44). This
reconstruction of experience led to a conceptualization of crisis research—“a day-to-day
experience of research in a crisis” (Enns, p. 42).

With this framework for comparison and reconstruction, I now propose to contrast
Clandinin and Connelly’s (2000) narrative inquiry, grounded in Dewey’s (1938)
philosophy that experience is education, with Diekelmann’s (1993) educational nursing
research in the Heideggerian phenomenological tradition, using Herron’s (1971)
commonplaces as subheadings to organize the comparison.

**Subject Matter**

In Herron’s (1971) terms, subject matter is the “boundaries set by the community
of scientists among whom he was educated and must work” (p. 180) which I take to mean
the phenomenon under study. In narrative inquiry, experience is the key term and
epistemology is of concern. Inquirers search experience to learn more about something
that is personally and socially relevant. A sense of what the phenomenon is changes over
the time of the inquiry, which for me began in 1995. Clandinin and Connelly’s (2000)
three dimensional narrative space conceptualizes life experience as personal-social,
embracing the past-present-future on a continuum, and as in a place. Place is a term
that “attends to the specific, concrete, physical and topological boundaries of inquiry
landscapes” (Clandinin & Connelly, p. 51). Therefore, thinking narratively involves
names, dates, events, and specific locations. The dimension of time captures experience as a flow, something in process, moving, and alive. In my inquiry, the subject matter began as a question of how nurses experience healthcare reform. Now, my phenomenon is how reconstruction of nurses' experience in healthcare reform matters to identity and knowledge construction and informs practice. Thinking narratively, "temporality is a central feature...an expression of something happening over time" (Clandinin & Connelly, p. 29), so nurses' identity and knowledge formation have continuity through their life experiences. Making sense of experience and having hope for a future as a nurse are two puzzling aspects of life that bring you and me dear reader to the subject matter of my inquiry. In my research, co-participants (which includes myself) are in conversation between January 1998 and April 2000 so our life experiences are reconstructed over more than two years. The meaning of our daily experiences, in relationship to our own past or in relationship with others, changes depending on our location in time, space, and relationships. There are many intersecting narratives at work in the three dimensional space of narrative inquiry (Clandinin & Connelly, 2000).

Phenomenology in the Heideggerian tradition is a fundamental ontology in which the question of the meaning of Being is the key term (Moran, 2000). Lived experience includes past-present-future all-at-once with temporality as a horizon of understanding. "Dasein as concernful present resides alongside whatever it is concerned with" (Heidegger, 1924/1992, p.16E) A phenomenon is revealed 'as it is' in the present. A phenomenologist might ask nurse participants to tell about their experiences of living in reform or to describe their lived experiences as nurses in healthcare situations. This description comes from 'everydayness' which is regarded as taken-for-granted unawareness, in contrast to narrative inquiry's reflective awareness of daily experiences. What is described phenomenologically is understood within a horizon of temporality. In Diekelmann's terms, everything past forms the lens through which the present is interpreted (email, August 28, 2000). Beryl describes her understanding of time in phenomenology as follows:

The only time we ever REALLY have is the present. The present is the horizon of understanding through which we understand what was (the past) and what will be (the future). And the present is continuously
shifting; thus, our view of what was and will be is forever changing. This view is also similar to Buddhist and Taoist philosophical perspectives of reality. I do not think that time can be understood on a continuum, inasmuch as what was, is, and will be are always known from the vantage point of our present reality, and thus, are always changing. In this sense, we see what was, is and will be ALL-AT-ONCE....Any account of experience is always given from the perspective that we have in the moment. When I study a phenomenon, the findings are meant to be a snapshot of a moment in time. And yet, that snapshot represents how the person experienced what was, is and will be, as it appeared in THAT MOMENT. I understand that at another time, the snapshot may look somewhat different—though probably still recognizable as being of the same subject. That is, the essences of a universal lived experience (like joy, sorrow, grieving a loss etc) are believed to be just that, essential (to the phenomenon)—but the phenomenon necessarily varies in nuances and details from person-to-person over time. As I understand it, for a narrative inquirer like yourself, your concern with lived experience is to capture just those nuances and particulars that shift over time for each individual. It is not your concern to delineate and name the core of experiences that endure (Pilkington. email. September 1. 2000).

As Clandinin and Connelly (2000) point out, the tension between seeing things in time (narrative inquiry) and seeing things as they are (phenomenology) is a fundamental difference. Although Dewey (1934) did not say he was disputing phenomenology, he did not agree that seeing all-at-once was possible, as in “a single instantaneous perception.” He elaborates further:

Any object in space (and all objects are spatial) sends out vibrations all at once, and the physical parts of the object occupy space all at once.....thus what at most reaches us simultaneously is the physical conditions of a perception, not the constituents of the object as perceived....an object is perceived by a cumulative series of interactions....an experience is a product, one might almost say a by-product, of continuous and cumulative interaction of an organic self with the world (Dewey, p. 219-220).
The sense of temporality in subject matter is different in narrative inquiry and interpretive phenomenology. The stories told in Diekelmann’s (1993) phenomenological research are in a data bank, ready for interpretive analysis. They are removed from any narrative inquiry sense of the temporality in a person’s life. Narrativists see time as movement through past-present-future in a continuous way and phenomenologists see temporality as conflated into a present moment. “Narrative...has the power to mimic the unfolding of reality...it can produce the feeling of events occurring in time” (Fulford, 1999, p. 15). Additionally, narrative inquiry is concerned with epistemology and life experience, and phenomenology with ontology and lived experience. As they stand in Connelly and Clandinin and Diekelmann’s two lines of inquiry, the subject matter, the phenomenon being explored, is considered differently.

**Agent(s)**

Agent in Herron’s (1971) terms is “who is assumed to have certain capacities, habits, predilections “originating is his own unique experience” (p. 180), and epistemological biases” (p. 179). These biases emerge “by virtue of his professional education, in favour of those early guiding conceptions of his particular discipline then currently in vogue” (p. 180). In narrative inquiry, the agents are co-participants in the research—researcher and participants. Their relationship is ongoing, temporal, and is part of the situation being studied. “Every experience enacted and undergone modifies the one who acts and undergoes, while this modification affects, whether we wish it or not, the quality of subsequent experiences” (Dewey, 1938, p. 35). In my inquiry, co-participants are co-inquirers who tell and reconstruct experience. My co-participants include seven people with whom I had one meeting and several written dialogues, Karly from my pilot study, Sasha with whom I met for over two years, and me. Each of us are in the research by virtue of our co-construction of the written texts. As a researcher, I am autobiographically present in my inquiry and occupy multiple positions, such as nurse-teacher, participant, (great-grand)daughter, friend and researcher. Aristotle puts it simply, “anyone who is telling a story, adds to it” (1981, p. 428). All of my co-participants were known to me on a continuum of colleagues to friends. None were total strangers.

In Diekelmann’s (1993) research in the Heideggerian tradition of phenomenology, the agent is the researcher and she works with written texts which are stories from
participants. The researcher creates the interpretation of the written text related to the phenomenon under study. “Understanding is considered to be a dialogue between current understanding and new concepts that emerge from the object of inquiry” (Walters, 1995, p. 797). While a phenomenologist in this example might meet more than once with participants, the significant role of the agent is with the text in explicating and understanding the experiences. In the nursing education study referred to earlier, Diekelmann (1993) met with 21 teachers and 21 students. I cannot tell from the article if she knew any of the participants prior to undertaking the research. In a letter of response, Diekelmann explained that her data bank of stories comes from people who are in pilot research sites, nurses at conferences, nurses who read her work and send her stories—all volunteers interested in participating. Some are interviewed by Diekelmann and some by her doctoral students. “It is from this huge coded data base that I select the stories I will use—paradigm stories, ones that say it all” (Diekelmann, email, August 28, 2000). The researcher has foreknowledge and foreconceptions about what is being studied which she/he is to make explicit (Diekelmann & Ironside, 1998). “Self knowledge is required to limit the interpreter’s projection of his or her own world onto the text” (Benner, 1994, p. xvii). This researcher stance holds the agent separate from the participants.

The difference between the two lines of inquiry related to agent(s) is sharply drawn. In narrative inquiry, researchers are autobiographically and temporally in the situation being studied, in relationship with co-participants. In Heideggerian phenomenology, as I understand it, researchers are aware of themselves in so far as they know their own assumptions and biases, but are not autobiographically implicated in the inquiry. The dialogue with participants is superceded by dialogue with emergent concepts.

Method

The method is “operations performed by the investigator” and must suit what the problem is (Herron, 1971, p. 179). In narrative inquiry, reconstructing life experience “is to make backward and forward connections between what we do to things and what we enjoy or suffer from things in consequence” (Dewey, 1916/1966, p. 140). In my inquiry, I met with seven co-participants to construct the professional knowledge landscape for nurses in healthcare and educational reform to show various locations. I also met three
times with one co-participant in a pilot study and then with one co-participant over a two year period of conversations which were taped and transcribed verbatim. Composite conversations were created from each co-participant’s transcripts which each person reviewed for authenticity and adequacy. Thinking narratively within and between the composites involves considering personal and social, temporal and spatial elements of experience. This leads to the significance of the research being revealed, written, and rewritten as the complexities of meaning are uncovered. The literature is blended with the writing and often re-consulted as the inquiry progresses. Re-visiting and deepening is how I would characterize my narrative inquiry process.

Writing by other people on similar and related topics to mine positions my work and enlarges my thinking. Clandinin and Connelly (2000) place narrative inquiry at the boundaries of formalistic categories and reductionistic themes. Staying with the “the individual, nuanced life” (p. 141) in phenomenon and method enriches understanding of a situation. Exploration of a person’s experience in narrative inquiry is contextualized by their life situations. Narrative plotlines are identified and co-participants work with experience, not with situational themes or essences. The person in the life that provides the ‘data’ also does the learning and chooses how to act in the world. Co-participants are involved in the method in terms of when, where, and how often to meet, construction of written texts, and evaluation of the research. Each meeting included consideration of how it matters to reconstruct experience in terms of being/becoming, knowing, and doing.

Interpretation in phenomenology begins with description of lived experience created by the researcher from dialogue with participants. Diekelmann (1993) describes her method as a seven stage interpretive analysis which identifies common meanings and shared practices. This analysis is often undertaken by a small group of nurse researchers who work with the texts and with different philosophical perspectives to uncover themes. Each text is analyzed and then cross-analyzed with each other to determine the themes. “Finally, the constitutive pattern, which expresses the relationship between themes and is the highest level of analysis, is explicated” (Diekelmann, 1993, p. 246). Through thinking contextually and hermeneutically—re-interpreting and conceptualizing, the nature of being in everyday life is explained. In Diekelmann’s current work, (Diekelmann & Diekelmann, in press) the concernful practices of schooling learning teaching include
common practices such as: Gathering: bringing in and calling forth, and Interpreting: unlearning and becoming. Excerpts from participants' stories are shared to show the analysis. Going beyond Heidegger and Diekelmann's interpretative phenomenology, Nadine tells me that sense-making in terms of how understanding matters to action in the world is a recent development in how she dwells in research phenomenologically.

The method differences between narrative inquiry and phenomenology flow from the differing conceptions of phenomenon and agent(s). While both kinds of inquiry involve conversations with others about their life experiences, the purpose of the research, how people are approached, what constitutes data, what is done with the texts, and how the researcher is involved shapes the method. Nadine proposes that narrative inquiry is most concerned with epistemology, and phenomenology with ontology. Beryl disagrees and suggests that both are grounded in similar ontological assumptions. For her, the difference is in how knowledge is constituted. For phenomenologists, knowledge consists in the interpretation of essences which describe lived experiences. They are created concepts which build on or expand theories. Beryl sees narrative researchers concerned with knowledge as construction and reconstruction of experiences, in all their nuances and descriptive vividness. I propose that narrative inquiry is concerned with being-becoming, and therefore ontology, as well as epistemology (knowing), both of which are expressed in a person's social situations, constituted by relationships and events happening over time.

Data

As with all categorical systems, overlap between the commonplaces is closer to life and its interconnections. Separation of subject matter, agent(s), method, data, and outcome from each other is done here for the purpose of displaying the differences between narrative inquiry and Heideggerian phenomenology. "The necessary data and techniques to obtain the data is determined by the conception of subject matter, and the forms of the problem" (Herron, 1971, p. 180). In narrative inquiry, life experience revealed through stories, pictures, conversations, letters, metaphors, field notes, and transcripts all constitute data. Additional materials such as journals, poems, a pilot study, and proceedings at professional meetings were collected in my inquiry. The data relevant to each co-participant are composed as field text and then reconstructed and rewritten as
research text. All co-participants chose a name for identification and confidentiality in the research. The original consent forms have their signatures and are filed separately from the data files which are given the chosen name. All transcripts and the composites are on computer hard drive and on disc, identified by pseudonyms only. Conversations and written communication were my chosen data forms as I wanted to explore with co-participants their experiences, over time and in diverse situations.

Diekelmann’s (1993) phenomenology relies on conversations, transcripts, and story data banks as data, which are the basis of interpretation leading to identification of themes. Lived experience can then be named and understood. Research done in this way requires reading and rereading of the texts, living with the data, to become familiar with and sense connections. My understanding of Diekelmann’s interpretive phenomenology is that the researcher works with participant stories, may include other researchers to also work with the texts, and offers excerpts from conversations with participants to exemplify thematic content. While a phenomenologist in the Heideggerian tradition may keep a journal to be aware of their horizon of understanding which relates to the interpretation of texts, it is not part of the data or findings of inquiry.

Outcomes/knowledge

Reflexive outcomes and knowledge are the last of Herron’s (1971) commonplaces to be considered. In narrative inquiry, co-participants show and explore experience for meaning-making, knowledge-construction, and living a life in a better way. Narrative inquiry, as a process, is educative in and of itself—the process of telling and reconstructing experience changes the people involved. Where there is learning, there is change and becoming (Dewey, 1920/1957, p. 111). Thinking narratively and doing narrative inquiry has changed me, which you will read about in more detail in chapter three. Each of my co-participants tells of how it matters to them to reconstruct their experience in terms of how they have changed in chapters four to six. “Growth signifies that a varied series of change enters upon intervals of pause and rest; of completions that become the initial points of new processes of development” (Dewey, p. 111). What we know now, based on reflection and reconstruction in relationship, is the start point of new inquiry.
Phenomenology aims for understanding through description and exploration of lived experience. Interpretation of that text involves identification of themes and patterns. Phenomenology in Diekelmann’s (1993) research usually stops at this point of inquiry. "Hermeneutic understanding leads to an inclusive position on what kinds of knowledge and understanding need to be in the curriculum....creating a place in the curriculum to have ongoing dialogues among students and teachers" (Diekelmann, p. 249). The researcher may be changed by her/his inquiry but this may be unarticulated in the written text. How participants are changed by the research is also unexplored and unacknowledged. "The interpretation must be auditable and plausible, must offer increased understanding, and must articulate the practices, meanings, concerns and practical knowledge of the world it interprets" (Benner, 1994, p. xvii). Understanding of lived experience of the participants is the desired outcome.

To Summarize

The narratives presented in phenomenological nursing education research include paradigm cases (Benner, 1984; Benner & Wrubel, 1989), descriptions of a nurse’s immediate experience (Nehls, 1995), or exemplar quotes from participants (Rather, 1992). Meanings, themes, and patterns are identified and cross-referenced in these studies. Understanding and interpreting lived experience is raised to abstract levels of language. While lived experience is the palette the phenomenologist dips her brush into, the picture we see is not of particular people temporally and spatially embedded in a social landscape with narrative histories. Story in phenomenology does not include a narrative sense of a life.

As Nadine and I discussed, meaning-making is one boundary between narrative inquiry and Diekelmann’s (1993) phenomenology. As the boundaries of phenomenology are expanding into meaning-making, going beyond understanding to significance, ontology could meet epistemology. For me, that is where narrative inquiry speaks to nursing praxis as being-becoming, knowing, and doing. Narrative inquiry is, from my perspective, ontological and constructs knowledge about how to be and act in the world based on reconstruction of personal, life experience. Narrative inquiry explores experience that reveals what Heidegger (1962) calls ‘foreknowledge’ and gives nurses a way to be in their lives by thinking narratively. The contribution of narrative inquiry to
nursing education research is its concern with how experience matters individually and socially, providing nurses with a way to include themselves educationally in praxis through identity and knowledge construction. The presence of the nurse auto/biographically as co-inquirer in research writing through narrative inquiry is a unique contribution to nursing education research.

So in answer to the question of why I am doing narrative inquiry and not interpretive phenomenology as do other nursing education and practice scholars, I have several answers. I discovered narrative inquiry at a time when I was not reading the nursing research literature. My supervisor is the co-creator of narrative inquiry that is a way of being and doing research that I am drawn to. Phenomenology is different from narrative inquiry and both are fruitful research processes. My inquiry enters a story of nursing research which is largely quantitative, somewhat qualitative, and most of that is phenomenological. Narrative inquiry contributes to nursing education research by inviting nurses to experience themselves as temporal, storied, and as part of a knowledge landscape. As our stories of experience are reconstructed and retold and we live anew, the particulars and details of our lives are fully presented. Reconceptualizing myself as part of situations and as in relationships means I see possibilities that were outside my awareness. As a narrative inquirer I am intimately connected, even implicated in, a social world that is our context so that my stories are part of my research. Therefore, separation from my inquiry is not possible and I am part of the “data.” As Clandinin and Connelly (2000) point out, we are not a structure or a framework or ideology—we are our life experience as part of our narrative unity. Dear reader, this is a paradox because while ‘I,’ Gail, am in this research and written account, my hope is that you include yourself in that “I” as well. In that sense, my presence is both real and a space for you to enter with your own experiences.

Whether at home or on family holidays, I will remember the summer of 2000 for the hours of writing to apprehend how my ideas connect with the phenomenon/method of my inquiry and with other researchers and writers. Thinking narratively and reflecting on the meaning of my thesis title “Nothing Personal?,” I reviewed my great-grandparents’ story as connected through generations to my time, nurse-teachers’ stories, and nursing education and research literature. I present dailiness writing to nurses as a way to put
themselves into their work, encouraging narrative inquiry that goes beyond describing others. Narrative inquiry and interpretive phenomenology in the Heideggerian tradition are compared in this chapter, using Herron’s (1971) commonplaces to show the similarities and differences between them. The contribution of narrative inquiry to nursing education research as a way to navigate through liminal space to nursing praxis is revealed. Nadine suggested that liminal space is my ontological perspective on narrative inquiry. Thinking narratively about experience integrates being-becoming, knowing, and doing. This is foundational to a practice discipline such as nursing.

The next chapter continues my inquiry by showing how it matters to explore my life as a temporal, storied narrative and how reconstruction of my experience has changed who I am as a person, nurse, and teacher. I will share my stories of being a nurse-administrator in the late 1980s, and then being a nurse who worked part-time in education, teaching and developing new curriculum, and in health policy in the 1990s. While you might say, “How does one individual matter?,” I would answer that if my experience is well-written, you will be invited into your own. “The autobiographical act is not complete until the writer of the story becomes its reader” (Grumet, 1987, p. 325). And I would add, until the audience becomes its reader, “and the temporal fissure that has opened between the writing and the reading invites negation as well as affirmation” (Grumet, p. 325). I am not looking for agreement; I prefer dialogue and a mutual opening of perspectives.
Chapter Two Endnotes

1. How experience matters is the question I ask throughout my research, mostly in relation to identity and knowledge construction. Purposefully I avoid the question of "why" because it returns me to earlier education and ways of thinking that are mainly psychological. While I value my time as a child and family psychiatric nurse, thinking narratively has broadened my perspective and included me in relationships. Asking how something matters links an experience to its social significance, which for me, surpasses simple explanation.

2. Other phenomenological paths relevant to nursing are: Dilthey's (1833-1911) hermeneutics in human science, to Parse’s Human Becoming scholarship to Mitchell, Cody, & Pilkington (all contemporary nursing scholars); and, Heidegger to Dreyfus and Taylor to Benner’s nursing scholarship on caring. An interesting note is that Parse (1998), in her latest work that describes graduate nursing education, includes Dewey as a philosopher consistent with her nursing theory of practice and research. Describing more fully the movement of phenomenology and its involvements in nursing theory is beyond the scope of my inquiry. My work is directly related to Diekelmann (who studied with Benner) and therefore, I explore for the most part phenomenology in the Heideggerian tradition.
Chapter Three

Autobiographical Stories of Experience

In-Between: On the way to Becoming

In liminal space, in-between what is known and what will emerge, trusting the process of narrative inquiry, I acknowledge unknowing as part of my work. Munhall (1994) contrasts the openness of unknowing with the closure of knowing. Sometimes what we know is beyond words or is preverbal awareness, something is being made sense of before words can describe it. Polyaní calls this tacit knowledge which is when "we know more than we can tell" (1966, p. 4). Accessing embodied and practical knowledge through natural and fine art materials, under the tutelage of my friend Regina who is an art therapist and nursing colleague. I have created collages, mandalas, and small sculptures that reflect experiences not yet named. A woman holding her heart in her outstretched hand with a hole in her chest was a recurrent image in my art through proposal and early thesis writing (1). Through the process of art, I learn some of the significance of my experiences which resonates in my writing and in my daily life. Gradually, what is unknown and unsaid emerges in language for reflection and sharing. In this way of inquiring, "the writer remains fully attached to the phenomenon but not to the product, which evolves as the writer understands more" (Vezeau, 1994a, p. 62).

An example of this unfolding is the writing of my inquiry. In addition to texts, and articles, and transcripts, and supervisory sessions with colleagues and professors. I have experienced intuitions, somatic nudges in directions that I did not understand but trusted to lead me. A thought about what to do next or where my thinking was leading would float into my awareness and I usually discounted it as too much work. Inevitably, it would be part of my thinking and writing before long. Sitting before my yellow, lined notepad or computer requires taking myself seriously as someone who can reconstruct experience and write about it, as being a knowledge maker. Reflecting on how her thesis inquiry revealed itself as a tacit quest in her life, Conle (2000) refers us to Dewey's (1934) notion of intellectual "Stop and Go":

Different ideas have their different "feels", their immediate qualitative aspects, just as much as anything else. One who is thinking his way through a complicated problem finds direction on his way by means of this
property of ideas. Their qualities stop him when he enters the wrong path and send him ahead when he hits the right one. . . . certain trains of ideas leading to their appropriate consummation (or conclusion) are beautiful or elegant (Dewey, p. 120).

Moving away from words periodically, I find walking, bathing, drawing, and listening to music have been fruitful for my inquiry. DeCarion (1999), in her narrative inquiry about home as *A Space Called Anywhere*, describes how she would walk in the woods surrounding her cabin, collecting downed branches. She removes the bark and smooths the wood until a walking staff has emerged. This physical and aesthetic practice informed her writing and can be conceptualized as narrative-in-action (Connelly & Clandinin, 1985).

Becoming aware of personal embodied knowledge makes it available for reflection and reconstruction. An exploration of the assumptions implicit in knowledge reveals how they might be educative or not, interpersonally helpful or hurtful. Breaking the hold of taken-for-granted positions us to "be present to ourselves and to look through perspectives rooted in our own reality" (Greene, 1978, p. 217). Reflection on personal practical knowledge, that is revealed through verbal, written, and art methods informs my inquiry and, therefore, my life.

In June 1997, I wrote a short piece of fiction that represented something I was struggling with in my writing. At that time, my perspective on the healthcare landscape was suspended in my experience with restructuring in the 1980s. When colleagues or my supervisor commented on how I was not in my writing or how there was no sense of the parade on the landscape, I did not know what they meant. I experienced their feedback as correcting me for putting something vital aside, as if the landscape were something I knew and had chosen to ignore. Writing from a sense of non-location, as separate from the world, is how I now understood myself at that time. Lacking the means to reconstruct my experience to learn from it, I stayed with decades old 'truths.'

Ariel, a member of my thesis writing group, insisted that I put myself in my writing. Not knowing what she meant, I did not know how or what she was exhorting me to do. Having strong feelings about my inquiry and assuming that being the writer meant I was in my writing, I wrote the following story of fiction called Frantically Frozen.
Emma lay paralyzed in the hospital bed. She could not move her limbs and could barely swallow. It was not that she could not feel her body; the horror of it was that she could feel its dead weight. Emma felt drawn down into the ground by its inertia. Only the water mattress kept her from being buried alive.

Each day she was washed and turned and fed and massaged to prevent bedsores. They were taking care of her body as if it mattered. But no one knew Emma was alive in her mind. Her suffering was because of fear and boredom and horror. She could live for years in this state and no one seemed to know that she was still there.

Her husband, Craig, visited each day and brought flowers. He sat silent by her side and sometimes he read the paper. He would lean over and tell her tidbits of the news and it made her hunger to see the words for herself.

When Craig left, the health care aide put on her favorite soap opera, which made Emma want to scream with rage.

Judy, a nurse Emma had not met before, introduced herself one morning. Judy talked as she bathed, massaged, fed and positioned Emma. When Craig came into the room, Judy asked him what Emma liked to do. He paused, reviewing what their life before this had been. He said “she used to read all the time, a book every two days. I don’t suppose that matters now”.

Judy came back when she worked the evening shift and she held out a book for Emma to see. “Emma”, she said, “I brought a book to read to you. I hope you like it”. Emma looked at the book and tears rolled down her face. She began to sob and shake and then it was hard to breathe.

Feeling she had upset Emma, Judy put the book down and tried to soothe her. She promised not to bring books into the room since it upset Emma so.

Whenever Judy came into the room after that, she was aware of Emma’s eyes and the look on her face—such pleading and suffering. On the bus on the way home, Judy could not stop thinking about Emma’s reaction to the
book and her unspoken wish for something. Whatever was going on about that book was not yet finished.

Judy visited Emma the next day and brought the book back into the room with a reading stand. Mentioning to Emma that both were on her bedside table, Judy offered to set the book up in the reading stand if it did not upset Emma like the last time. Judy told Emma a volunteer would sit beside her to turn the pages for her and to blink her eyes closed if that would be alright. Emma closed her eyes in gratitude and wondered if she would explode with the rage of not being able to say what she wanted.

Judy sat at the bedside and adjusted the book so Emma could see the pages and read for herself. The sight of words and their sound inside of her were like a benediction for Emma. A world was open that did not require her body to move—only for her mind and heart to expand to take in the world in the words.

Emma thought. "The rest of the staff don’t even know I’m here so I can pretend they are nothing too. They are just hands making my body clean and straight. Judy noticed me. She woke me up to the possibilities of my life as it is now. I am more than waiting flesh. I can have a life. I can feel joy and strength distilled from my rage. I will not lie here passive and grateful—I am fierce with a passion to live”.

Unknowing when writing this piece, I now realize that the paralyzed woman Emma, her husband Craig, and Judy, the nurse are identities that constitute me. Emma is unable to act on her own behalf for the most part, but she is aware of her desires. Craig is functioning in the world and well-meaning, but doesn’t know what to do or what is going on emotionally for Emma. Judy is willing to act, make mistakes, learn, and try again to connect with the frozen woman. I interpret Craig’s state of well-meaning to be education as cultivation. Being aware and working towards relationship is awakening, with the possibility of transformation. Interesting that in this fiction piece, the nurse is the identity that is able to think, act, reflect, and change. Judy wants to know Emma and to connect meaningfully. I notice that fiction writing says more than is in my awareness at the time
of writing. It also raises questions and possibilities that might be dismissed out of hand and never get written otherwise.

Unknowing can be understood as the in-between and the beyond, similar to my notion of liminal space. Nursing authors Silva, Sorrell, and Sorrell (1995) describe this space as:

What exists or reveals itself through nonlinear, meditative thinking that moves in all directions and depths…those aspects of reality, meaning, and being that persons only come to know with difficulty or that they cannot articulate or ever know….puzzling or mysterious (p. 3).

Taylor (1989) links experience and identity as something that “happens not so much in the work, as in the (inter)spaces the work sets up” (p. 475-6) in-between words, images, or objects. He suggests that “only when we recall it (the original experience) in memory can we see behind it to what was revealed through it…between an event and its recurrence. through memory” (p. 479). Reframing Emma/me being frozen and disconnected. I imagine being in liminal space where retelling my stories of experience moves me toward awareness and new possibilities for living.

Exploring experience autobiographically and narratively to show a nurse’s becoming, knowing, and doing is the purpose of this chapter. As a co-participant in my inquiry. I work first with my own life and experience. It is important to me to undertake the work that my co-participants and students are doing. Understanding what it means to discern narrative threads and plotlines from reconstruction of experience is fundamental to my development, teaching/learning relationships. and research. Exploring my experience through narrative. as a source of identity and knowledge. is neither an egotistical nor a narcissistic activity.

We are embodied agents, living in dialogical conditions, inhabiting time in a specifically human way, that is, making sense of our lives as a story that connects the past from which we have come to our future projects (Taylor. 1991, p. 105-6).

My story necessarily includes other people, events, things that have storied, temporal qualities themselves. It is within the intersection of all these stories that I shape my identity. Taylor (1991) encourages us to “break with our temptation to discern irreversible trends and to see that there is a struggle here. whose outcome is continually up for grabs” (p. 79). Presenting my experience in rich texture and detail allows you as a
reader to see how my interpretations come to be in the layering of my identity and knowledge. It also invites you into your own experience and further interpretation. Narrative inquiry shows time, space, relationships with self and others in the world as intrinsic to education. “This is the sense in which (I) cannot be a self on (my) own” (Taylor, p. 36).

Stories about family-centred care (FCC) are the core of the chapter, telling and retelling an experience from 1987 that is reconstructed over the time period of 1991 to 2000. The multiple versions of the family-centred care story intermingle with ongoing stories of people and events from my daily life. My thinking about the meaning of these experiences, showing how identity and knowledge are constructed in light of more connections and context, is written in-between stories.

The format of this chapter represents several “I” positions. Clandinin and Connelly (1994) describe the researcher’s voice as an issue of multiple I’s including “researcher, teacher, man or woman, participant, critic, and theory builder” (p. 416). Deeply involved in learning to think narratively, writing my own stories, and meeting with co-participants, I am a nurse-teacher, research participant and female person. Becoming a researcher and claiming that identity has taken the better part of the two years of my inquiry. For a long time, co-participant and writer roles were foreground for me as I enjoyed the accomplishment of being in my writing. The researcher and critic is emerged strongly after creating co-participant composites and compiling my own stories—in fact, while I was writing the first third of my research text. The shift into researcher and critic awareness was a kinesthetic experience, a scholarly ‘aha’ as I embodied the questions of meaning and significance, in my writing in deeper ways.

Dewey (1916/1966) writes about learning from experience as “discerning the relationship between what we try to do and what happens in consequence” (p. 144). He suggests that we come to know through “the twilight zone of inquiry” (p. 148), characterized by uncertainty and suspense. This chapter explores a fault-line of my experience, the FCC stories. It has taken me years to be able to look at what happened and even longer to discern meaning from that experience. It is my example of frozen experience. full of feelings and unavailable for learning. I constructed the first version of this story in 1991 as a novice university, sessional (part-time) teacher. I used it in a
nursing leadership and change course to illustrate how good and thorough planning for change could be derailed by a group of stakeholders. At that time I told the story to students as a puzzle since I still didn’t understand my part in the situation or how it went so terribly wrong.

**Family Centred Care: Version One**

In September, 1985, both my husband and I began new jobs and our 16 month old son started going to daycare. It was my fourth year of being a Director of Nursing, but my first year at a new hospital. My areas of responsibility included five obstetrical units. I was a member of the interdisciplinary maternal-child committee which recommended policy and planned for care delivery on those units. An item that was brought forward on many agendas, but never addressed, was combined care of mothers and their newborns. After my initial meetings with the nurse managers and their staff nurses, we assessed that the care of mothers and babies was fragmented. So, I proposed that nursing examine the issue of taking care of mothers and babies together. I felt implicitly mandated by the longstanding, combined care item on committee agendas.

The nurses and I formed a planning committee for what we called family-centred care. We consulted the literature, other hospitals, our own patients, and a Community Advisory Group. We invited a panel of nurses with experience in the implementation of combined care to speak to our nursing staff. The Chief of Pediatrics and senior administration supported our plans. By the end of a year, we created a document that outlined the rationale and recommendations for the change to FCC. A general meeting of physicians and nurses was arranged to share all this information and invite their input in the fall of 1986.

The nurses and obstetricians ranged from neutral to supportive in their reaction to FCC, yet the pediatricians were outraged. Within a week, I was in the Board Room of the hospital with the President, Vice-President of Patient Services, and all the pediatricians who wanted me fired. Babies would die if they were brought out of the nursery to be cared for with their
mothers they said. Stunned by their opposition, I was angry at the disagreement with our nursing plans. As a well-intentioned and responsible oldest child, my disbelief at being challenged was stronger than any fear about my livelihood and career. Since we had engaged in a many months long and thorough consultation process related to nursing care delivery changes, I could not credit their objections to anything more than male pediatricians treating a well-intentioned female Director of Nursing badly. I could not see that I had done anything wrong and certainly resented being treated like I had to have physician approval to improve nursing care. By the end of the meeting, it was agreed that FCC would be piloted on one unit and would be monitored through the maternal-child committee. I was still employed, although the disagreement continued to feel very threatening and personal. As the implementation of FCC progressed on the nursing units, a female pediatrician continually argued against it at the maternal-child committee. She would swing her pony tail and rage against the system until she cried or I burst out with counter-arguments, appalled at the behaviour of both of us, yet compelled to defend myself, the nurses, and the mothers and babies who were being cared for together.

I did not realize the extent of disruption posed by taking the pediatricians out of their territory in the nursery, into the mothers' rooms. Away from their nurses, out on the postpartum units, pediatricians would have to conduct their practice with babies in front of the mothers. Seeing this change as only related to nursing and patient care, I naively thought the chain of command would work in the physician group since the Chief of Pediatrics had given his approval to the plans. I was surprised and undone by the active resistance of individual pediatricians. At the time, I did not know people could ignore or disagree with hierarchical command.

Relationships with my administrative peers and Head Nurse group are illustrated in the following story which happened as FCC was being implemented. I wrote it in the Fall of 1996 when we were asked in the Foundations of Curriculum course taught by Professor Connelly to write a picturing exercise about leadership. Reflecting on my
nursing practice as a Director of Nursing, I identified a situation that is still poignant and cautionary. Writing this experience is significant because it was the first time I reopened a time in my life that was shattering.

**Wendy’s Face**

Three Director colleagues, the Vice President, Nursing, and I met in early December 1988 to review staffing over the Christmas and New Year period. The Vice President suggested that we rescind posted schedules on all units (schedules are negotiated months in advance and show at least six weeks of shifts for all staff). Since these schedules are hotly contested with personal arrangements and consistent coverage vying for priority, it would be a huge issue to ask managers and staff to change them. There were written policies and unwritten understandings about who got what time off based on seniority and past practice.

My units were well managed by the Head Nurses and usually my relationship with the managers was more facilitative than interventionist. This was partly based on my lack of experience as I had never been a Head Nurse and partly on my ‘management philosophy’ which is to treat people the way I want to be treated. Since I like room to move and the autonomy to do so, I gave that space or so I thought to my manager group.

One December afternoon, I called a meeting with the Head Nurses on short notice and arrived at the conference room feeling full of important news. Feeling anxious, I skipped the usual informalities that started our meetings. I stood before them and began to present the staffing issues as discussed in my peer group. One of my managers said, “Whoa, Gail, sit down. Why are you standing over us? Come and join us.” From a sitting position, I continued to share the conclusions of the Director group. One of my managers began to cry. She asked me how she could tell her Mt who had been working flat out for months, that their reward would be to cancel already promised holidays and perhaps to work on unfamiliar, short-staffed units to provide patient coverage?
My picture of that moment is captured in Wendy’s contorted face as she asked me, as I heard it, to recognize the humanity of her staff. Feelings of shame for not representing my group in the discussion with my peers surfaced in my awareness—no wonder I was anxious at this meeting. I bought the party line that we all had to do the same thing and that what the bosses said was the way it would be. Being on-side with my peers took precedence over thinking and supporting the staff in my areas by working out multiple solutions and offering managers a choice.

Writing this now, I wonder what this situation with my colleagues, Directors, and Head Nurses meant to me? Reflecting on that afternoon, I remember the feeling of my dilemma. Being seen as part of the Director group (to hide the fact that I didn’t like them and didn’t want to be part of that group) seemed vitally important. Counting on the goodwill of my Head Nurses, I hoped they would go along with the plans. An underlying tension for me was the sense that I had to choose between them—that I couldn’t be part of both groups. What I perceived to be the Directors’ expectation was undermined in the presence of my Head Nurses and I woke up to my convoluted thinking. Why did I not want my Director colleagues to know about my relationships with my Head Nurses? In retrospect, I see this situation called up my compliance with authority even at the expense of those I care for. And that compliance was a cover story, a protection of myself from acknowledging I was acting irresponsibly. I hoped my Head Nurses would bear the consequences of my actions and pass them along in their units to preserve my identity as Director of Nursing.

Wendy’s story is the beginning of the end of my career as a nursing administrator. I viscerally felt the cost of participating in a role I hated but fulfilled as if I had no choice. To this day, Wendy’s face at that meeting is a symbol of being called to account for a deep betrayal. I was complicit in a system I was critical of, trying to be ‘the rose in the outhouse’. a role my father identified for me as the eldest of four siblings. I think the learning is poignant because I wonder what would have happened if Wendy had not been honest with her reactions at that moment. What if the Head Nurses went away grumbling and put on their staff what I had put on them? Would the front-line nurses then put that pressure on patients? It is awful to contemplate.
This experience formed a theory that feels true—issues that do not get worked out at higher levels of the organizational hierarchy are pushed down the system until many people are embroiled in issues and conflicts not of their making. I practiced as Schmieding (1988) found in her research, in charge and out of relationship. As she pointed out:

Administrators frequently acted without considering the nurses' thoughts and ideas about problem situations. Thus, rather than initiating a process of inquiry with the nurse, a large percentage of nurse administrators would handle the situation alone or tell nurses what to do. Consequently, neither the nurse administrator nor the nurse reflected on her or his particular reaction to the situation to determine the real problem or to identify how each of them might have contributed to the problem situation. (p. 243).

In the winter of 1997, my second year of doctoral studies, I undertook pilot research based on my undigested family-centred care story. My friend and co-participant Karly, reconstructed this story with me. As a colleague at the hospital where the situation occurred, Karly was a member of the maternal-child committee because of her managerial responsibility for the prenatal program. She was witness to and participant in the unfolding drama and agreed to meet with me to reconstruct our decade old experience. After signing a consent form, Karly met with me twice over a two week period for three hours each time. I taped and transcribed our conversations and gave Karly a copy for feedback and for her own use. We also journaled and then read to each other at our second meeting. I wrote a paper that documented our mutual exploration of the FCC experience and Karly edited it for accuracy, confidentiality, and grammar (Lindsay, 1997). This second version of the FCC story is extrapolated from that paper.

**Family Centred Care: Version Two**

In September 1985, my husband and I both started new jobs and our 16 month old son began daycare. It was the fourth year of my being a Director of Nursing, but a new hospital. I was responsible for the five obstetrical units and a member of the maternal-child interdisciplinary committee. Meeting with the five nursing unit managers and their staff, I was struck by how many nurse-midwives were on staff who were used to caring for mothers and babies together. After a woman had a baby at our hospital, she could go to one of two units and her baby could go to the
regular or intensive care nursery. That seemed terribly fragmented care and so we began a nursing planning committee to look at how other places were caring for mothers and new babies, surveyed the literature, our patients, community advisory committee, senior administration, and physician chiefs.

When we held a meeting of all the doctors, the obstetricians' response ranged from neutral to positive, unlike their pediatrician colleagues who were outraged. The obstetricians were less affected than the pediatricians by the change and needed my goodwill to argue with administration on their behalf about another program which OHIP would no longer fund. The pediatricians' territory, time, and clinical resources were affected as their little patients would be on the post-partum units with their mothers. Perhaps they saw the nursing initiative as a further erosion of their practice autonomy and certainly were savvy enough to figure out they might lose space and staff if the well-baby nursery was empty most of the time. A woman pediatrician took care of ill and vulnerable babies every day. She insisted babies would die if they were taken out to the open nursing units. The nurses, mothers, this pediatrician, and I were all women but I continued to talk with the male pediatricians and plead for their acceptance.

New meaning emerges from this second construction of my FCC story. In response to our conversations, Karly wrote in her journal:

Towards the latter part of our meeting, when we are talking about the system the maternal-child committee meetings come from, I developed an uncomfortable sensation deep in my gut which eventually simply stayed with me. It disappeared on the way home as I ran a few errands, but was noticeable again when I got home. I wonder if it is related to challenging authority? It is deep within my gut, my womb, the very deepest part of me and the very seat of my femininity. I sense it relates to powerlessness and shame in the face of what Ada calls “phallic rigidity”. I am drawn to an image of myself as a small child, going to kindergarten at
the age of four. The strongest figure is the teacher who had congenitally
and bilaterally dislocated hips. Her gait is such that she hoves from side to
side as she moves forward. She is short but broad in stature and a very
powerful woman. She uses sarcasm and ridicule as her weapons. Its hard
to believe that so warped a human is allowed to teach, especially in the
lower grades where the teacher is really a surrogate mother. One of the
pediatricians used to diagnose “teacheritis” for the variety of morning and
especially Monday sicknesses that children developed.

I remember the shame of being singled out, being ridiculed for
twice asking to go to the bathroom in a morning. Later when I took my
little sister to that classroom, the teacher would greet me at the door and
direct my sister to tell me what she did in school that day. The poor kid
would have to relive her shame and tell me she wet her pants and her navy
knickers would be drying on the radiator for all to see. My response to this
is to keep my head down and hope the teacher doesn’t notice me. I now
know this will be my response to ridicule, unequal power, situations where
verbal assaults are potential. I weep as I write this. As the feelings persist
through the week-end. I call Gail to share my feelings but also to say, that
because of this feeling of being powerless, one of my responses in
meetings like the maternal-child committee was to keep my head down
and not speak up when a defense of myself and someone else needs to be
made. I need her to know that I can be like that and collude with those
powerful rather than support what I know to be right.

Karyl and I remembered together that in the mid to late 1980s there were a lot of
pressures on physicians from women who wanted less institutional childbirth and from
the government which would not allow extra-billing for their services. Senior
administration was pleased to hear nursing was responding to consumer preferences and
saw potential cost savings in the FCC plan. The competing narratives of doctors,
administrators, and nurses were outside my awareness at that time. I did not know how to
hold the multiple strands in that environment. The way I storied my identity in that
context was not coherent—it was embattled, conflicted, and unsure of what story to live
by. I can try to understand by making meaning of my experience through “retelling stories that refigure the past and create purpose in the future” (Connelly & Clandinin, 1988, p.24). What other story could I have lived?

As reflected in my journal, I was still very troubled by what happened in the implementation of FCC and judged myself and nursing harshly:

The most painful work for me was in the administration of hospitals. In nursing administration, I demonstrated my own complicity in the status quo by controlling other nurses. At the heart of any health care institution are the nurses, usually women, who have joined with the power structure, either as a cover story or as their identity, who keep the general population of nurses in order so the place will run. My theory is that nurses, as housewives of the health care system, are meant to be unaware of themselves, to perform as cogs in a great wheel, interchangeable and endlessly giving. Within hospitals, they are to produce and gracefully withdraw to wait upon the needs of a system that is absorbed in its own survival. At administrative levels, nurses are co-opted and comply or do not survive (personal journal, April 8, 1997).

In response to my relationship with Karly and reflecting on the meaning of the FCC story, I continued to write in my journal in the spring of 1997.

Family-centred Care: Version 2B

I hate that all I can use is words and sit at my desk typing. I am so angry and hurt—I want to throw myself around the room at top speed, whirling and smashing and shouting. Thinking I was doing my best, doing what was expected, leaving my own child in daycare to spend the day at work fighting to have mothers and babies together. I sided with powerful men and couldn’t understand why they would argue so vehemently against FCC. Because my framing of the situation was men against women, I totally missed the fact that the major dissenters were the female pediatricians.

A most painful issue for me is how a woman is treated when she has a baby in a hospital. At the time I did not consider how my own experience of being born and of
having a baby might influence my work as a Director of Nursing of obstetrical units. My own mother went into labour late one evening on January 20, 1953. Dad took her to the hospital and went home as husbands did in those days. A little after 2:30 a.m., the hospital called to say I was born. Dad went to bed and called my maternal grandparents in the morning. As they were sitting by the phone all night and assuming Mom was having a difficult labour, they were upset that he did not call them after he heard the news. Mom told me that what mattered a great deal was the nurse who went off evening shift but stayed with her, bringing my mother tea.

The Birth of My Son

I awoke in labour at home in the early hours of April 12, 1984. After waking up my husband, I called the obstetrician and got into the shower. Stroking myself with a soapy hand, I said good-bye to my body. I knew the coming day would change me forever. We went to the hospital and I spent most of my labour lying down, anaesthetized and with a fetal monitor strapped across my abdomen. As the epidural medication wore off, strong contractions and feelings of nausea swept through me. I did not know I was in the transition stage of labour and could soon deliver my baby. A nurse assessed my labour and responded by topping up the epidural. I couldn’t do the work of labour after that. A different nurse came in to coach me but left when it became clear my contractions had stopped. Pushing when the machine said my uterus was contracting, I couldn’t feel anything and the baby did not move down the birth canal. A doctor cut me open and used forceps to pull Paul out of me five hours later. Repaired with stitches, I was transferred to the end of a recovery room behind a curtain. On a stretcher, holding Paul, still profoundly immobilized from the anaesthetic, I wanted to talk with my mother. My husband had been with me all day and through the delivery. He asked if I minded if he went for dinner with his best friends to celebrate. I told him to go ahead as he needed a break and the event was over. Waiting for what I needed, Paul and I were alone on a stretcher behind a curtain for three hours until being moved upstairs to a room at 10:00 p.m.
Late in my pregnancy, I attended a Nursing Research Workshop (E. Hodnett, personal communication. Winter 1984). One of the researchers presented a comparison of hospital and home births. She showed better outcomes for women who do not go to hospital with “a list of demands” and recommended home births for women with such a list. Interpreting that to mean that I would receive better care in the hands of experts if they perceived me as cooperative, I expected a good experience from clinical experts who would support me in a natural labour and childbirth in exchange for my passivity.

As I reconstruct this experience, I interpret my actions as self-betrayal and complicity with “authority figures know best” as a life story. If I give myself over and mirror you, will you love me and approve of me and take care of me? If I had no sense of needs or desires of my own. I applied the story that had always worked for me (or so I thought) to having a baby—be self-reliant, take my body for granted, and assume others’ needs come before my own. I had no presence to myself in this life-altering event once I reached the hospital and handed myself over in a bargain the staff were unaware I was making. My husband was with me all day so I had a loving witness. Not recognizing my own needs. I could not share them with him. Left alone on a stretcher behind a curtain, recently delivered and holding Paul, I felt bereft.

As these personal resonances are storied, I can see the connections that were invisible to me at the time between my woman-body, nursing, mothering, and family-centred care. Now I can ask how did it matter that the nurses, obstetrical patients, female pediatricians, and I were women? How did we identify with each other and how did we abandon each other? How were institutional practices, hierarchy, and professional practice roles implicated in how women were treated by us? Now I interpret that the doctors and I were fighting about power and status and control when the real casualties were bloodied and alone in the birthing rooms. In acknowledging that I was partially driven by autobiographical experience outside my awareness in this situation. I wonder what narratives the physicians and nurses were enacting? How else have I practiced as a nurse, influenced by unreconstructed experience?

I have held this incident inside me as evidence of failure and incompetence and as a reason to not do administrative work again. In retelling the story, intertwined with new
life events, more context and relationship are revealed to me. My role becomes less central, others are foregrounded as equally involved and deeper exploration is possible.

In the spring of 1997, I call Karly and talk with her about a women's retreat where I dropped her at the door and only connected again on the ride home. She writes:

One night Gail calls. She has let herself feel how all of the nurse managers, the nurse educator and I didn't support her in a particular maternal-child committee meeting. I think how abandoned she must have felt. She apologizes for abandoning me on a spiritual retreat the week-end following that committee meeting. Even as I am saying that I didn't feel abandoned, my body is telling me not to deny that, to allow it. And once off the phone I do that, I simply allow it and the feelings just flow in and perfuse my gut as they do now (as I write). I am called back to childhood when I'd be left out when part of a threesome and I was so often one of three (sisters). And the tears come. And I let them.

It is a relief to know my experience was shared, and yet disturbing to realize both Karly and I, in middle management, could not ally with other women on behalf of women. We took for granted that we had no power relative to those we inscribed with authority. This thought has dangerous implications which are illuminated in the following story.

Transit Story #1

One morning in Spring 1997, the same semester as Works-in-Progress and my pilot research with Karly, I got on the bus to go to an early class about narrative in research and teaching. I sat in the last row, on the driver’s side of the bus, by the window. My purse, school bag and jacket were tucked on my left, between my body and the side of the bus. I looked up as we stopped at a major intersection and a teen-age boy got on. He looked about 15—my son’s age—and had the same fashion sense with an oversized shirt and his jeans skimming the bottom of his hips. He carried a knapsack and had the hood of his sweatshirt up over his head. I idly thought it was a shame that bus drivers hassle kids, as the boy and the driver seemed to be engaged, and the bus still wasn’t moving. Idly wondering if my son needed a driver to remind him to show his student card, I questioned if the
driver experienced that as authority or as an inconvenient rule. In the same moment, I looked down to read my book and heard shouting. I raised my head in some confusion and saw the bus driver holding the boy by the arms and pushing him, yelling something at him. The kid seemed strangely silent and passive, allowing himself to be maneuvered down the bus.

I felt shocked, both at the boy and driver. Another woman stood up and had her arm out in front of the driver. Flying out of my seat, I put my body between the boy and the driver and said loudly to the driver, “Stop it both of you. He’s only a kid”. The driver said “he assaulted me”. Another passenger called out, “then call the police”. The driver returned to the front of the bus and made a phone call. Without a word or a look, the boy wheeled around me, opened the bus window behind the rear doors and rolled out the window onto the road. I last saw him running across the baseball diamond across the street. The driver invited anyone who could give a statement to stay and told us there was a bus right behind us for anyone needing to be on their way.

One man remained with the driver. I got onto the next bus not wanting to make any statement. I asked the woman who had been sitting at the front of our bus and had also intervened what happened. She said the boy had given the driver a monthly pass and when the driver had challenged the validity of the pass, the boy tried to grab it back. When the driver held onto the pass, the boy punched the driver in the head. This had happened in seconds and I had seen none of it. I responded to what I saw as an officious, unnecessary conflict where the driver was at fault. Partly because of my actions, the boy had gotten away. The driver, who was defending himself, got little help. I decided to call the transit company from my office and explain what happened in belated support of the driver.

Getting off the subway near work, I saw a man in a transit system uniform crossing the street. I asked him whom to call to report an incident on a
bus. He gave me the number and I called from my office. The supervisor asked me to fax my account of the situation which I did, making my interference clear and stating that the driver acted in self-defense. He did not hit back, he just moved the kid down the bus, out of the driver cubicle. I also asked if the transit company had any critical incident debriefing policy and practice. I wanted to talk with the driver and understand with him what had happened.

There was no further contact from the transit company even though I called twice. I wrote about the experience, much as I have journalled here, and talked with Regina. Reflecting on my actions, I understand that I acted as if what I knew and my good intentions were justification for what I now understood could be seen as interfering. Then I pondered where else in my life I do that; at home, with family and friends, at work? Several weeks later, no longer thinking about this on a daily basis, I got a call from the bus driver. He sounded young and he was still scared about what could have happened if the young assailant had a weapon other than his fists. I too had thought about “what if” the young man had a knife or a gun. The driver thanked me for sending the fax after the incident to his supervisor. It had been leaked to him because someone at head office was concerned about the driver. He was grateful that my fax showed how he had acted and that what happened was not his fault. Apparently, his supervisor wanted to know what the driver did wrong to cause the passenger to hit him. The supervisor’s thinking reminds me of the violence against nurses in workplaces where they are told it’s part of the job or that they invited the abuse. (2)

The bus driver and I talked twice on the telephone. Repeating my apologies for interfering in an unhelpful way, I reiterated my belief that he had acted appropriately after being assaulted. This was the least I could do after my part in this situation. The transit company had no critical incident debriefing process so the driver and I created our own version on the phone. A debriefing process involves retelling the experience, especially its emotional impact, and stress education (Cooper, Saxe-Braithwaite, & Anthony, 1996). Our conversations were reconstructions of the original situation and I experienced this relationship as significant—as a call to wide-awakeness (Greene, 1978). My identity of being a person who knows best, who is expert, and whose judgment is
always correct was interrupted. I began to see my actions as a form of taking over which resonated with how I felt as a teen-ager with my mother, wanting to be free of her shaping. As an older sister, I would be aware and try to avoid enacting this behaviour in my family.

My assumptions about the driver’s authority contrasted with the reality of his position, revealed in our conversations. Mulling over how it felt to know that senior administration could actively victimize and withhold support for a front-line worker, I questioned how that played out in my administrative actions—did I do it; was it done to me? Could I imagine, therefore, another interpretation of my family-centred care story?

**Family Centred Care: Version Three**

In September 1985, my husband and I began new jobs and our 16 month old son started daycare. I am an eldest daughter in a family of four siblings and a nurse who was offended to be told as a student that reading about an experience might not be enough knowledge to help someone going through that experience. Generally liked, organized and very busy, I assumed that my intentions to do good for people automatically made what I did alright.

Each morning, the three of us got up at 6:30 a.m. and my husband and I alternated driving our son to daycare by 7:45 to get to work by 8:30. Within six weeks of starting my job at the new hospital, I hated it. I couldn’t stand the pride they took at this hospital in ‘making do’ after coming from a hospital where every one of my nursing units had administrative, educational and clinical nursing resources. I would leave the hospital at noon to eat lunch away from the site and as early as possible at the end of the day. Trekking across the city to my son’s daycare and then driving west into the glaring setting sun on my way home was excruciating. When my boss asked me if I was happy in my new job because it was unusual for people to leave the hospital during the day, I lied. I said everything was fine because it felt too threatening to tell the truth, to tell my secret of despair. On that treadmill of dread, exhaustion and fear of discovery, I met with my Head Nurses to get a
sense of their experience and suggestions. About six months into my job, I decided to pursue the project of mothers and babies being taken care of at the hospital. Who could argue with such a good idea?

At the time that I wrote this version of my family-centred care story, I was in a doctoral writing group. From April to December 1997, we met weekly for three to six hours, including a meal. Our activities together included driving to Ames, Iowa that November for our first American Educational Research Association special interest group meeting on Research on Women in Education. One of our group members, Ariel, left the group in December. I wrote the following and gave a copy to my three writing sisters. They have all agreed I can include it in my thesis.

**Leave-taking and Learning**

Ariel has left our writing group and I feel so tired, angry and sick. It took all week for my feelings to surface because at first I did hear her reasons and could make space for how she felt. And today I called her to ask if I did something to cause her to leave the group? Do you know that you matter to me? Why are you breaking a pattern of intense relationship? She confirmed that it was for her own sake, that it was her own issues related to the group. Clarifying this felt so important because I feel so abandoned—our group feels vital to my survival as a doctoral student, and because of the depth of our relationships, vital to my life. I am aware, yet again, of the level of fear I have about doing this work for myself and somehow Ariel’s decision leaves me smack up against my own responsibility for myself. Perhaps this is partly why she left, because she felt engaged in or responsible for other people’s well-being, and maybe I handed over too much responsibility for my own work to her and to the group?

Has this ever happened before in my life? Aha, yes, and that time, it was me who left. In the fall of 1995 I was part of a women’s spirituality group that met monthly over a year. My journal writing recaptures what happened at the end of that group.

Thursday, September 21*th, 1995
Took a cab to Sally's from OISE after my Transformational Learning class. There was no break in the discussion as I entered the living room and I went upstairs to the washroom. When I came back down to the group, there was still no acknowledgement of my presence. I felt like I was somewhere in space, not really there in the group. We talked about the purpose of the group and it became obvious that I want something the others don't - a kind of connection I found hard to articulate. I learned to my shock that Valerie (who has come four times and is friends with three of the group members) had a terminally ill husband this past year and he died last Saturday. Shit, I never even knew she was married. Talk about an example of the point I was making. I hope I can sleep.

Friday, September 22nd, 1995

Thought a lot today about last evening's group meeting. The group is about Sandra holding court with several of her friends or last night was. I knew as I offered to do the next meeting's ritual that I shouldn't—that I don't want to go—and I have been trying to decide if I should go or not and if I should tell them in person, by phone or write a letter.

Why was there such group silence when I expressed my feelings and needs. I feel like a banked fire in the group. I decided to call Joyce and ask her to do the ritual and I could supply the food. She said yes to both ritual and food so I have decided not to go at all. I'll write to each member of the group.

Monday, September 25th, 1995

Drove around the city and dropped off my note to each member of the group at their homes. Went to a store on Queen Street and bought a raku oil lamp to celebrate and have gratitude for what feels like acting on my own behalf.

My journal records that I did not hear from anybody, including Sandra and Karly, the two women who were my friends before the group started. Joyce called after a few days to say she was sorry I was leaving the group because she liked my energy. She suggested we might see one another and I described one of my favourite restaurants. She
said that sounded like a good place for her husband to take her out to dinner, so I thought, you don’t really want to get together with me after all, and concluded the conversation.

Sandra, whom I had known for 10 years, called a few weeks later and said she did not understand what I meant about the group. We talked briefly and then did not talk again for months. Seeing her for dinner, I tried obliquely to talk about our group breaking up. I perceived her response as changing the subject when she told me about the diversity workshops she facilitates. At the time, I did not see the connection she might have been making between our group failure and her expertise.

Talking more openly with Karly, I asked her why she didn’t call after the group meeting or when she got my note. She said she knew how upset I was and that she didn’t want to bother me. Since she knew of my upset, I wanted her to call me. For two years I have avoided Sandra and continued to see Karly. When Karly read this reconstruction, she noticed how even still I was only hearing what confirmed my interpretation of these events. She repeated to me that at the time, she was also processing what had happened in our group and needed some space and clarity before calling me in recognition of my upset. Hearing this now, I am embarrassed by how my perspective is limited and self-centred in this story. Two years later, in late November 1997, Sandra called me about getting together. I did not call her back immediately because I needed to think about my response and I knew it was time to clear up our situation. It felt inevitable that we would talk to move past this stuck place. Calling Sandra back, I admitted a need to talk about our women’s group dissolving. She said she had felt the distance, still didn’t know what my issues were about the group, and agreed to meet for dinner. That was the night that Ariel called me to tell me she was leaving our writing group as she needed to attend to her own work.

Reflecting on leaving the women’s group, I see how the others were expected to show their caring by calling me and recognizing my feelings about how the group was functioning. I did not have the same expectations of myself—to have empathy and care about how others were feeling. I did not want to go to the group and say what was bothering me and then decide whether or not to stay. I also conflated how I felt about Sandra ignoring me as I entered the living room for our meeting into feeling excluded.
from the group. The group met twice after I left and then folded as members just stopped coming. To my knowledge, the group never talked out the issues.

Similarly, our writing group never met again and we did not talk about our issues in our foursome. Making connections between these two experiences, I know how it feels to leave and to be left. Reconstructing the two stories shows the assumptions and meanings embedded in our actions. I interpret now that our writing group called up our narrative plotlines. We embodied a web of past experience, expectations for the present, and hopes for the future. Our work together provided us with the opportunity to reconstruct our experience and learn new ways to act in relationship with each other. Instead, I stayed in my story of avoiding conflict and others stayed with their plotlines of always having conflict with women, or always having to do everything alone, or whatever the story was in each case.

I am reminded of a book by May Sarton (1978) in which the female protagonist is given a fatal diagnosis by her doctor. She decides to make a final reckoning of her life and to deal only with real connections: she will only see the people that matter to her. She realizes how much time she has spent in service of a cover story in her relationships. As her contacts dwindle in number and deepen in emotion, she realizes that “women’s feeling for one another has been a buried world for so long, a cause of fear and shame—now at last we are beginning to understand the blessing” (p. 143), and I would add, the blaming. Regretting that we did not reconstruct our group experience together, I have learned a great deal by doing so in my writing and by sharing that writing with my colleagues.

From these reflections, I can now imagine what motivated Ariel to leave our group—it is a group issue and I am part of it. Perhaps it was not safe. Perhaps we called up life issues and then didn’t know how to work on them together. Maybe wanting out but not being able to say so is operative for more of us than Ariel. Recognizing my aversion to conflict means acknowledging that I will do everything possible to smooth things over. A person who needs to disagree openly has to cut through the nice blanket of silence I work hard to maintain. Learning this means that I can recognize how I silence others when there is tension. Now that learning is part of me and I hold the tension within me in similar situations, letting it unfold further than I could have allowed in the past.
My theory is that one person acts out what is actually a group notion or pattern; theorizing that leads to the question of what Ariel was to do for me (and the group) that I/we should be doing for ourselves? I now see how group issues are shared by all, but usually voiced by one or two. As a member of a group, if I choose to see an issue as only belonging to one individual, then I am not in a collective with them and that person is constructed as a scapegoat. Going below the surface to see how I am implicated in the verbalized issue reveals motivations, assumptions, and competing tensions. This learning is important for my comportment in colleague and student groups. As this story and its aftermath proceeded, an experience involving a large nursing group unfolded.

The Provincial Nursing Landscape

In January 1998, the Ontario Ministry of Health and Joint Provincial Nursing Committee (JPNC) held a one-day consultation on provincial nursing education. I attended as a representative of an urban university where I worked as a program manager in nursing continuing education. There were one hundred and ten participants attending the consultation. We were university and college nursing faculty, nursing employers, hospital-based clinical teachers, nurses in clinical practice and researchers. The Nursing Committee and the Ministry of Health wanted our response to the JPNC Education Subcommittee’s Operational Plan (1998). The Plan outlines an integrated system that allows nurses to complete their education in a seamless manner in a variety of educational settings and to gain relevant credentials. The nursing coordinator and a policy advisor in the Ministry of Health spoke at the beginning of the day, inviting us to plan for nursing education that would provide Ontario citizens with adequate numbers of nurses with appropriate preparation. They acknowledged the severe nursing shortage that was building as the new century approached.

The day was structured so that we could choose two focus groups to attend related to continuing education, basic and/or advanced practice education. Each group had a facilitator from the JPNC Education Subcommittee, a volunteer recorder and a set of questions about the draft plan. I attended
the continuing education session first, as it was most relevant to my work. Seated in a narrowly rectangular room which made seeing each other difficult, we began by responding to the facilitator's questions. We did not share introductory information and terms such as continuing education were used to mean different things within the discussion. Hospital-based teachers asked if universities would give credit for one hour or half day inservices. Prior Learning Assessment (PLA) which gives students academic credit for experience as well as formal learning is differentially implemented in post-secondary education. While the community college sector has moved ahead with PLA systems, the university sector has not. At the university where I worked, credit transfers for equivalent courses or challenge processes through portfolios, assignments and examinations for entire courses existed. Whether this is a good thing or not, there is no other mechanism for recognizing practical experience, learning modules or informal education. It was clear in listening to the discussion that we were in many different practice worlds with not very much understanding of each other's perspective or organizations. Each person spoke into the vacuum of no shared context or language. I felt frustrated and apart from my colleagues by the end of this session.

In the advanced practice session that followed, I was interested to learn about the issues related to post-baccalaureate education for nurses. I was not familiar with the shape of the debate or what constituted advanced practice at that time. My experience with advanced practice over the past two decades related to having a Masters in Nursing which was required to be a Clinical Nurse Specialist and then a Director of Nursing. My Masters was also a necessary credential to be a sessional nursing teacher at the university. Again, I experienced words to mean different things. We politely argued with one another about who can be an advanced practice nurse, with what credentials and what they can do in clinical practice, research, administration and education. Each person spoke their position with certainty and firmness. There did not seem to be any question that
there is a social need for nurses with advanced educational preparation for nursing complex patients, consulting, educating and research. Of particular interest to me was the discussion about who or what should impose and enforce the rules once they were articulated. Both government and regulatory mechanisms were proposed by participants. Wondering why any group outside nursing needed to set standards and educational levels for us, I wandered back to the large room where lunch would be served. Criticizing my colleagues for not having answers to the questions about advanced practice and for expecting the government to make the rules, I did not know myself what should be done. The issue of elitism and access to advanced education both in financial and geographic terms had been given short shrift in the discussion. I impatiently shrugged away my thoughts on what seemed to be exclusion of nurses by nurses.

I hungrily surveyed the lunch buffet that included cans of pop, plastic trays of sandwiches and two plates of vegetables. It seemed to me that the food and how it was displayed, still covered in plastic, was another sign of how the day was going. I thought of the cheesy vegetarian lasagna, deliciously marinated chicken, salads and homemade desserts that are offered to my group of teachers at our fall and spring dinners. Food is an important symbol to me; a symbol of family and being together to share our lives. This is the value that informs how I feel about the dinner for my teachers and it is a small way to convey my gratitude for their work on behalf of Registered Nurse students. I saw the consultation lunch in those same terms. Would the quality of listening to our input be commensurate with the quality of the sustenance?

We reconvened at one o’clock as a large group and the recorder volunteers presented the focus group discussion summaries. There was a microphone in the centre aisle in the meeting room and we were invited to comment and expand on the presentations. Several nurses did make a point or ask a question although it was difficult to hear them because of problems with the amplification from the microphone. The atmosphere in the room was
markedly subdued. In response, the nursing advisor recommended that we contact the Education Subcommittee with any further comments, suggested that we skip the break and grab coffee and cookies on our way out of the meeting. There was a gasp from the crowd and someone called out, “there are no cookies”. Was the advisor ending the meeting because so few of us were responding to the focus group reports? Sitting on the edge of my seat and wanting to speak, I was full of emotions stirred by the day.

Suddenly I was at the microphone, waiting for the nursing advisor to recognize me at the end of her closing comments. ‘Suddenly’, means being under the influence of how I felt, not what I was thinking. Something in me was pulling me to speak rather than to go home full of unsaid words and wishing I had spoken. I said I felt invisible because at my university workplace, we collaborated with community college and clinical partners to create degree level courses and that work was not reflected in the Operational Plan. It mattered a great deal to me that our work was not recognized by our JPNC colleagues—mirroring the invisibility I felt in my workplace. This intensified my anguish about not feeling at home in nursing. I encouraged others in the audience to let the Education Subcommittee know of their initiatives. By this time the nursing coordinator was looking at me in a way I interpreted as concern; about what I did not know. She could have been interested in my comments or feel criticized by them or she could have been wondering why that fool doesn’t sit down. I remember thinking, “I better finish fast, before they take me away”.

My body sensed danger; perhaps I should not be speaking about my experience? Taking a deep breath to calm my racing heart, I commented that the planning document articulated guiding principles about nursing and meeting societal needs in terms of external system changes, like technology and reduced funding, and improving efficiencies. It did not say why society needs nurses and will continue to do so. This absence touches
my own questions about being a nurse and how it matters to contribute to society in this unique way. Overcome at this point by my feelings of vulnerability, I waved my arms in a gesture of "you know what I mean" and sat down.

Interpreting this story about acting on my feelings as if they were static on a screen (and not meaningful) and privileging only thinking responses, I ask myself, what was that about? It is the same confusion I felt as a young child when my mother would remind me before we went out in company that everything I thought need not be said. How do I know what is alright to say then? What helps other people discern the parts of their experience that they can share? What story of this consultation day did I interrupt, struggling to find meaning in it? Criticizing myself for not understanding more, instead of exploring my questions about the day, I worried about having gone to the microphone and revealing too much.

I watched from my seat as nurses got up to speak. They pointed out the consensus in the room about the baccalaureate degree as the entry level of education to practice nursing and questioned why the JPNC did not get on with implementation of this policy. There were challenges about the purpose of the day and what the committee needed that it didn't already have. Several people pleaded for action so that when they retire, these career-long issues about nursing education will be addressed. One woman felt so strongly that she stayed in her seat at the back of the room and called out loudly, "When are we going to have the baccalaureate as the entry degree for nursing?" Another nurse, halfway up the room turned around in response and said, "Let's not lose it now!" I felt the undercurrents of emotion swirling in me were also in the room, like an undertow. The muttering increased.

As the meeting ended, still an hour earlier than planned, staff brought in platters of freshly baked chocolate chip and peanut butter cookies. Knots of nurses gathered to munch and talk. Two colleagues said to me, "Good for you. I agreed with what you said." Smiling, a cookie in each hand, and saying "Thank you", I didn't know what they meant. I felt so resentful that
they did not get up to the microphone and speak their agreement. Maybe then I wouldn’t still feel like an idiot. I felt unsettled; not part of the group and not sure what had been accomplished. As we began to move out the door and down the long ministry building hallways, a nursing colleague said to me, “It was like this at the last provincial consultation. I don’t speak at these things. I just go home and do the work.”

Was I naïve to think the meeting mattered, that speaking up about my particular experience could make a difference? Was the purpose of the day a mystery to others; did they end the day perplexed and resentful as I felt? Disturbed about the meeting, I mulled it over all week-end and talked about it with my husband and with Regina. She asked if I felt any connection to others who spoke up at the meeting and suggested meeting with one of them. There was one woman who spoke several times and I knew her. Assuming Flora shared my perspective, because her face and tone of voice seemed to express frustration similar to mine, I called her and she agreed to meet with me. This is what happened next:

The following week, Flora welcomed me into her office. As she yawned, she apologized for the late start to our meeting. I felt the anticipation of meeting with a kindred spirit and said I wanted to talk with her about the JPNC meeting. We talked for about 25 minutes. She asked me questions and I elaborated on my concerns and suggestions. During our meeting, I was confused and caught off-guard because she was not offering what she thought about the day at all.

Wandering slowly along the street back to work after this meeting, I began to laugh—the kind of laugh that is equivalent to a sob. Flora and I had been in the same room, only a small table apart, but we had been at separate meetings. I had forgotten that she was a member of JPNC. Wanting conversation with a nursing colleague, I hoped to talk reciprocally about a problematic meeting. Flora’s coolness disabused me of my notion that my nursing administration and health policy background constructed me as a credible person. Now, I assume she was in a story of being a member of JPNC and feeling responsible for the consultation day. That might explain the one-way interview of our meeting. I thought about her comments at the microphone and now saw her directing
her words at the audience, not at the Education Subcommittee as I had assumed. Seen in 
this light, I would not have called her for a follow-up meeting.

I wonder what sense Flora made of our meeting? Who was I in her narrative? My 
curbside laughter was rueful as I pondered how I bring this thread of wanting connection 
and never finding it to my professional life. In this case, it would seem my seeking was 
blind to the context of the situation I was in. What are the consequences of my 
unawareness with Flora? A narrative thread for me is how awareness in daily situations is 
known and shared, with risky consequences. In these two situations I keenly felt that 
sharing my experience, which contradicted the dominant story at the meetings, was 
dangerous or at least held risk. Somehow this translates into my awareness being a secret 
which is operational for me even yet. Holding knowledge that feels forbidden makes 
connection and relationship with others a fearful thing. In the face of my experience and 
storying Flora as powerful, a plotline about the danger of telling my truth to authority is 
undisturbed. I subsequently wrote a pleasant note to the Nursing Advisor at the Ministry 
of Health recommending that all continuing education in nursing specialty courses and 
certificates be degree-linked.

In the light created by this reconstruction of my experience, I learn about myself, 
my relationships, and how my actions have consequences. "This process of becoming 
aware through living, telling and retelling stories (of experience)" is a story of awakening 
(Connelly & Clandinin, 1994, p.155). This idea of waking up and becoming aware feels 
central to creating "stories to live by," an identity shaped by knowledge and context 
(Connelly & Clandinin, 1999, p.4). Identity and experience are related through stories. 
My concern with waking up suggests I am asleep or unaware. It begs the question, how 
have I come to be asleep, disconnected from my world of experience? How does it matter 
to have a story to live by as a nurse-teacher? Through writing, I am awake enough now to 
re-journey through my past.

**Family Centred Care: Version Four**

At a community hospital where I had been hired as a Director of Nursing, 
the obstetrical nurses had seen administrators and their pet projects come 
and go. They negotiated daily with the physicians how care would be 
delivered to patients despite administrative and budget barriers. Each of
the five nursing units had a purpose and a culture and long history together. New mothers were cared for with their babies for some of the time and allowed to have time on their own if they wished. Some of the nurses had experience in caring for mothers and babies together and found the Canadian way of separation odd. The idea/ideal of mothers and babies being taken care of together all the time was both advantageous and problematic from a variety of points of view. First time mothers gained confidence in caring for their babies while mothers with other children at home wanted to rest. Was it realistic to have one system of care for everyone?

Given all the resistance to the nursing project for Family Centred Care, it was a relief to concentrate on one unit for a pilot project. I was good friends with the manager which was also a source of conflict for me as I did not think I should have perceived or actual favorites in my management team. Not only was Flo the point person for the project at work, she was also my personal stability as I kept secrets—I was falling apart, separating from my husband, moving and co-parenting my son—while maintaining that any problems with FCC belonged with the doctors. There were days where I stood in the garage beside my car, wailing at my son to hurry up. I needed to get him to the daycare as soon as it opened because I had an early meeting at the hospital. He was four years old and did not understand what he had done wrong. Beside myself with anxiety, I wanted to act in such a way at work that I could not be criticized. I knew being late for an early meeting with physicians would be bad form. A colleague who had rather publicly advertised her marriage break-up, and her resultant breakdown, was my model of what not to be. No one would say that I didn’t carry my weight, shoulder the burden, show up every day but what I did not acknowledge was how deeply unhappy I was, exhausted from my own marital separation and how much I hated my work as a Director of Nursing. I’d go to Flo’s house at the end of the day shift, beeper still on, terrified I’d be called and be discovered off premises.
Collapsing on her couch, I'd sob and try to say what was happening. Since it was beyond my understanding, it was beyond words. She would hold me and I would hold her back and think this is how a woman feels, this must be how I feel. Profoundly separated from a sense of myself as a person, not knowing where I was going in my life but sharing this only with Flo, I drove the highway to my home in the suburbs.

Looking at this story, full of narrative resonances, I wonder about many things. It is only in this reconstruction and with the intersection of ongoing life events that I begin to understand what was so totally missed in the first living of the situation. How did being a nurse and in a position of perceived authority matter? How did it matter that mothers and babies were together? What difference would it make to relate to the nurses and female pediatricians in the knowledge of my own narrative motivations for this system change? How would it matter to invite them to share their experience and wishes for relationships with patients? What difference would it make if I told people in my life about my feelings and thoughts and invited them to share theirs with me? These are very different questions from where I started—when 'what did I do wrong?' and 'why can't I do what I want?' were my focus. Reconstructing this experience also reveals how personal life and professional practice are inextricably connected despite my attempts to hold them separate.

The fifth version of the family-centred care story was written in the fall of 1998. I had met a senior nurse from that same hospital at a curriculum-planning meeting. We connected and I asked her to be a guest in my leadership course. She accepted and afterwards we had lunch. In conversation I learned that many of the same physicians were still at the hospital and had been instrumental in deposing a senior executive. There is also a deep resistance from the physicians about nurses implementing patient-focused care on all the units. Ruminating on how little seems to have changed between nursing administrators and these doctors, I wrote the next version of the FCC story.

**Family Centred Care: Version Five**

In the late 1980s when I worked at a community hospital at a job I disliked, I was looking for something to do that would make a difference.

It was obvious from meeting with nurse managers and their staff that
patient care in obstetrics was fragmented for patients geographically and temporally. A representative group of nurses got together and planned how to address the care gaps based on patient and literature surveys, site visits to other maternal-child services and our own thinking. The pediatricians, who had a conflicted relationship with their Chief, resisted the idea that he had approved in consultation with Nursing and Administration. After meeting with the doctors and hearing the pediatricians’ anger, a resident gave me a piece of paper with a change process written on it. He suggested that we would get further if we understood the doctor’s point of view.

I still have that piece of paper but never did follow his recommendations. The resident’s advice sounded to me like playing the doctor-nurse game which was first documented by Stein in 1967. This game involves nurses conducting themselves as if they do not know what they know and getting the doctors to do what is necessary for patients without feeling the nurse told him what to do. By 1990, Stein, Watts, and Howell noted that nurses had stopped playing that game with doctors—or had it emerged in new forms?

In the nursing literature about implementing the curriculum revolution in clinical practice, Baker and Diekelmann (1994) suggest that interdisciplinary team members need to understand “the lived experience of the other within her or his caregiving practices” (p.66). The example they provide is about a nurse and physician in conflict about a patient and his wife. The nurse and wife’s narratives are revealed and the physician’s story is unknown. The authors suggest that if the nurse invited the physician to share his sense of the situation, the event would not have had the same unhappiness and conflict. I read this article with my FCC story in mind and felt resentment that not only was a nurse responsible for her own awareness and advocacy for patients, but now she was called to invite the physician to tell his story. I interpret that suggestion as telling me to take care of the physician. My lack of collegiality and the grudge I still hold is revealed to me in my response. What is operating for me, still, is not knowing how to include physicians and be in relationship—my story of them gets in the way of being with them as people.
Is there a way to work with physicians and retain a sense of identity beyond their permission? In my experience, we live in uneasy relations. How can I not add to their power by giving away my own? When a nurse in my leadership class asked in the spring of 1998 how to use the course materials that she valued to fix the doctors she worked with, my response was “I do not know.” I can know my story to the extent of my awareness and I know our narratives intersect in relationship and context, but there does not seem any way around our human responses and inevitable conflict. It interests me that, for my student and I, a real concern is our relationship with the doctors. I put them ahead of everything including my son and myself. Are nurses a central concern for physicians? In July 1998, I explored some of these questions with Martin, a children’s doctor. He observed that:

Our reduced capacity to take children into the unit currently is related to caregiver numbers, especially nurses. There is excess capacity in terms of space, beds and equipment that is not used because there are not enough nurses. This results in the transfer of children if they do not need the specialized resources in our unit and discharge as soon as possible if a child can be cared for safely elsewhere. The recent nurse layoffs have come on top of a strained system and has had a major impact which has brought these issues into the public domain. The latest philosophical divide that I see in nursing is the issue of experienced practitioners who do not have a baccalaureate versus the new, modern, well-trained, well-informed but inexperienced individual. You are giving a message to experienced people that what they know doesn’t count, that they do not have value. Being a bedside nurse is not good enough it seems. So the combination of all the changes has a major impact.

One construction about nursing’s situation in reform is that we are victims: oppressed and powerless, women doing devalued women’s work. In my family-centred care stories, I attributed power and authority to physicians but never saw nurses as holders of the same resources. Gordon (1991), a writer who is not a nurse and champions nurses’ work in the healthcare system (Buresh & Gordon, 2000), documents that a female resident was told in her training to get along with nurses because “if you don’t, they can
hurt you” (p. 45). In this situation, the physicians are more aware of the nurses’ power than perhaps the nurses are themselves. Martin is saying that if there are not enough nurses, children cannot be admitted to the unit and he is limited in his work to negotiating with other sites to take the patients. So from his position, nursing is powerful as the gatekeeper for admissions.

Thinking back to my family-centred care experience, perhaps it is not a story of physician power; maybe it is more about my arrogance and ignorance of others’ points of view. Perhaps the conflict was inevitable given I was unable to see the worldview of physicians as valid and as more than self-serving. They were not human beings to me at the time by virtue of the power I invest in them and that they have socially. So, how does this matter in my life now? With Martin, I experienced a narrativist’s curiosity. I could listen to him without putting my interpretations on his story, although I was aware they were prowling at the edge of my thinking. And, to my surprise, his vulnerability with regard to nursing was revealed and for the first time I saw the power that nurses have to shape physician practice. This is one of the ways that narrative research is my education. By paying attention to my experience. I avoid the common pattern Dillard (1977) describes as “the idea of a thing which a man framed for himself was always more real to him than the actual thing itself” (p. 23).

At Christmas in 1988 my nursing friends, Flo and Rachel, sat in my living room and said it was obvious I was unhappy and it was time to quit my administrative job. Immediately, the relief of that possibility rose in my body. The only alternative I had imagined meant being revealed as inadequate or wrong. I could not see any different future, nor could I imagine, in the year 1988, a story for myself of becoming a nurse-teacher and of reconstructing my experience as education.

An imaginary version of my family-centred care story suggests itself to me as I reconstruct this chapter in the year 2000.

**Family-Centred Care: Version Six**

A year after I completed a maternity leave and returned to work as a Director of Nursing, my husband ended his home-based work and took a new position. We talked about the options, including what our both working full-time meant for our 16-month old son. My work was nearing
completion as the senior administration at the hospital was leaving and I discerned we were in for roll-backs by the interim managers. My volunteer work as a chair of a Board of Directors was interesting but replicated the administrative work of my employment. Happier doing social justice work, I turned the chair over to my experienced vice-chair and joined the Social Action Committee. Our son began attending a daycare halfway between home and our workplaces. I took on a new Director position at a unionized community hospital to gain different experiences. Within six weeks, hating my job, I quit. Doing work that involved reflection and growth appealed to me, not implementing top-down fiscally based directives. Perhaps there is another place for me in nursing—I’ll take some time to reflect and write to think my experience through. A call to the Director of the School of Nursing where I sit on the Advisory Board about the possibility of my working as a part-time teacher might be fruitful. And, our son can come home. Part-time nursery school should balance our needs. Just imagine.

Living these stories requires being awake in my life and it feels like such an effort. It is only in doing narrative work that I realize how anaesthetized daily life can be if I am not aware of being in it. Is this common to others’ experience of going through the day—how much is habit, routine, automatic pilot—missing the connections between home and work, inward and outward, over time? For me, reconstruction of experience is an awakening to new possibilities and to naming ongoing tensions. My identity at the time of the FCC experience was totally job related. What is apparent to me as I read and reread this chapter is how I was trying with family-centred care at work to create what was eluding me at home. I remember going to Flo’s after work one winter day as it began to snow. Calling my husband at home, he suggested I spend the night where I was. Initially agreeing and then feeling I should go home, I drove across the city in blinding snow. Moments after getting home, numb with anxiety and unable to settle, I packed an overnight bag, said good-bye to my uncomprehending husband and drove back to Flo’s. Following a snowplow’s flashing blue light on the highway, I wondered if I would ever
feel part of my family again. The parallels between home and work are clearly drawn. Taylor (1991) captures this aspect of my life when he says:

It's not just that people sacrifice their love relationships, and the care of their children, to pursue their careers. Something like this has perhaps always existed. The point is that today many people feel called to do this, feel that they ought to do this, feel that their lives would be somehow wasted or unfulfilled if they didn't do it (p. 17).

The call for me was feminist writing in the early 1970s (de Beauvoir, 1972; Greer, 1971; Millett, 1971) which I interpreted as saying my mother's life was not enough for me—being more like the men and having a work-based identity was the ticket to happiness. Of course, this construction of who I was and what was of value required the sacrifice of my feminine self which seemed little enough price to pay at the time. I only recognized half of my ordinary life which Taylor (1989) describes as "productive and reproductive aspects of daily life" (p. 211). The issue of feminine/masculine and gender aspects of identity plays out in the FCC stories. How does gender matter in nursing?

**RNAO Annual General Meeting 1998**

Hundreds of RNs, out of a total membership of 13,770, attended the annual meeting of the professional nursing association. There were no more than ten men in the hotel meeting room and the rest of the nurses were women. The most time consuming agenda item is the debate and voting on twelve resolutions. The first resolution was concerned with how the health care system restructuring is devolving to place more responsibility and burden on unpaid caregivers in the home who are usually female relatives. The recommendation was that RNAO form links with other women's groups to take action on behalf of family caregivers. A male nurse went to the microphone and disagreed with women being specifically named in the resolution even though family caregivers as a term includes male partners and spouses. Several female nurses then spoke, agreeing we should use gender neutral language to be inclusive and work with all groups. Two other women spoke in defense of the resolution as worded as home caregivers are 97% female. Health and social policy
makers seem to assume women are at home, available as an unpaid labour force.

This is the second nursing meeting in two months where a man objected to nurses saying women have gender-specific issues and women agreed that they should not use language that speaks to their particular issues. Despite my objections to generalizations using a gender oppression framework. I am angry that as soon as a man says he feels excluded by female nurses looking at women's issues, some of the women agree to be silenced or offer to make themselves invisible. For me, nursing is a place to be in a women's community and my resentment suggests I perceive that the men are intruding. I will be alert to this issue in conversations with my co-participants and acknowledge it bears more thinking about.

**Michigan Research on Women in Education Conference**

Late in the fall of 1998, I went with Bev to the Research on Women in Education conference in Lansing, Michigan. We co-presented a paper about how experience matters to social service worker and nursing students in post-secondary education. Afterwards, we went for a walk in the autumn sunshine. At a beautiful arts shop, I found a magnet that said, “If you want your dreams to come true, wake up!” I bought it for my office at home because it reflected the way I felt—it is time to manifest in my daily life what had been happening deep inside me over the past decade. I recognized a tension in me between what I know and what isn't in my cognitive awareness yet, embodied feelings of something there, just not discernable and yet to be described.

**Getting a Life**

Still in the fall of 1998, my supervisor challenged me to think about the audience and purpose of my thesis, if it were to be research that mattered. I take for granted that I want to have my inquiry make a difference, but felt contextless about why and to whom. He also questioned me about career plans because a thesis needs to fit into a life, not be in a vacuum. I am extrapolating from what he said and putting it into my terms. This is what I heard—what is your life? How does what you are doing matter? What world are you connected to? I was acutely distressed as anyone is when something deeply important and resisted is pointed out. I did not have a story of myself as a nurse to live by
that was reflective of my current experience. I was still telling myself a story of fixed identity—grounded in chaos and conflict that was 10 years old.

Without knowing where it would take me, I took up my supervisor’s challenge. I met with a nursing colleague who is the past-chair of a university School of Nursing. We talked and I felt encouraged to look at academic positions while completing my thesis. I realized that I had not thought of myself as professorial. Mired as I was in a part-time management position at another university. Following these discussions, I decided to apply for an Assistant Professor, tenure stream position.

Rings Again

At the spring 1998 nursing association meeting, I looked at the Canadian Nurses Foundation exhibits. A nurse’s ring, meant to be a sign of profession similar to the engineering ring, was featured. It is a plain gold band with a stylized N in the middle. I tried it on. I liked it but I hesitated. I felt like I should think about it instead of just buying it. The issue was partly financial but a deeper tension was: do I want to wear this ring as a symbol of my commitment to nursing? Would it be honest for me to wear it? It would be a statement that I was a nurse. I searched my heart and could not buy that ring. I wonder if doing my thesis will clarify how I am a nurse or if I am one at all.

In February 1999, 11 days before I mailed my application, I bought that nursing ring to wear on my right hand. I was also teaching the leadership course for what I hoped was the last time as a sessional teacher. In class, I read some of my family-centred care stories to the students. At the end of the telling, I shared the reconstructed meaning for me in terms of leadership and management. A tall, slim, blonde haired Registered Nurse leaned forward in the front row to speak to me. She had tears in her eyes and said, “Something like that happened to me and I thought I was a failure.” My response was that it has taken me 10 years to begin to work with and to understand what happened. In the next class, I approached this same young woman and asked if we could talk about her response to my story of leadership. She said she had tears in her eyes because listening took her back to being 15 years old and starting to work part-time in a long term care facility. She worked in the same place while she completed her diploma in nursing and upon graduation was made a Director of Nursing. For two years she did what she was told and experienced increasing dissonance between what she thought was right and
organizational direction. When someone made an error she wanted to support and teach them, not discipline them as her superior expected. She made what changes she could and then left that job, feeling a failure, to return to school at the university. Now she is a unit manager and refuses to be a Director again, although she is getting pressure to consider it. She felt that her story and mine were parallel and that if I could show my learning through retelling my experience, perhaps she could do the same and feel less like a failure.

Applying to York University

Afraid to believe it might happen and yet deeply certain it was right to do so, I sent a letter of application to the Chair of the Department of Nursing on February 18, 1999. Excerpts from that letter show my research and teaching-learning experience, an articulation that would not have been possible even a year before.

I am submitting this letter of application, with curriculum vitae and relevant reprints, for your consideration in response to the Department of Nursing advertisement for positions at the Assistant Professor level commencing July 1st, 1999. Four referees will be writing to you in relation to my research, teaching, community college collaboration and curriculum development activities. The position as advertised draws my attention as an opportunity to be part of York’s nursing curriculum innovations and scholarly work.

The BScN course I am presently teaching is Leadership and Change which explores leadership/followership, change and organizational theories and practices. Students and I share life narratives as a means to illuminate and investigate our assumptions and taken-for-granted knowledge about nursing practice. I facilitate students’ writing of scholarly papers to show connections between who they are and their practice. The core of my teaching philosophy is a belief that who I am as a person is who I am as a nurse. It is within this context that I nurture classroom relationships and plan problem-posing and peer dialogue activities which aim to enhance awareness, responsibility and connection. My philosophy is further implemented in the curriculum by encouraging
students to construct practice-based theory and to question received knowledge in light of life experience.

My teaching is informed by my doctoral research which is a narrative inquiry into Registered Nurses’ experience in reform environments. The context of my inquiry is the turmoil in the health care and nursing education fields. I question how our experiences matter to being a nurse-teacher and to the relevance of baccalaureate curriculum. My three co-participants, who are Registered Nurses in clinical practice, education and administration, have met with me over the last year to explore our individual and shared experiences of reform. In my experience, personal and professional matters are sharply separated. However, in conversation with my co-participants I can see how we are in multiple roles, have many ways of knowing, and that education, health care and social educational reform is explored as I write my dissertation. My in-depth study shows how nursing students’ and teachers’ personal practical knowledge, which is constructed in reflection and relationship, shapes baccalaureate nursing curriculum.

There is a growing scholarly community in nursing related to narrative pedagogy and research. My work is grounded in the nursing theorists Peplau, Diekelmann and Bevis and Watson in that the relationship between teacher and students, in the context of their life experiences, is central to their education. Narrative inquiry traces its origins to John Dewey and I am doing my doctoral work with the narrative researchers Connelly and Clandinin who have created a major line of work related to curriculum as experience and construction of personal practical knowledge...

One morning in the spring of 1999, I was waiting to hear from the university about my application and feeling suspended between lives, I was on the bus going downtown—same route as before.
Transit Story #2

Because the bus was so full, I was standing by the rear door and could not really see much ahead of me. I did notice a big man sitting on the front seat and wondered why he wasn't standing so an older person could sit. He had a big neck with hair covering ripples of flesh between his collar and the back of his head. When he looked around, his eyes looked funny, light blue or silver—almost eerily without depth I thought. “I wouldn’t want to have to make contact with you” went through my mind as the bus continued to go along and then my thoughts wandered elsewhere.

As we approached the same major intersection where my first bus incident occurred, I heard shouting from the people at the front of the bus. They were pressing backwards and yelling something I couldn’t make out. I stood on tiptoe and saw a man face down on the floor of the bus, near the driver. Someone shouted, “Is there a doctor on the bus?” Giggling at the incongruity of that thought, I drew in a breath and said, “I’m a nurse” and pushed through the crowd to the open space around the man. He was big and took up most of the aisle. I pushed my purse and school bag behind the drivers’ seat and knelt beside the man who was clearly in the grip of a major seizure. He was gritting his teeth and moaning and shaking all over. The bus driver kept saying, “Thank God you are here and that you are a nurse”. I took the batik scarf that my friend Constance gave me off my shoulders and put it underneath the man’s face. He had on a medic-alert necklace that identified him as having a seizure disorder. I remembered that it was no longer considered safe to try to put something in the mouth of a person having a seizure. He was already laying on his stomach so I didn’t need to roll him onto his side to prevent airway blockage. I put my hand on his back and stroked it, talking with him and telling him he was not alone and we would get him help. I told him my name, that I was a nurse and that I had read his medic-alert tag. I wanted him to know he, specifically and in his particulars, was accompanied in this experience.

The bus driver called for an ambulance and invited the other passengers to
disembark onto the bus behind us. By now, I realized the man on the floor, the one I was touching and caring for, was the man with the silver eyes. My worry was that he keep breathing and so I leaned over with my other hand close enough to his face that I could feel his breath. Feeling the ridges on the rubber floor of the bus digging into my knees, I felt the urge to laugh—as if God had given me a second chance to be part of something important. This time I answered the call as if I had a world of relationships and an identity to live in. The ambulance arrived and by then the man had sat up and told me his name was Bryan. He seemed to be about thirty years old but he reminded me of my young nephew—soft-spoken, shy and hesitant. One of the ambulance men called the man by name and asked him if he had forgotten to take his medications that morning. I said goodbye to the man, knowing he was in good hands. The bus driver kept thanking me, saying “Thank God you were here”. and asked me to write my name and phone number on her schedule paper.

Doing what she asked, I documented my presence as a nurse, not because I expected there would be any follow-up. I asked her for a transfer and walked to the next bus stop, tearful by now and wondering what this is all about, marveling that I identified myself as a nurse in this situation when for so long I have not considered myself in that role or as part of that profession. Holding that paradox, I felt rueful as if this knowledge surprised me, or as if an identity-in-waiting was saying “See, I’m here! I’ve been waiting for you to listen to me!” This situation felt like a bookend to my earlier transit story. For the first time in years, I could imagine that I was a nurse after all.

RNAO Annual General Meeting 1999: For Your own Good

Arriving at the Annual Meeting of my professional association in April 1999, I took the elevator from the parking lot up two floors to the shopping annex. Walking around the corner, I looked at the still escalators in front of me with dismay. I gazed at the lobby above, open in atrium style, and wondered what the stopped escalator foreshadowed about the day ahead. Coffee in hand, I walked up the stairs. The crowd of colleagues I met in the hotel hallway embodied my career as a nurse. They were from
my undergraduate nursing class, several hospitals, community college and university schools of nursing and the professional association.
The meeting room was set up in three sections of chairs with a central bank of tables for voting delegates. Sitting immediately behind the delegates, I wondered how I could move to the tables to be more comfortable with my coffee, water, papers and bag of goodies from Registration. A Director from the university where I worked part-time came to sit beside me. She volunteered to give me an update on what was happening with my position in negotiations between her, my current boss and Human Resources. At an earlier meeting, moving my job from one department to another, changing the title from manager to coordinator, reclassifying the position from management to union, and posting the position, for which I was welcome to apply, was presented as the ‘only way to save’ my job. According to the Director, one glitch in the proposed plan is that I hire and supervise teachers so being in the same bargaining unit with them is problematic. All of these arrangements were being negotiated at senior levels of the two departments and while I had been informed this was going on, my advice was not sought.
I had also learned from my boss that the organization views my ten years of sessional, semester-by-semester teaching and five years of sequential contracts as a program manager as discrete pieces of work, not as cumulative service. So each of the five times my management contract is renewed, I am viewed as a new employee. In contrast, I have storied myself as a ten-year employee who represents the university on many external committees and through public relations contacts and has made substantial contributions to nursing education. This collision of viewpoints was not discussed by the Director and myself.
As no one had claimed the tables and seats ahead of us, the Director and I moved there. As I listened to her update, I wondered why this interaction was happening at 8:35 a.m. on the morning that was starting a two-week break from the strain of working under such uncertain conditions.
What the Director did not know was that I had applied for and been interviewed for a faculty position at another university. I was in suspense about that possibility until the interviewing was completed in May. I made the link between what is happening to my program manager job to the experience of Registered Nurses who have been told by employers to re-apply for their jobs or have been laid off or moved to new clinical areas. I am angry that what is happening is framed as protection of me and my position. What else is happening at senior levels about my program that has not been shared with me? It matters that there has been no consultation with myself or the program assistant about what we do and how it could be done under different circumstances. The assumption seems to be that I will want and be grateful for the new position. I see myself as someone with options beyond what is being storted for me.

How does it matter that other nurses who are where I am in my doctoral program have been hired as assistant professors at this university? I feel invalidated and resentful about this situation. Not having all the information about what is happening, I assume that the assistant and I are players in the chess game that is about issues and stakes that belong to levels above us in the organization. This parallels my theorizing about what happens to frontline staff as a consequence of administrative conflict. Now I question if what was happening to me here was the flip side to what I implemented as a Director of Nursing. Storied in this way, my learning includes an acknowledgement of responsibility and heightened awareness of consequences.

Montreal American Educational Research Association Meeting

In the second week after the Annual Meeting of my professional association, I went with Bev to the AERA meeting in Montreal. On the Wednesday of that week we attended the Musee Beaux Arts exhibit of Monet paintings. At best I could be described as ignorant about art history and art appreciation beyond the simple adage, 'I will know what I like when I see it.' Yet the metaphor for my thesis that I imagine is a painting that fills a whole wall of a room, full of people in daily activity. Depending on where you stand viewing the picture, you will see different possibilities for understanding the work before you that intertwine with where you are emotionally and temporally in your own life.
Bev and I rented the audiocassettes that explained Monet’s life context related to the paintings which were mounted in several rooms of the museum. There was a crowd of people in each room so the tape helped to reduce the oppressive sense of noise and bustle. The series of paintings included scenes of Monet’s house, garden, footpaths, and pond. The paintings were grouped by subject and showed the same object, flowers or bridge, in different lights and seasons. Most of the paintings intimated a shape of a thing and did not show distinct images or a whole outline. I liked how that invited me to inhabit the painting and to consider what I brought to the experience of taking in Monet’s work. I noticed he often did not fill the canvas to the corners and left space in the painting so edges of stems and leaves were shown. The tape told me he wanted his paintings left unvarnished so the texture and brush strokes and globs of paint would be seen as part of the painting. In this way, I as a viewer could imagine my hand following his as the brush strokes were so clearly laid on the canvas. “Impressionists are narrativists” I generalized in my journal which I held awkwardly in one hand while I fiddled with the volume on the tape recorder. Monet reconstructed the same images throughout the day, the seasons, his life. The colours and mood change over time but the suggestion of what he was literally seeing had a constancy in the paintings.

Six months later, when I read a teaching/learning manual co-written by Dr. Beryl Pilkington (Pilkington & Jonas-Simpson, 1996), one of my new colleagues at the university, I saw in amazement how Monet had affected her writing partner, Dr. Christine Jonas Simpson. Christine also saw how textured Monet’s paintings were and how standing close or further away revealed new knowledge and choices about how to understand experience. Reading Christine’s words and recognizing her response as nearly identical to my own, I felt affirmed and a bit put out. My reaction captures the narrative tension of wanting to belong, to have colleagueship and also wanting to stand out, insightful and ahead of the group.

Looking at Monet’s work, I recognize that being drawn to something before I understand it or the source of the appeal is part of how I construct new knowledge. I was moved and pulled into Monet’s images and remarked to Bev that I often felt tearful viewing these works, especially the picture of a dark and weeping willow tree. I loved the idea that Monet painted nature while he was in nature. This feels like narrative inquiry—
being part of what is constructed and explored. The tape told me that during the first world war, Monet could hear the artillery which was not far away. His son was off somewhere fighting in that war. During this time, Monet employed six gardeners to keep the Giverny property pristine. One gardener had the responsibility to keep the lily pond free of anything but lilies. I began to think about the resources this vigilance required and the self-contained and constructed world that Monet created to paint in. This bothered me and contradicted how I felt about the paintings. I assumed that clearing the pond and maintaining the gardens with paid staff meant Monet was cut off from the messiness of life, especially from the turmoil of war. Was he blocking out his social context as beyond his control the way I have in my nursing experience?

This tension remains with me as I write my thesis in the summer of 1999. At bookstores and art galleries, I look at Monet prints and books about Monet’s life and art. On the day in August when I submitted my first course package for copyright approval and duplication at the university bookstore, I found a book called *Monet’s Water Lilies* (Russell, 1998). I learned that Monet decided to stay at Giverny during the first world war despite others leaving the village for safer regions. He had lost his beloved wife and his other son in recent years and did not want to lose his work and his garden. He was racing against time as his vision was failing and all around him were the war wounded who inhabited his village. He painted in the belief that creating beauty during a time of horror was his contribution to peace.

Now I have a story of Monet in Giverny during the war that makes sense to me. My first interpretation was a judgement and assumed privilege and isolation. This way of seeing the world is not unique to my story of coming to understand something about Monet’s life and world. This is how I approach my experience. It matters to know this about my way of seeing the world and my way of thinking about experience. Now I interpret Monet’s work as an act of reconstruction which reveals in-between space, a place for me to connect with others, to learn and grow.

At the AERA meeting in Montreal in April 1999, Maxine Greene talked about Schwab’s sense of eros as in hankering after, wanting, the energy of learning. She suggested we begin as teachers with the learner’s experience and eros; to resist categories and to continue to choose ourselves by our actions. Greene encourages us to move
beyond passive empathy, to be aware of anesthesia about experience as Dewey warned, to deal with freezing cliches, flattened by rhetoric, and to keep the desire aflame. But, how does it matter if experience is unexplored, not learned from, rejected? How does unexamined, unreconstructed experience influence our actions? Exploring these questions through autobiography and dailiness writing becomes theorizing towards wide-awareness.

Meeting with the Dean in mid-May, 1999 at the university, I joyfully accepted his offer to join the Department of Nursing, starting July 1. It is in this place and role that I write my thesis. Intuitively, I feel that this location in my life is important, and perhaps makes it possible for me to write. As I come to story myself more as a nurse-teacher, I write to other nurse-teachers as readers of my thesis. I accept Dr. Diekelmann’s challenge to be part of creating a research base for nursing education in the context of a curriculum revolution.

Coming to terms with my experience through rereading and rewriting this chapter, I record in my journal a walk on Pass-a-Grille Beach in Florida,

At eight a.m., the sun is already bright and hot. I can feel it on one shoulder and my ear until I turn around on my walk and have equal exposure on the other side. Walking slowly along the shore, I pause to consider the seashells washed up overnight on the beach. My walking companion and I see a shell at the same time, rolling in the waves towards my bare feet. Pleased at her refusal to take it, I rinse my morning gift in the waves and hold it in my hand. My calves begin to ache with the pleasure of walking on firm damp sand. I notice how the pink hotel looks like it is floating in the air; eye candy against the turquoise morning sky. Turning back to the breakfast grill to meet my friends who ran to the beach, I see a sister shell to the one in my hand. The outer spiral of the shell is broken open revealing the soft pink inner layer. I pick it up and rinse it to join the other in my hand. Somehow the shells connect to my thesis work as in, I am broken open by my inquiry but not totally revealed, the layers spiral still inward; protecting interiority and privacy.
I see a third shell, the same colours, also broken open and with two small flatter shells nestled inside the open space. Inside the broken open space there is companionship and relationship. This too I have found at home and in my nursing work—not yet completely unlayered but accompanied, loved and capable of loving (Friday, May 19, 2000)

The shells are nestled together on Florida sand in a Bristol blue bowl on my desk where I write, in my home office.

**Family-centred Care: Version Seven**

Rereading this chapter, ready to take it to Dr. Connelly next week (September 20, 2000), I think again about how temporality is important to narrative inquiry. My son has started a new school midway through high school. Listening to his end of the day stories about how the new place feels like a jail, has no pictures or colour on the walls, how other people live their ongoing stories while he struggles to know his, I return to my family-centred care story. If all the beginning elements were in place, new jobs, son in daycare, how would it matter if I approached the situation narratively? What if I took the advice I gave my son and understood that the hospital and those in it were in a story that I entered. What if I took my responses and feelings as information about the situation and was not hooked by my good intentions and taking over impulses. Perhaps there was a reason that the combined care issue sat on the agenda month after month with no action. Talking at the maternal child committee about the meaning of that and exploring what it would mean to all of us in various professions and roles to commit to that philosophy might have made it clear at the beginning if the project was alive.

At the same time, conversations with mothers and fathers about their experiences of being in the hospital at such an intimate time of their lives would reveal what helps and hinders being a new family. These are conversations nurses may have as they care for mothers and their babies each day and meet the rest of the family at visiting hours. Such an approach would undermine the traditional notion of families being in the way and patients doing what they are told and following the rules. A position of inquiry about the experiences of patients on the part of nurses, including me, already changes our relationships and actions. Thinking narratively and inquiring about ongoing stories of people intimately connected to new families shows me for the first time how I could be in
a similar situation in the future—a possibility denied until now. The ideas of ongoing stories and converging conversations in social situations come alive in the stirrings of hope I feel about being a nurse-teacher and in learning about how knowledge is constructed from reflection on my experiences. And, this all matters because it changes how I am in relationships and actions in my social world.

This chapter shows how my identity and knowledge are created by reconstruction of daily experience. Awareness arises from instructive moments in dailiness which includes all aspects of my life. The significance of narrative investigation of a life is shown through my evolving to become a nurse-teacher aware of self, relationship, and social context.

The notion that each of us has an original way of being human entails that each of us has to discover what it is to be ourselves. But the discovery can't be made by consulting pre-existing models, by hypothesis. So it can be made only by articulating it afresh. We discover what we have in us to be by becoming that mode of life, by giving expression in our speech and action to what is original in us (Taylor, 1991, p. 61).

Rereading my stories, I am struck by how different I am in my world as a result of this inquiry—more in relationship, more inclusive and open to diverse perspectives. My narrative tensions and threads are still operative for me, but I notice heightened awareness and more sense of choice in my daily life. My being-becoming and knowing have moved over time and changed how I act in the world. As Conle (1999) observes, my way of being in the world hindered or advanced my research and my research pushed me to live my life differently. My stories are told across time and reconstructed in light of intersecting, ongoing experiences. Temporality, as an element in narrative inquiry, includes experience as remembered, as changed by new events, and as shaped by increasing awareness. As you read my stories, were you drawn into reflecting on your own experiences? Did you accept my words as related to you or resist some stories? What did you learn about yourself? As reconstruction of experience matters, perhaps you constructed knowledge that changes how you are in the world.

The fourth chapter shows the healthcare landscape as a place with nurses in many settings, roles, and relationships. Seven co-participants responded to a request that they explore out loud their experiences in healthcare reform, the stories they tell themselves to
live by. We now move beyond my story to understand the experience of other nurses in healthcare restructuring.
Chapter Three Endnotes

1. There is a whole other story that is not in my thesis which relates to my mother. She died of mediastinal cancer on April 23, 1993 at the age of 60. My father and I were with her in January 1993 when she was given her diagnosis and prognosis by the oncologist. He explained that the cancer was in the centre of her chest, partially blocking and pressing on her heart, lungs, and major blood vessels. The tumor was literally eating a hole in the centre of her chest. The summer after she died, I made an ashtray and plasticine sculpture of a cigarette, ashes, and paper hearts. Then I made a plasticine woman, with her arms outstretched, her heart in her left hand and a black hole in her chest. For a long time, I thought that figure was me. One day in the fall of 2000, around the time Regina’s brother Charles died, also too young, I said to her, before knowing how it mattered, “That figure is not me, but it is connected to me, it is my mother.”

2. Nurse abuse, in my experience in the 1980s, was seen by many to be part of the job of working with patients. For instance, when no-smoking policies were brought in on the open wards, orthopedic patients who could not make their way to the front sidewalk would sometimes hit out with a limb in a cast at nurses who were enforcing the policy. The experience of nurses with regard to violence on the job seems unchanged, as presented in a letter to the editor of Canadian Nurse:

I am a registered nurse who has been nursing for 3½ years. Last year I was attacked by one of my patients. This changed my life. I began having nightmares, crying spells and feelings of anxiety when caring for alcoholic patients. I decided to take control of this situation and press charges against the individual. When I inquired about pressing charges, I was dissuaded by some of my peers, the Workers Compensation Board of British Columbia and the local police, all of whom seemed to feel assault was part of my job. I am writing this to call attention to the important fact that this is not part of the nursing profession.

When I went to the police station, the officer at the desk advised me against pressing charges and went as far as to say that as an RN, this was part of my job. I was shocked. Not during my three years of nursing school, nor during any hospital orientation, was I ever told that assault would be part of my job. This statement from the police officer made me even more determined to go ahead with the charges and to begin to educate the public.

If I was wearing my nurse’s uniform and this man had attacked me in a bar, on the street or ran me over while driving drunk, would this be acceptable? Because I am a nurse, does this mean that I have less rights than anyone else? Do laws not apply if you assault a nurse? If I wore a police uniform, there would be a charge—Assaulting a Police Officer. I love my job, and would have no other. This does not mean, however, that I am open for abuse….of any kind. I deserve the same amount of respect as anyone else. Kim Lowry, R.N., New Westminster, BC (Lowry, 2000, p 6).
Chapter Four

From Autobiography to the Professional Knowledge Landscape

This chapter is the middle of my inquiry. So far, dear readers, we have reviewed the last 12 years of fiscal and other healthcare policies and some of organized nursing’s responses to restructuring and re-engineering. Introduced to my inquiry about RNs’ experience in healthcare reform, you read several studies and discovered what they contribute to our understanding and what we do not know. Stories of my family and education show narrative tensions and threads as I offer myself as a template for how reconstruction of experience matters to emerging awareness and changing praxis, connecting becoming, knowing, and doing. Dailiness writing as instructive for narrative thinking is presented with examples from the literature. Interpretive phenomenology and narrative inquiry are contrasted to illustrate the contribution of my work to nursing education research. Autobiographical exploration of my life over the same time period of late 1980s to 2000 reveals how temporality, retelling life stories, and new ways to live in relationships with other people and places construct identity and knowledge for a nurse-teacher.

From chapter three, readers can see how “we tend to write about a few issues over and over again, always in a different context” (Conle, 2000, p. 195). My thesis work and my life conflate and are expressed in becoming a nurse-teacher, in being a mother who offers her son a narrative understanding of his misery at a new school and, therefore, choices of action, through reconstruction of experience over time. Griffin (1999) believes that “if you search long enough, you will find each story contains every other story within it” (p. 150). This idea of nested stories and intermingling of narrative threads is part of where we go next in exploring nurses’ experience in healthcare restructuring on a professional knowledge landscape.

Chapter four introduces co-participants and their stories of healthcare restructuring as a way to illustrate the professional knowledge landscape of nurses. You will remember from the second chapter that the landscape is conceptualized as people, places, and events in relationship over time. These conversations emerged from a suggestion made by Dr. Martha Rogers at my proposal meeting. She suggested that I meet with an administrator and perhaps others in healthcare to show multiple points of
view on the landscape and to avoid presenting my own as if it were THE perspective on reform.

Accepting this suggestion as worthwhile, I considered who it might be possible to contact. One of the many synchronicities in my research occurred as a senior nurse executive who had been restructured out of her position called me to discuss the possibility of teaching in the program I managed at the university. We met over lunch and at the end of our conversation, I asked her if she would consent to be in my research. Sara, who you will meet in a few moments, became my first landscape participant. An organic process unfolded as I considered what other vantage points in the healthcare system might be included in illuminating the landscape...perhaps a nurse in health policy, in community health, in international work in business for herself, a student...possibilities and names emerged in my thinking.

Each of the seven nurses that I called accepted the opportunity to have one face-to-face conversation about their experience in healthcare reform (1). Part of my purpose for our meetings was to show the diversity of nurses' work in relation to settings, persons, roles, and functions. At the beginning of this part of my thesis, it was a puzzle to me whether there would be different points of view about healthcare organizational restructuring or if all nurses found it as negative as I did. For all of them, the commonplace language for restructuring (as I have been using it in this writing) was healthcare reform. At the time of these conversations in 1998, neither my co-participants nor I had distinguished between reform, restructuring, and change. That clarification of terms occurred in the writing of research text in the year 2000. You will see, dear reader, that each of them defines reform from their perspective, which plays out in their relationships, in different places, on the landscape.

After our meetings, my participants received a verbatim transcript of our conversation and then iterative copies of the composite I created for them to edit. The conversations were rich and detailed with possibilities for future inquiry. For this chapter, I composed their words as if they were speaking directly to a reader/listener. My own voice is, for the most part, edited out so that I too am a listener to their perspectives. Together, these participants and I shaped and re-edited their composite conversations for accuracy, anonymity, and authenticity. They chose a name to represent themselves in my
research. Some felt comfortable using their actual names and some chose pseudonyms. As I worked with the composites, an order that does not reflect the linear time of our meetings emerged. Relationships within and between the composites showed themselves and I could see tendrils of narrative reach back into my stories and forward into other co-participant stories. You might wonder why seven co-participants? I took as a sign that it was enough when Dr. Mary Kooy needed her transcription machine back. In this way, chapter four is an example of the inquiry having its own story—I did not plan for or know this would emerge as it has, but I became aware that it needed to be written. This chapter moves from my autobiography in chapter three to painting the healthcare reform landscape with biographical explorations of other nurses.

Dear reader, consider what can be discerned about the professional knowledge landscape from their stories. Their unique constructions of healthcare reform are revisited by me to complete each vignette. Wanting readers and these co-participants to connect as directly as possible, and to stay with each individual in their particular experiences, my thoughts on how it matters to reconstruct nurses’ experience is offered at the end of the chapter. We begin with Cassandra.

Cassandra’s Lament

My friend Regina introduced me to Cassandra. Regina thought Cassandra’s point of view would add to readers’ understanding of nursing as a personal construction in a world of normative influences and change. Unlike the composites that follow which are based on a face to face meeting, Cassandra and I connected through her writing.

Why have women passion, intellect, moral activity – these three – and a place in society where no one of the three can be exercised?...In the conventional society, which men have made for women, and women have accepted, they must have none, they must act the farce of hypocrisy, the lie that they are without passion... Women often strive to live by intellect. The clear, brilliant, sharp radiance of intellect’s moonlight rising upon such an expanse of snow is dreary, it is true, but some love its solemn desolation, its silence, its solitude -- if they are but allowed to live in it....But a woman cannot live in the light of intellect. Society forbids it....What wonder if, wearied out, sick at heart with hope deferred, the springs of will broken, not seeing clearly where her duty lies, she abandons intellect as a vocation and takes it only, as we use the moon, by glimpses through her tight-closed window-shutters?... Women long for an education to teach them to teach, to teach them the laws of the human mind and how to apply them – and knowing how imperfect, in the present
state of the world, such an education must be, they long for experience. not patch-work experience, but experience followed up and systematized. to enable them to know what they are about and where they are ‘casting their bread’ and whether it is ‘bread’ or a stone...they would not need to have their story told, for all the world would read it in the mission they have fulfilled. It is for common place, everyday characters that we tell our tale – because it is the sample of hundreds of lives (or rather deaths) of persons who cannot fight with society, or who, unsupported by the sympathies about them, give up their own destiny as not worth the fierce and continued struggle necessary to accomplish it....these wear out the very life necessary to make them...But if ever women come into contact with sickness, and crime and poverty in masses, how the practical reality of life revives them!...If they see and enter into a continuous line of action, with a full and interesting life, with training constantly kept up to the occupation, occupation constantly testing the training – it is the beau-ideal of practical, not theoretical education – they are re-tempered, their life is filled, they have found their work, and the means to do it...It seems as if the female spirit of the world were mourning everlastingly over blessings, not lost, but which she has never had, and which, in her discouragement, she feels that she never will have, they are so far off....there is no longer unity between the woman as inwardly developed, and as outwardly manifested.

Dear reader, how are you responding to Cassandra’s lament? Which issues of hers touch yours? Cassandra wrote this in 1852, feeling suffocated by her mother and sister shaping her into the life of an upper-middle class Victorian lady. She wants an intellectual life, one that embraces thought and action with purpose. She intimates that reform is created by those who wish for something better—who cannot look at sickness, crime and poverty without acting. She encourages women (was she giving herself instruction?) to have a continuous engagement with seeing and acting, to make a study of what she does. I take this to mean Cassandra, like me, sees daily life as a source of learning and education, as an unfolding story that shows the mission of her life. She found her independence through a 500 pound annual allowance from her father and a move to London, England. Cassandra also found her vocation and went on to write prolifically under her own name—Florence Nightingale (1852/1993).(2)

Stories of seven nurses follow in this chapter and they address how daily life experience is a source of education and an unfolding of identity and purpose.
Sara: A Marriage that Ends in Restructuring

Sara and I had our conversation in 1998 on a hot summer afternoon in my living room. We have known of each other’s work for several years but this is only our second lengthy conversation. A fan was rotating the air and we were sipping cool drinks of soda water and cranberry juice. I admired out loud Sara’s beige, brown, and black print dress that looked like African paintings. We talked about her experience in health care through the lens of reform. She was recently restructured out of a senior executive position in a health care facility where she represented all the non-medical health disciplines.

I have been involved in health care reform more than once in my 29 years of nursing; first in the mid-1980s in another province where I worked as a Vice President, Nursing in a mental health hospital and then in the Ministry of Health, and more recently in Ontario. In both situations I was in nursing executive positions. In Ontario my work was as a Vice President, Nursing Services in long term care. I would broadly define reform as fundamental changes to the health care system in terms of services that are provided and how they are configured. Health care reform is a euphemism for doing more with less. When you add things to the system, it is not called reform even though you are changing it. The sense of turmoil in both of my reform situations is different in terms of degree and intensity. Perhaps some of it has to do with geography and the different clinical settings, but there was a different emotional feeling in both situations and its difficult to figure out why. Reform in the west took place when nursing numbers were stable and there was a homogeneity of education in the kind of nurses I dealt with. Provinces talk about the sociology of reform—the systems, components, and chunks, it makes me nervous. It’s like there are no people involved; there is a psychology to reform too. Maybe this is germane for nursing education. Maybe teaching nurses about change in traditional ways, like unfreezing and refreezing, isn’t the right thing to give them. Maybe the studies on reform and change don’t apply to nurses’ experience.
This goes against type according to how nurses define themselves as responding to others' needs all the time, instead of acknowledging being good at certain things and not so good at other things. I think nurses should go off and find a context compatible with their skills instead of sacrificing themselves. Health care reform is only one reform that individuals are going through. There are huge societal and personal changes underway as well. Being able to make the personal/work/social connections gives us a context and meaning for our lives. Nurses need skills for life, not only for work. This may be heretical but maybe nurses aren't expert at the macro level of reform. Maybe we should stick with the relationships and expertise of daily care. High level decisions cascade to the bedside so bedside nurses need to know how the goals of reform can be realized with patients. On the other hand, if nurses were involved in health care reform at a macro level, we'd see more Nurse Practitioners, nursing-run funded services, fewer doctors, the Canada Health Act acknowledging other practitioners as system gatekeepers.

I think reform is different for nurses than it is for other caregivers who are with patients episodically, only for a short time or for a treatment. Reform might mean less time for an episode or less episodes but your relationship with the resident doesn't fundamentally change. When nurses and their managers talk about health care reform, they are inevitably concerned about the amount of time they have to spend with the patient. The nature of their relationship is being changed and their care is based less and less on knowing the resident. Nurses have never felt there was enough time but there is a contagion that goes with reform—the worries and words sound the same but the intensity is different. There is desperation and ultimately it gets to the point where nurses disengage and stop trying.

I have seen nurses who are passionate about what they do and who throw themselves into the situation they are in. For new graduates, what is happening is the only system they know, for them this is the way health
care works. But with all the downsizing, their relationship is often casual on a shift length basis. So they either throw themselves into making their work meaningful on that shift or look at it as an episode. People left in the system after downsizing are exhausted. They are the recipients of others’ actions in reforming the system. There are fewer senior nursing positions with line authority so they tend to work with the givens rather than changing what is given. The other reality is that senior nurses are shaping the system as health executives, not necessarily as nurses.

When the antecedent to reform is scarcity of resources, what do you do? What model do you use? Well, stuff has been imported from the corporate and for-profit business world. And I think it is deliberate to eliminate senior nursing positions. I don’t think there is anything wrong with reducing the layers of management, but what is wrong is the timing because it assumes that the caregiver who is in partnership with patients has the requisite knowledge and doesn’t need the resources nursing managers provide. If I look at my own career in nursing management, the first school of thought was that your Head Nurse tells you what to do. That’s gradually changed to a unit manager working alongside you as a resource person who makes sure you have the resources you need. All of that is being thrown out. When the Vice President, Nursing or Patient Services goes, so do the Clinical Nurse Specialists, nurse educators, and unit managers. Spans of control broaden and distance between patients and administration deepens.

What is interesting and heartening is when organizations have taken out line authority for nursing but have implemented a Chief Nursing Officer role. If they listen to that senior nurse, then resources will be allocated so the baby isn’t thrown out with the bathwater of reform because of her allegiance to the patient. This can be more powerful than functional authority, for instance, Gail Mitchell at Sunnybrook Health Sciences Centre (3) who is recognized as being an essential ingredient to enact the values of relationship and patient-focused care. We haven’t had
enough experience with these new models and maybe nurses in the system don't know how to operate in that model. The start point is the baccalaureate as the entry to practice nursing, one nurse at a time but all together.

Part of our dilemma may be that we are not using the right words to describe what is being experienced. Your research may provide some insight into that. I think the dichotomization of nursing into being/doing or science/business are attempts to place the dilemma in a context that comes with its own set of language. I think it works something like this. I can be a nurse anywhere. I should be able to nurse in any context. And if I am clever, then somehow I have the understanding that my responsibility is to the patient. Discharging that responsibility means figuring out enough about the corporate context so that I will be allowed enough room to carry out my responsibilities to the patient. That includes using knowledge that is acquired scientifically, philosophically, spiritually, historically, all the ways of knowing. Nursing is an integrative way of living so I want to establish a relationship with a patient that allows us to work together.

We also have profession-related ways of speaking that are not necessarily gender-related, like we have to be caring or nurturing. I remember a diploma-prepared nurse being upset with a baccalaureate-prepared nurse who had offered a cognitively impaired patient a range of choices. The diploma nurse felt it was mean to confuse the patient and kinder to tell him what to do. The baccalaureate nurse felt she was being patient-focused. I think these language and relationship issues are more about professional expectations and education level than gender-related.

I was headhunted for the Ontario job and left what felt like experiencing reform at 30,000 feet in my government job to day to day intimacy with patients, families, and nurses. Because people live in long term care facilities, they and their families are not shy to talk about patient's well being. I could see the impact of reform on the individual and on the elderly population. There is a constant and pervasive worry about
who is going to look after me? How will I be vulnerable because I now live in an institution?

The family model also extends to the administration of the organization that I left. I think the President and I fell out of love with one another and the reform context contributed to our falling out of love. If the context hadn’t changed, then it probably wouldn’t have mattered if we were in love or not. We had to work hand in glove. So whoever replaces me will be the second wife. Ten years ago if you fell out of love, you could do your own thing in your own circles and overlapped a bit and the world would go on. Now there are fewer members of the senior team and the relationships are more daily, the tensions more intense. I would say that he lost confidence in my ability to provide what was needed within the reduced financial resources.

Isn’t it screwy that we critiqued reform for not looking at people issues. yet the fallout of reform is all about the impact on people—patients and staff. Components of the system put pressure on individuals and relationships, so it’s a paradox. In retrospect, maybe I didn’t feel the impact of reform so much the first time round because I had a good marriage with my boss in Alberta. The analogy of marriage has been useful to me to understand what happened. I don’t think I’ll ever go back to that kind of work or relationship. I’ll find other ways of contributing.

Sara feels that she can look at her own downsizing and lay-off experience as God giving her a chance to ask what she wants to do. She reflected on her experience during the Middle East War when her husband was drafted into the army. She had twin babies, born by caesarian section, and could not carry them both at the same time. She was horrified at the thought of one baby being left behind while she carried the other. What if something happened to her? She had no electricity, no water, and no fresh diapers. Everything involved the choice of how and in what order to get the babies to a shelter or to a store. She decided they would stay together and face whatever came. This story mirrors for me the unforgiving nature of being a nursing administrator. Every action is
fraught with competing values. Gail Mitchell calls this the paradox of leadership (personal communication, January 18, 2000).

Sara asked me if I ever thought I’d be where I am now and I assumed she meant she hadn’t imagined being where she is now. My answer to her was, “No.” It scares me how easily I could have missed what has happened—being back with my husband, being at graduate school, and working as an Assistant Professor in nursing education. This meeting with Sara touched me because I felt connection with her and a connection to Gail of a decade ago. That earlier “I” believed that a person can separate the duty to show up from how it felt to do so, that personal life comes second to work, and that pretending to be competent and in control is a cover story hiding a secret story I did not even tell myself. Cover stories allow teachers to portray themselves as “characters who are certain, expert people who are managing situational dilemmas” (Clandinin & Connelly, 1995, p.15). As an administrator, I thought I could divide myself into personal and professional compartments, although as Sara points out the family story comes with us to work.

Sara now commutes to her new workplace where she is an executive officer of a nursing organization. Just as I did after leaving nursing administration, she has entered a professional nursing, almost all-female workplace. While this work cannot be constructed as a story within a traditional marriage, it does have conflict. There have been nursing strikes and government interference with nursing education and curriculum for her to face. I wonder what story Sara will tell to guide her practice in this new situation?

In Sara’s terms, reform means ‘doing more with less,’ and that has resulted in fundamental changes in the healthcare system in terms of services and how they are configured. She sees healthcare reform within a broad social context that includes many situational and personal changes. Nurses’ relationships with patients are also fundamentally changed in reform as Sara feels that nurses do not know the people they care for as well as in the past. In her experience, patients worry about that and ask “Who is going to look after me?,” feeling vulnerable in a system where nurses have no time to connect. For Sara, the impact of reform is all about people—what happens to them and their ability to be in relationship.
**Florence: From Immigrant to Citizen: From Student to Graduate**

Florence and I met when she was a Post-RN student in a Leadership and Change course where I was a sessional teacher. She spoke to me at the end of that winter semester about her home-based business, which is making clothes like the kind she observed me wearing. As we talked, I felt intrigued by her recent experience as an immigrant and as a new nurse. We agreed to meet after the marking for the course was complete. I also chose a beautiful red damask material from Florence’s samples.

Florence came to my home on a steamy hot July day, looking elegant and cool in a sleeveless blouse and long skirt. She told me it is like this everyday back home in Ghana and people wear the heavy cotton that she used in my gracefully shaped blouse. As we sat in the breeze created by my floor fan and sipped lemonade, Florence told me about moving to Canada four years ago with her physician husband and two children.

At first I wanted to be a doctor, then I decided to be a nurse. I did well in science and was interested in pursuing my studies in it. But in Ghana, parents have a say in what is studied. My father decided that managerial studies would be better than science because it would not take so long and then I could settle down with a husband. When I did my secretarial studies, I became engaged to my husband while he was at medical school. When he graduated and set up a practice, I did all the managerial aspects of his business. I was drawn again into my interest in nursing.

In Ghana, many things are scarce and there are not lots of resources. A lot of people are poor and anyone who works in health care is held in high regard. Dehydration, malnutrition, and other diseases that are rampant kill people. Health care providers are respected because they intervene and save people from poverty and heat-related problems. Back home you have to improvise. You sterilize water and add sugar and salt for little kids with dehydration when you don’t have intravenous bags.

I asked myself why I was doing secretarial stuff when I was really interested in nursing, in helping people, doing something about their pain. I began nursing courses, but my husband started to travel and we had two
small children so I stopped my studies. When we immigrated to Canada, we arrived in January and I started nursing school at a community college in August. I was concerned about not getting any younger and knew about the year 2000-degree policy so I enrolled at university as soon as I finished my diploma program.

It was an eye-opener to come to Canada because nurses are not treated with the same respect as in Ghana. There are more resources here, but I was troubled by how I saw the nurses treat each other. When I arrived there was downsizing and nurses being laid off. I saw nurses with lots of experience being thrown out and it was difficult to get work. I wondered if I would get the same satisfaction as back home where I knew nurses made a difference in people's lives. I could get a job easily back home because nurses are needed everywhere. I could make a good salary and be respected but I did not want to leave my husband and children.

There are so many issues when someone from another culture comes here. When I was here one month, I didn't feel well so I went to the doctor and he booked me for day surgery. My husband took me to the hospital and the nurse told me to get changed. She commented that usually people wear jeans or track suits to hospital so I felt she was criticizing me for being overdressed. In Ghana, people do not wear jeans to an appointment with a doctor. We give respect to doctors and nurses. We wear jeans to the park. I was in pain. in culture shock—now I would understand but then I felt like I didn't know how to behave, how to talk, or what to wear.

I have to be alert all the time about what I say, what I do, how I eat. Back home different communities have different ways to socialize. Some people socialize when they eat—because food is scarce, sharing it with you is a great thing. We cook lots of food and invite lots of people and talk. It is a gift and a happy time. Over here you eat silently with a friend because you don't want to talk with your mouth full of food. Back home this would be the time when you would slap each other on the back
and laugh and eat. Here you have to be alert, cautiously controlling yourself all the time and it is very stressful.

I said to my husband, we should start a business in our community to help people learn about how to do things in Canada. Even taking the bus can be embarrassing when you don’t know where to put the ticket because back home we hand it to the driver. These things happen within a few seconds and you go home and they bother you. And if you stay home because of your fear of embarrassment, you get depressed and that affects your health.

I am glad I did my nurses’ training here because I learned how things are done here. It is harder for nurses trained elsewhere because they constantly have to prove themselves. A good nurse feels comfortable about what she is doing and can think of how she is helping the patient, not worry about Canadian standards about procedures.

When I went to work after completing my diploma and RN exams, I experienced a lack of mentoring because the older nurses were being laid off. I want to have someone to fall back on, someone who knows the ins and outs and we can support each other. The reform pressures are making nurses not work together—there is job competition, layoffs, animosity and worry. If a colleague has 12 patients on a 12 hour shift, how much time and attention can she give a new nurse? The system is chipping away at the root of nursing. Even with patients, with everything to be done, with the next shift coming on expecting everything to be done, a nurse doesn’t have time to find out why a patient is crying. She can only offer reassurance that everything will be ok. This is not the kind of nursing I want to practice. Maybe it is better to go into business than to not be able to offer the comfort needed at the bedside.

Here is an example of the dilemmas of practice. I worked for an agency and they sent me to a long term care facility. The patients were old and many had cognitive problems. To make the setting more home-like, many of them did not wear wrist namebands. I was there as the Registered
Nurse who gives medications. There were four patients in each room and some of them did not know their names. I had to give medications three times that day. Nobody had the time to go with me to identify the patients. I went to the supervisor and said I did not want to lose my license and I could not give the medications without being able to identify the patients. The supervisor thought this was a waste of time for someone to go on rounds with me and I was never called back to that facility. That is the way it is going.

When I was in another long-term facility, the supervisor got mad that a patient was not dressed for the ambulance transport that had been booked for 8:00 a.m. I told her the patient took time to open her mouth, chew her food, and swallow. I was not going to shove breakfast down her throat and have her choke. I come on shift at 7:00 a.m. and get report. That gives me about 30 minutes to get this patient ready. It takes me longer than thirty minutes in the morning to get ready. I get up early and take time to clean myself, get my clothes, and eat my food before I rush off to my day. How do they expect an 89-year-old bedridden lady to dress and eat in 30 minutes? I was not called back there either.

There are some principles of nursing that reform must take into account. Maybe others did not feed this lady. Many people are too feeble to feed themselves. You go between rooms putting food into their mouths and reminding them to chew and swallow. If they are not assisted, the tray is removed without finding out if they are hungry. Reform needs to be about patients with enough caregivers to give care that includes the knowledge of nursing and for the relationship between nurses not to be so frightened and competitive. I will not do things that jeopardize my license or hurt a patient. Yet if I speak up about these issues, I do not get called back to work. I could get to a point where I’ll go with the flow to get work, but then I’d be practicing unsafe nursing. I want to feed them like I’d feed my grandmother, coax them into eating the food. It’s not nursing
anymore so maybe I should work in business. How long can I refuse to work, what do I do for money?

The nursing managers don't seem to be able to do anything to change it either. There isn't enough money to hire sufficient nurses to give proper nursing care. They give the impression that they agree with the issues but their hands are tied. They would rather you didn't rock the boat. They fear for their own jobs, it's all about managing with the money you have and that makes you a good manager. Everybody is trying to do their best and slowly it gets away from the standards I am used to. If I keep leaving and nothing changes, what am I going to do? I hate to think I spent four years in nursing education and now I am thinking do I want to be here? What do I do?

Listening to Florence and thinking about the amount of energy it must take for monitoring her actions, watching others for cues, and remembering how it is done back home, what I take for granted becomes foreground and problematic. I squirm at the image of Canadians as uptight about food and public or noisy expressions of affection. Imagine food being a source of joy and community instead of part of an obsession about body size and shape. This feels like familiar territory for me—issues of fitting in, feeling different, self-monitoring for acceptability. My thoughts spiral into the classroom—how am I paying attention to the experience of students born and raised outside Canada? There are many nurses from other countries in my nursing classes—what are their curricula and stories to live by?

Within the week that Florence received this version of our conversation together, she called to tell me it needed no changes and I could use it in my thesis. She is finished her BScN program and applying for nursing jobs. If she has no positive response by June (1999), she plans to investigate the United States and United Kingdom for jobs. She would leave her husband and children here in Canada and work for a year to gain the experience employers seem to expect her to have.

The threads of staying or leaving, choices about how to act in situations that feel compromising, and questions of fitting in resonate with my experience. If who we are as persons is who we are as nurses, how do these issues come to play in our nursing
practice? The notion that nurses bring knowledge to bear on healthcare situations and have choices about how they will act and be in relationship with people is a richly textured and often painful story about being a nurse. Florence experiences reform as downsizing of institutions with nursing lay-offs, with the results of job competition and animosity between nurses. She sees many nurses with experience being 'thrown out' so that there is not enough mentoring for new nurses like herself. The system, in Florence's view, is chipping away at the root of nursing which is relationships between people. As Florence moves to different workplaces as an agency nurse, she encounters a lack of respect for patient comfort and safety. By insisting on caring for patients according to her standards, as if they were family members, she jeopardizes her employability. Reform, according to Florence, needs to take principles of nursing into account, principles about patient care and nursing knowledge. She also wishes nurses would not be so frightened and competitive. The dilemma of reform for her is to go with the flow to get work or to perhaps to leave nursing, her chosen vocation.

Florence called me at the end of June to acknowledge the graduation card that I sent to her and to tell me that she had two jobs. One position is full-time on a pediatric unit of a general hospital and the other work is part-time in the community, visiting people in their homes.

**Helen: Bedside Nursing and Mismanagement**

Helen is a nurse whose career has interested me because of her scholarship in nursing history, bedside clinical practice, and government relations work at a nursing union. Wanting to have a conversation with her about my inquiry and to hear her perspective on nurses and reform, I was not sure how to locate her. One day on the southbound subway, I looked up and Helen was coming through the doorway. Silently debating within myself whether I should bother her, I moved to sit beside her. Re-introducing myself, I was pleased when she graciously agreed to be contacted about a meeting time.

As we met in my living room in the spring of 1999, I noticed my impression of Helen as self-contained, lady-like, and patrician. I make these assumptions because of her elegant and slim appearance and careful way of speaking. As we sip herbal tea in china teacups, I am aware that my behavior is disciplined by seeing Helen as a critical and
perfect figure. My image of what I perceive to be coolness or distance gives way to Helen’s warmth and openness of manner in conversation.

I always wanted to be a nurse. From when I was a child. It was the fashion to also get a liberal arts degree so I went to a feminist women’s college in Boston where I majored in history and graduated in 1953. I finished my nursing at Columbia with a baccalaureate in 1956. I worked on a surgical unit and when I got married, left nursing work for 22 years. In 1982, I took a refresher course at a community college and went back to hospital nursing. I was very struck by how much things had changed. In my earlier years of education and practice, we did not have authoritarian, paternalistic teaching and the head nurses were all young and university educated. What struck me the most was the tremendous divide between the management and the staff nurses. I had a sense that many of the management nurses were trying to escape hands-on care and were not interested in it. Even nurses in the locker room who had day jobs talked about shiftwork and hands-on care with disdain. It just seemed to me that the problem had to do with how nurses saw themselves.

Your question about collegiality and the sisterhood of nursing is a very penetrating one. I think that collegiality was there, at least among the students, head nurses, and supervisors at the hospital where I practiced forty-some years ago but now it all seems to be gone. I think that’s partly for historical reasons. We all lived in the hospital and knew each other well. And if we were on nights, for example, we could always go down to the next ward and ask a senior student for help and so on. Now with the just-in-time staffing and casualization of nursing, no one knows most of the people she works with, and everyone seems to be in it for herself. People would think a nurse was out of her mind if she went to the next nursing unit and asked for help now.

At the same time, I think that nursing administrators have to take some responsibility for the lack of collegiality because so many of them are anxious to leave bedside nursing behind and really don’t have any
respect for their subordinates. When I went into nursing, we thought there would be a big breakthrough in the 1950s and that nursing would come into its own. We thought nursing was a wonderful job, a useful job that offered so much to so many people. It was rewarding work but not in terms of career, salary, or benefits. We thought all that was going to change.

I was very distressed 20 years later at the morale amongst the nurses. I thought at first that it was because the workplace was unionized but after I had been there awhile, I realized that wasn’t it. We didn’t have a union in the 1950s and since I now had to pay dues I was curious to see what I was paying for, so I started to go to union meetings. Then they needed a union representative on my unit and since I was one of the few people who went to the meetings, I said I would do it.

The nurses kept telling me all these dreadful things about our Head Nurse (HN). She always had a hit list of two or three staff that she would verbally abuse to tears in her office and so forth. I just couldn’t imagine it was true because she always treated me fairly. She seemed intelligent and smooth, verbally skilled. One day one of the nurses asked me to accompany her into the HN’s office for a meeting. I had heard so much by that time and I thought “that many nurses can’t be crazy.” Once the door to the office was shut, the scales fell from my eyes. I could see how horribly dishonest she was. She was trying to get rid of one of the orderlies and wanted this nurse to support a letter the HN had written to management. The HN claimed in the letter that this nurse had observed the orderly mistreating a patient. I kept asking to see the letter in which the HN documented that this nurse had come to her with complaints about the orderly. The letter was not forthcoming and I went up the nursing chain of command and no one would listen to us. Nursing management said she is one of the best managers. The orderly was suspended. A male nurse and I organized the resistance about the treatment of this orderly who was one of the best we had on the unit. We grieved his suspension and I got all the
nurses on our unit to support our statement about him. He was transferred to another unit. I was very disillusioned about management listening to us.

Then the HN began to document one of the physicians on the unit. It was an incredible story with fabricated documentation. I was afraid to talk to anyone but my husband about it because it sounded so bizarre. We documented everything and could only get management's attention with paper—they never paid attention to anything we said. We would have gotten nowhere without the union behind us because they supported us, filed the reports, and we had evidence of raising these concerns. Finally, nursing management interviewed all the nurses on the unit one by one and they came to the male nurse and I and said, "You are the odd men out. everyone else thinks the HN is wonderful." Of course, we knew that wasn't true but we never did see their documentation.

It was very moving to me the lack of verbal support we got from the nurses because they were so afraid of losing their jobs. We were too. But we said you have no right to sit here and complain if you are not prepared to do something about it. So many nurses were complaining bitterly about what the HN was doing, but they were so afraid that they even felt they couldn't be honest in exit interviews. They were afraid of the reference the HN would give them. She had files on all of us. Some of the documentation was true; some of it out of context, and some of it was fabricated. One nurse wanted to transfer to another unit and our HN took her file to the other HN and said, "You wouldn't want a nurse like this on your unit."

I used to go to work with my heart in my throat. It was awful and outrageous but sometimes you have to stand up and fight. I became very committed to the union. Like all organizations it has its failings, but it stands up for nurses. I became very genuinely aware of the terrible position you are in if you have absolutely no political power in the organization. That's how I became so deeply involved in the union, because the union staff believed us and were willing to support us. I can
remember saying to our labour relations officer, someone has to help us. She is destroying nurses right and left. We considered reporting the HN to the College of Nurses but the Director of Personnel, who was a lawyer and a nurse, told us that the College would go to management first. We know how highly management thought of the HN and how terrible they thought we were. They used to refer to us as "the rabble." So we realized we would not have a chance at the College Complaints Committee.

The other awful thing was the HN used to come to work beaten up, but she would tell us about walking into a cupboard door or being in a car accident. Senior management was telling us we were terrible people but when the HN was admitted to another hospital’s Intensive Care Unit with her injuries, management asked her to resign and gave her a three month leave of absence first. This HN went on to other nursing management jobs in other hospitals but was finally exposed when she took on an executive position and lied about her credentials. She was disciplined at the College of Nurses and lost her certificate of competence and is no longer a Registered Nurse.

When that situation ended, management transferred a HN with psychiatric problems to our unit because we did such good documentation. They wanted us to create a file on him. We told them that’s up to you as management and ultimately they did fire him. We had two excellent HNs after that. The first one left because of restructuring and impossible economic and time deadlines. The second one arranged for the nurses to have a lounge for breaks and as a place to eat their dinner because the cafeteria closed at 6:30 p.m. We used one of the empty four-bed rooms with management approval. One day our HN came to work and all our furniture was being moved out into the hall and the workman told her it was being made into a room for the accounting department. She had not been consulted about this change on our nursing unit. It’s another illustration of how nurses were treated. She left and then a new president came to the hospital. In the downsizing that followed, nursing
administration laid off the HNs who were the biggest nurse advocates. The second good HN was also treated very disrespectfully by the hospital’s Chief Financial Officer who used to address her as “Look honey…”

I left the hospital at that point and traveled with my husband to do nursing history research. Maybe it will help nurses to have a comprehensive history to look at the old nurses and why they were replaced and how it was done. Nursing has stayed frozen with rigid rules from the past that no longer fit. This is my retirement project—to put all the articles and research I have already published into a book. It is interesting to me though how people react to my doing a history of nursing—as if historical scholarship is of value but nursing isn’t worth the pursuit.

Shortly after I returned from the four months abroad, I went to work for the nursing union in government relations. In my efforts to look positively at restructuring I don’t get very far. At the union we were pleased to break through the confrontational approach and to work with other groups. In a sense it was because the management nurses were driven back and so the other nursing organizations were more open to staff nurses and what they have to say. We were trying to get the nurses more politically involved. That’s where nurses’ view of the union is not ideal. They say we pay you $500.00 per year to do that work but that isn’t how the system responds. Numbers are critical in government relations.

I have a very cynical view of restructuring, of reform. Budgets have to be balanced and things can’t stay the same, but health care restructuring is not giving nurses any more respect than the old system did. It’s a big problem because in the old days we really subsidized the health care system since none of us had a salary that would support a family and student nurses were used as free hospital labour. I think it’s a big problem. None of our three daughters thought about going into nursing for a career. But, people will always need nursing care. It is so difficult listening to the news about emergency room back-ups. All the consultants
and accountants may have good advice for General Motors but health care is not an assembly line. Everything should be individualized. To say that nurses who look after nine patients instead of five are more productive is simply untrue. They are giving poor care to nine patients instead of good care to five.

Anyone who has been in hospital knows it is the nursing care that is most important. The nurses do everything, especially when the other disciplines are off. When I broke my leg, I remember the sense of relief I felt to see a nurse come into the room who knew what she was doing. My husband says the same thing. He badly mangled his finger in a piece of equipment and when he went to the local hospital, the clerk took his information and left him to sit for an hour and a half. When the triage nurse appeared and asked to see his hand, she disappeared and came back instantly with the plastic surgeon who sewed all the tendons together.

When we had all the problems at the hospital, it was easier for me to speak out because I was married and my husband had a secure job. If I lost my job, we would have had to borrow for our children's education but that was minor compared to people who would have lost everything. So it was easier for me to stand up but I thought it was pathetic to see highly skilled professional women afraid to speak out. It seemed wrong to me. I would also say my age and liberal arts education was an enormous help for me. You had to learn how to write and how to think and think quickly. And yet the male nurse who worked with me on the resistance was diploma prepared. So I don't think you have to have the liberal arts education but it does make it easier.

Nursing does seem to have gotten the worst of everything, as a woman's profession and coming from a domestic service. It is appalling to me that nursing administrators in hospitals thought you could take kitchen staff and cleaning people to do nursing tasks. Nurses have to have contact with patients to assess them. It's so painful that nursing work is regarded as having no intellectual content. It's the clinical assessment skills that
distinguish good nurses; it's a different theoretical basis than medicine. However, although I am sympathetic with the idea of autonomous models for nursing, we have to be honest and recognize that a lot of nursing knowledge is a subset of medical knowledge. I thought the concept of overlapping scopes of practice in the Regulated Health Professions Act was one of the really good things about it.

I am continuing my scholarly work, doing it as a hobby. I am looking at the history of our efforts to define what nursing really is—something nursing has been struggling with ever since it was set up as an independent occupation. In the historical context there are two things that skew nursing education. One is the failure to define what nursing is and the other is our relationship to the doctors, which has always been difficult.

I think that nurses are afraid to be identified with the medical model because they want to have their own autonomous model. But I think they have focused on areas that move them away from real nursing practice. I was on the national registration exam panel and discussing what was needed for nursing education for 2001. Reading the questions, I would have thought this was an entrance exam for a social worker. There was nothing in it about biochemistry, stuff you have to know to practice safely. I think we are trying to move too far away from the medical model.

Having an autonomous model is more than challenging doctors' orders which I see nursing students doing. They call it critical thinking. But you can't create an image of a professional nurse by artificial public relations. You have to create the image by doing worthwhile work and having the courage to stand up for its value which is what a lot of nurses have never done. Nurses get out there and do the work but they don't seem to think highly of what they do. This was one of the biggest problems when the union supported nurses in pay equity challenges. When asked to describe the work they do, they would say, "Oh, we give basic care" or, "We do what no one else will do." It was interesting that it was largely the
West Indian nurses who seemed to take pride in their professional knowledge—they were some of our best witnesses.

Nursing came into existence because doctors needed someone skilled to be with patients who were ill around the clock. Our main thrust is patient care and in some ways it comes down to the self-confidence of a nurse and more belief in their own work. I was impressed when I went back to nursing in the 1980s with the immigrant nurses who were the backbone of the nursing staff. It was cheaper to import already trained nurses from third world countries than improve working conditions to attract people who live in Canada into nursing. Most of the immigrant nurses said they would not encourage their children to go into nursing—it was a terrible and a dirty job. I think from the beginning nursing has not had the political power to insist on better education, better wages or living conditions. What they did was talk about the image of the nurse and how to create a better public image of nursing. A lot of nursing reform has been superimposed. If you look at medical reform in the 19th century, the doctors themselves knew what they wanted and that’s how the change happened. With nurses, it was a group of upper class women who superimposed their views and their thinking, but it didn’t come from within the profession at the level of caregiving.

One day recently I went to the dentist and the young woman dentist who was stabbing in the Novocaine said they taught us to never give needles this way in nursing school. And the dental hygienist said, "Are you a nurse too? I lasted one year in nursing school before transferring to dental hygiene." The dentist said she started nursing school, lasted two years and left for dental school. She said, "I just couldn’t stand it. How could they treat intelligent women that way?"

How this conversation started, with my assumptions about who Helen is, is an example of how unreconstructed experience colours knowledge and actions. I could have this conversation with Helen so shaped by my own assumptions that I do not actually encounter her in the present moment. If I think of this dynamic in nursing and teaching
situations, I see where danger lies—a person who is the other half of the conversation is not seen or heard in her/his own terms. For me, this is one meaning of “nothing personal” that nurses and their teachers can ameliorate through reflection and reconstruction. Once the connection between my assumptions and our current situation are interrupted by awareness, I am open to pay attention differently as Helen begins by telling me about being a nurse and her union experience in a hospital.

Similar to Sara’s story, the question of the need for nursing administration and its impact comes up in Helen’s story. On the one hand, you could say that the removal of administrative and management nurses from the system created the opportunity for staff nurses to speak for themselves. On the other hand, you could ask how prepared they feel to do this or what opportunities there are to speak out for patients and our profession. I wonder what it means to nurses to be more directly exposed to organizational policies and politics?

Reform for Helen is just-in-time staffing and the casualization of nursing work so that nurses’ relationships with patients and others are undermined. She finds that nurses do not know one another or help one another as they did in the past. She sees management nurses more or less forced to work more closely with staff nurses because the middle manager group is so reduced in numbers. In general, Helen feels the way that hospitals are being restructured disrespects nurses and their contributions. The factory, assembly line model of care results in poor care for more patients because nurses’ productivity is not enhanced by caring for more people all at once or by distancing nurses from patients in supervisory roles. Historically oriented, Helen sees current healthcare system changes as once again superimposed on lower class caregivers by the upper class nursing administrators. From her perspective, restructuring by administration does not recognize the intellectual content of nurses’ work as evidenced by dividing nursing tasks for kitchen and cleaning staff to perform. The lack of language to say what they do is a major impediment, in Helen’s mind, to nurses constructively resisting reform efforts that are detrimental to patient care.

**Ginny: Entrepreneurship as Nursing Practice**

Ginny and I met in 1995 on a university Strategic Planning Committee where she was an alumnus and I was a part-time staff member. Her work as an entrepreneur
interested me very much and I was pleased that she agreed to participate in my research. Ginny arrived at my house midday, looking elegant in a blouse with a satin finish, black pants, and gold and pearl jewelry. We settled in the living room with tea. Ginny's story of herself in a reform environment starts in 1992/93 when she decided to leave full-time clinical nursing practice in critical care to return to school to complete her baccalaureate degree.

Reform for me was the merging of two intensive care units. At that point I wanted to make a change myself and take a risk. I knew it was time to break out from what I had been doing for so long. When the merger occurred, I chose the severance package and went to university full-time to finish my degree in nursing. I had been doing it part-time while working and feared I would be 106 before I finished. I left my job with some fear and trepidation and anxiety because people know you and we identify ourselves so much by our work. I had a period of about six months of adjustment when I went to school full-time and then I really enjoyed myself. I was really concerned when I finished in 1995 about what was going on in health care. Hospitals had shorter/faster discharge times so recovery was at home. The senior population was at risk, being sent home quickly from emergency departments on their own or with chronic illnesses or injuries. There weren't the resources to support them. Since all this care was shifting to the home, off-loading health care onto families and patients, in environments that were not prepared to handle this rapid change, I decided to make it my concern.

Prior to this time, homecare meant a bath and basic nursing skills. Now, it was acute care in the home with pumps, chemotherapy, home ventilation, dialysis, wound care, and palliative care. Not enough resources were being put into the community. I knew I wanted to be in the community and I wanted to start my own business, but there was a part missing for me. So I went to the community and got a job as a Corporate Director of Canada for Education for a large, private health care agency. I wanted to see first hand what was happening.
All seven of the provinces where my company had offices were going through the same massive reform. This was having a profound impact on nursing because nurses in homecare had no opportunities to work with what was suddenly coming at them within a 24 month period, starting in 1992/93, and from that point on exponentially. Nurses outside hospitals didn’t traditionally have the knowledge and skills for what patients needed in terms of technology. I had to do a lot of work with the nurses at the agency about the Regulated Health Professions Act, College of Nurses Standards, and working with unregulated providers. It was a world turned upside down. No money was flowed to the community and the Community Care Access Centres are being asked to cut back. There’s a profit and not-for-profit mix. The profit can be Mom and Pop operations. It’s a very dysfunctional environment in the community—there’s no overarching model or philosophy although each nurse has to meet the same regulatory standards. It is all adhoc with no money.

Now to move onto the entrepreneur part, I left the agency in May 1998 to start my own company. I had talked about it for a long time and had registered my company but only had small contracts and motivational speaking engagements. I bit the bullet last summer and spent a few months at my cottage thinking about my future. There is never a good time to do this, so I thought, do it. I also began to teach critical care nursing at a community college. As a professional woman and as a nurse, I felt I had skills that could be utilized in a reform environment. I have been consulting with a new home health care agency to help them put together a nursing program for delivering critical care in the home, as well as teaching and facilitating the Quality Assurance Program for the College of Nurses. My whole purpose is to influence the environment of healthcare in the way that any one individual can, by participating in a way meaningful to me and by having a positive effect on those who deliver care. As an entrepreneur, I think you have to give yourself credit for the experience that you have. My nursing skills and knowledge are very transferable.
When hospitals slashed and burned and cut nurses, they did not save money. I talked to a unit manager of an ICU who said they have spent two to three times more money than if they had kept the nurses on because of the cost of severances, buy-outs, overtime, agency staff, and bringing new nurses into the system. For instance, the community college critical care program where I teach is 14 weeks long and employers pay the nurses’ salaries while they are in the courses. Reform has resulted in triple the costs and experienced nurses are not necessarily coming back—they have found other employment, not necessarily in nursing.

For me, reform is uninformed people at the table making decisions despite the efforts of nursing leaders and organizations trying to educate them. I see a different mentality in the nurses coming to my classes. There used to be a victim mentality that hospitals cultivated, but new nurses have had to feed themselves in a difficult environment so the circumstances made them more independent and more interdependent. They have an entrepreneurial frame of mind, working multiple jobs and having an internalized sense of control based on values and beliefs about being a professional person. While lots of health care reform is negative, I see a more entrepreneurial point of view in nursing and I am impressed by that. At one point the Nurses in Independent Practice Group had 25 nurses and now we’re over 100 members.

Nurses in the community are the definition of an entrepreneur. They have no back-up, they have to be critical thinkers and link with other providers. They have no alliance with the workplace and see themselves as paid by different sources as independent practitioners. Some experienced nurses are forming their own networks which is very heartening. When I did a survey in my last job, only 13% of employers emphasized education. My company was investing less than one percent in education. So nurses are really on their own for their learning.

Education was the first thing cut in reform—it’s considered a luxury. I gave my Director of Nursing a T-shirt that said, “You think
education is expensive? Try ignorance.” Is this a management agenda to keep nurses down and dumb? Do organizations not want thinking, analyzing staff? It’s the insanity of doing things the way you always have and expecting a different result. On the one hand, managers talk about the need for knowledge workers and shared governance, but they want change without changing—they are steering the ship without navigating so you end up with the status quo. But there is nowhere to run and hide anymore.
A whole new accountability paradigm is emerging. Nursing’s place in health care reform is interesting because nursing is reforming itself at the grassroots, not as fast as it needs to but individually we are being forced into new ways of thinking and living nursing. The university of life has more to do with structuring the outcome of what we will be as a profession than we can academically structure. We are giving up the institutionalized attitudes fostered in hospital environments. It’s a sellers market and nurses will pick where they want to go. They have options. Yet, hospitals are blowing the opportunity to look at retention—it’s all recruitment. The degree is being used in isolation from experience and senior diploma-prepared nurses have been treated so badly. It looks good on paper to say we have so many baccalaureate nurses but what about the reality of practice expertise? Nurses feel so alienated.

It is important to look at nurses’ experience of reform because we are the largest group of health care providers in the province and we have the most intimate and longest relationship with clients that influences their recovery and this is a cost issue. Nurses who are truly entrepreneurial are going to have a very different relationship with a client. Clients want more information and to know what caregivers are doing. This can move the system to a more holistic and healthier view than the medical model. So telling our evolving stories is a way to increase awareness and break out of institutionalized patterns; a way to see our place and choices in the big picture.
We need to have expertise beyond direct practice. Health care reform is a global issue, therefore, we need to be involved in policy, management and education. Bringing all the dimensions together is the power of nurses to influence reform. I’d like to do my Masters degree and look at self-leadership and learning organizations in relation to the healthcare environment.

Ginny reminded me that the College of Nurses has practice standards for nurses in clinical work, education, administration, and research. The College recognizes there are different roles and niches on the healthcare landscape for nurses. I thought about how Ginny conceptualized her business and suggested to her she is a partial remedy for the knowledge loss occurring with the layoffs of experienced nurses. She is role model or mentor for novice nurses because of her own experience in acute care, critical care, the community, and education.

For Ginny, reform started with the merging of two intensive care units and a reduction in numbers of nursing staff. She saw this as an opportunity to reframe her work in nursing to include university education and community settings. Observing the healthcare situation across Canada, Ginny noticed the pace of change and the kind of change as a challenge for community nurses. Acute care in the home required by patients who were discharged after shorter stays in hospital created demands for family members and nurses. The ‘world turned upside down’ requires the skills and knowledge Ginny brings to situations. She thinks that uninformed people are making healthcare reform decisions despite nursing leaders’ attempts to influence policies. She imagines that administrators want change without fundamentally changing things. However, the ‘slash and burn and cut’ approach to reform has created a sea change in nurses’ construction of their work. Nurses are more entrepreneurial with often only a shift by shift relationship with a workplace. A new accountability to patients instead of institutions is emerging with nursing reforming itself at the grassroots. As the largest group of caregivers with the most patient contact, this is fundamental reform of relationships and economics.

**Maggie: Community Nursing and Evil**

Community and public health nursing are not generally showcased in media reports on health care. Yet, healthcare policy has named the home and community as the
locus of 21st century health care. Maggie is a public health nurse (PHN) in the amalgamated city of Toronto, soft-spoken and articulate about what she sees everyday in her nursing practice. Maggie and I met in a public health department office in the fall of 1998. It was early evening and we went into a room that appeared to belong to no one. It was furnished with a desk, two chairs, an empty bookcase, a teddy bear, and a TV/VCR on a stand with wheels. Maggie was dressed in black pants and a green top with simple jewelry. She speaks in a measured way as if the words she says matter; as if the meaning and emotion conveyed must match her experience. What follows is Maggie’s story of healthcare reform in the public health system.

Over the last five years, there has been an explosion of social suffering. Nurses are trying to shout loud and clear to try to affect system decisions. On the week-end I spent a bunch of hours trying to gather together information for the Street Nurses Network submission in response to the United Nations Committee on Economic, Social and Cultural Rights. So I look at health care on a big “H.C.”-kind-of-scale; looking at determinants of health, housing, decent human relations, poverty, job development, all of those areas that in my mind refer to Health Care. Health care in little letters is the dispensing of medical services, and even public health services and health promotion.

About a year ago I did a report for a news conference on children from a clinical perspective, about stories I was hearing and seeing. I presented our increasingly wrecked capacity in human calling to function in ways that might help people beyond Band-Aids. At the time, my only saving grace was the clinical work I was doing in a district where I was part of the community, part of its significant development. And then I was transferred, which I had to comply with. It was a deliberate action on the part of nursing management to move anyone who had been in a district for ten years or more. The rationale was to move everyone in case they were obstructive or stuck in an ineffective groove. Nurses working effectively with a community were not allowed to remain there. The policy is nurses must work two years in another area before they could apply for a transfer
back. It's very frustrating. There is no similar degree of community
development or grassroots work being done in my new district made up of
many neighbourhoods. It takes years, three or four, of piecework to
become an organic instrument for community development.

The story of reform over the last five years is very painful. The
capping of the federal funding for health had a two-year implementation
lag so when the shit hit the fan, the feds were scott-free. It appeared to the
public that the provinces were doing it. There has been a major spiral
downward, but essentially one must remember that Canada reduced
transfer payments to Ontario by 3.6 billion dollars. In addition, Ontario
government policies of the last three years have systematically dismantled
years of efforts and its heart-wrenching what it is doing to the most
vulnerable. Its awful to be in a place where once you could make a real
impact, experience and education in combination with opportunity, luck,
whatever it may be, and then to have the social and political environment
slip away to such a degree that you are struggling on a case-by-case basis.

The last Medical Officer of Health tried to bring in lay substitute
workers to replace some nurses five years ago. He wanted to cut the home
visiting stuff. And it has come to pass. With the Megacity amalgamation
and economic downsizing in public health, we have lost the ability to
adequately nurse women and their children. Almost none of the other
cities had kept individual visiting as part of their spectrum of services.
They went totally to group intervention and health promotion teaching.
Harmonization of services across the new city means areas that had
service lose some and areas that had no service gain some, but all are at a
less than adequate level of care.

Let me explain. The original Healthiest Babies Possible (HBP) is a
prenatal program model that included nurses and dieticians in a
partnership with pregnant women. It was a highly evaluated program with
comprehensive services to women, including home visiting. In an
evaluation of HBP in 1996, 419 clients had the following issues in their
lives: 72% had severe financial problems, 45% had extremely inadequate housing, 20% had relationship problems (including abuse), 16% had legal and/or immigration problems, 32% had more than one medical condition, and 40% had pregnancy complications. As a result of provincial government downloading, public health services are now municipally funded (4).

The original HBP model was reviewed by the new Megacity public health mandarins and politicians and, while the name was kept, the service was drastically reduced. Instead of 8 dieticians and 8 – 10 nurses for the old city, there are now 13 dieticians across the Megacity and 0.25 nurses per district for referrals (for a total of 8 nurses). Intake is centralized and performed by a dietician with criteria for referral to a nurse. Women must give written consent for a referral to be made to a PHN. Since there is no data being collected about the number of women being referred for nursing services, the most obvious of women’s needs for PHN services effectively disappear from view. There is no baseline nursing assessment of all the pregnant women in the program and their situations.

Part of my hustle today was nursing a 21-year-old woman who is acutely mentally ill but not sick enough to be detained in hospital. She is 32 weeks pregnant and her first baby had been apprehended by Children’s Aid. I saw her twice today as her original HBP nurse. She was flying around. Her needs are so massive. Who will intervene, who will work with other women like her? One quarter of a full-time nurse person across a district won’t know the local resources in the many neighbourhoods and won’t be able to microintervene and won’t have time for intensive services when they are called for. It is so distressing. I know from my own work that when system consequences come forth, its helpful and healthful if people can relate the consequences to their own actions and not to “systems against them.” Those are two different stories with a different kind of analysis and a different kind of emotional impact. If I met a pregnant underhoused woman in the past, she had a fair chance for
significant assistance. It’s so hard to make real contact with women who have been through so much. It’s hard on them to open up and let someone in. And now they do not have the same access to public health nurses, even for a basic nursing assessment. It’s so disrespectful for an internal referral to a PHN to require the client’s signed consent.

Comprehensive knowledge about pregnant women and their health needs is lost in this new diet dispensary system. Clients lose all basic PHN services that ensure preparation for labour and birth, post-partum, etc. As women in the former other municipalities gain a program, the women in the old city have their program diluted and basic access to a PHN is sacrificed.

The other program related to women and children is Healthy Babies, Healthy Children (HBHC) which is funded by the provincial government. After a woman delivers her baby in hospital, a nurse assesses her risk factors using a standardized evaluation tool. Any high-risk woman is referred to a public health nurse for further assessment. This means that there are two nursing assessments of women and their children for social and other health risks. In the old city of York, a pilot project is integrating the two programs (HBP and HBHC). A dietician still does the centralized screening and lay visitors look at the referrals to take whomever they want. Nurses do not see the referrals and the 0.25 nurse does not know what percentage of referrals actually come to nursing.

In this pilot study, vulnerable and high need clients are being streamed to diet counseling and lay home visiting. There is no comprehensive nursing assessment. I have a strong belief in the capacity of an indigenous health worker, while also having a deep sense of the complexities of her living in the ethnospecific community she serves. But, I live and practice daily with the knowledge that many of those vulnerable pregnant women are being made invisible to the system by these maneuvers. Part of my practice is moving the system on behalf of clients
so they can be cared for and have healthier environments for themselves and their children.

I described to Maggie my first meeting as a community representative at the Toronto Board of Health. I felt like Alice in Wonderland in a large room with formal desks, microphones with red lights shining “on,” the public and media in the outside row of seats. The presentations made to the Board were by Senior Staff of the Public Health Department related to the budget. It was all very impressive and overwhelming. I asked one of the experienced members of the Board of Health, who is also a councillor, about simple things like when it was all right to get myself a coffee or go to the bathroom. I was told I could move as long as there is a quorum at the desks facing the Board Chair. She also mentioned that there had been a nurse in the selection process with a great resume but was clueless at the interview and I wondered if she meant me. The alternative was equally bad, that someone else had represented themselves and nursing badly. It crossed my mind that it would be easy to be present at the meetings and not speak up or challenge anything.

On the surface, it would look like democracy and community representation were served with seven councillors and six public members. For the first time since entering the application process. I felt the possibility of examining what is happening for context and counter stories—stories that cut across the dominant social narrative. Talking with Maggie revealed to me how real people get lost in talking about numbers and categories. For instance, I now understand how human resource, policy development, and funding decisions can be made as if the population of vulnerable pregnant women that needs nursing service does not exist. The program that is meant for them now offers food advice and a bureaucratic hurdle to get any more comprehensive services. Will I hear an argument at subsequent Board meetings about cost savings gained from laying off redundant nurses or as rationale for redistribution of nurses across the Megacity? Maggie calls this an evil shellgame.

The recent plotlines for public health nurses is told in research that uses interpretive, narrative, and oral history methods (Diekemper, SmithBattle, & Draper, 1999; Rafael, 1999). Rafael tells a story of public health nursing as it has changed between 1980 and 1996:
District nursing involved the assignment of nurses to geographic districts: as a philosophy it represented the belief that the community was the client and the nurse an integrally connected part of it (p. 51). In 1987, a restructuring of the Public Health Branch of the Ministry of Health of Ontario concentrated administrative and legislative powers into the Chief Medical Officer of Health position, again strengthening medical control over public health. A shift to program-focused delivery of services narrowed nurses' expertise from a generalist in a geographic district to a specialist within a specific program (p. 54). The health promotion movement and administrative directives from a medical world view are the two prevailing and competing paradigms in public health. The paradox in nursing narratives was clear: nurses were directed to consider the whole community while reducing it to parts and focusing on only one; they were asked to develop communities while being distanced from them (p. 58). (Rafael, 1999).

I am not on the Board as a nursing representative and operational decisions belong to the staff. Yet I am drawn by Maggie's stories, wanting to bring this experience to the policy-making table. From my inquiry, I know that being personal, experience-based, and inclusive matters. I wonder how these characteristics will play out—with what success and with what risk and consequences for Maggie and I?

Reform, in Maggie's terms, is painful and starts with the federal government's capping of health transfer payments. She observes that provincial responses to the decreased funding have dismantled years of effort at the community level and created an explosion of social suffering. Maggie's capacity to help beyond Band-Aids is compromised as she struggles on a case-by-case basis with clients. The system is purposefully centralizing and limiting client access to PHNs by making lay people and professionals with one focus (such as dieticians) the point of entry to care. Harmonizing services so that everyone gets a little of all services also means that reform is dismantling relationships and knowledge within local communities. Maggie knows in human terms what health needs exist, so the tensions created by economically driven reform becomes yet another obstacle to doing her nursing work. The evil shellgame, according to Maggie, is that no data are kept on unmet need and so the people not represented by numbers disappear, as if they do not exist, from anyone's concern except for individual PHNs.
Constance: International Health and Social Development

Constance was a Director of Nursing who was acclaimed by her managers when new administration came to our downtown hospital in 1980. At that time, all the other nursing leaders were offered exit packages or the opportunity to do project work. The most senior nurse retired and her assistant went back to school. Four new Directors of Nursing were appointed—Constance, two others, and me. For me, Constance was the strategic intelligence of our new group.

When our Vice President left the hospital with his Chief Operating Officer colleague in 1985, the Director group took turns on a quarterly basis covering the Vice-President, Nursing position. It seemed clear that the returning administrator would also appoint a nursing leader he knew, also from the old days. He chose the Senior Nurse’s assistant who had completed her graduate degree. Two years later she told Constance it was time for new blood. Constance was restructured out of her job and replaced by someone with an Masters in Business Administration.

Constance had always traveled extensively, and I thought exotically, on her vacations. She decided to marry her avocation with her nursing experience and applied to work overseas. She has worked on water and sanitation projects, health teaching, and gender and community development, largely in South East Asia, since 1988. She lives and works with people from the country where she is working and speaks their language fluently. I visited her in 1989 and spent a week travelling through the northern part of her province, often on deeply rutted roads. We took pillows on the journey—not in case we were tired and wanted to put our heads down—but to cushion the jolts that took us into the air and crashed us down onto the unpadded bench seats. Our relationship continues through letters by email and conversations in person when she comes to Canada, usually at Christmas. I wanted to say when she comes home but I would have to ask her if it still feels like that or if she is leaving home to come to Canada to visit family and friends.

While Constance is currently living overseas and working on social changes, and my thesis is largely about Ontario healthcare restructuring, our relationship reminds me that our world is one world with many people, events, and places undergoing ‘reform.’ Our friendship fuels my thinking about here through hearing about there—almost as if the contrasts and similarities bring my own experience into sharper relief. Our email
conversations about our daily lives link us across the world. Constance tells me of her experience:

June 2\textsuperscript{nd}, 1998

Dear Gail,

I am finally back in the city after ten days of nail-bitting in Singapore. As I was not prepared for an evacuation, the stay was a bit nerve wracking. The whole thing was really unfortunate as the city was quiet the whole time and had I been there and not attending meetings in the capital, I would probably not have left. However we were there for a government presentation on May 14 and the student demonstrators were shot that day. The capital went up in smoke as we were doing our presentation! It was stopped and we all ran for our cars to go back to the hotel. The streets were empty and some barricaded. The hotel was preparing itself by boarding the doors and covering the windows. That night we ate in our rooms as the dining room and almost everything else in the hotel was closed and dark.

The next morning the embassy called to tell us to move hotels, as ours was no longer considered safe. We moved with difficulty (as transportation had stopped) to another larger hotel near the Canadian embassy. At 4 p.m. we were called by the embassy to tell us that flights were being arranged for Americans and Canadians. We were given instructions to go to one of three places to meet, to carry one bag, and have all exit permits etc. available. We left the hotel at 10 p.m. having bribed a driver and arrived at the closest point of departure to chaos of thousands of people struggling with children and baggage. As Canadians, we were directed to an area to wait...and wait...and wait until 3 a.m. when they announced that no more flights would go that night. We went to the house of one of our project advisors and came back the next day in the rain. We got on one of the thirty-five buses to go to the military airport. With a police escort, we managed to get lost, passing burnt out tollbooths
and blackened out road signs. Once at the airport, we waited for hours and eventually got on a plane for Singapore.

We are all back now and faced with looking at the relevance of our project in view of the crisis situation and the needs of the country. We will need to redesign the project in order to continue. Since the army is now keeping the government supporters and students apart in my city, I have repacked and am prepared to go again should this become necessary. I feel no danger, however, is this stupid? I'll keep you posted as best as I can.

How's the thesis coming? Love, Constance

October 18, 1998

Dear Gail.

Politically things are a little more unsettled than usual. The 'rape' committee report has come in and has been rejected by the military and other establishment figures. There was great conflict in the team between NGO and government representatives, so the report is generating all kinds of comment. Remember I wrote you about seeing the rape pictures of young girls and women, horrifying. We are also gearing up for the special session of the parliament to set the rules for the next election in May 1999. The students are protesting like crazy and thousands of the army are in the capital to guard the parliament area. We are quiet here in my city though and I am enjoying the daily rains and dark skies. Love, Constance

November 17, 1998

Dear Gail.

Last Friday students took possession of the runway here in the city, preventing planes from arriving and departing. The army, after trying tear gas, finally negotiated for them to leave. Since then, the airport has been surrounded by military and the students are burning tires and going about town in trucks, waving banners and shouting slogans. Except for the traffic jams from the burning tires, the city is quiet. The unceasing rain is probably helping to keep things controlled and the situation is not dangerous, just inconvenient. The embassy has put out an alert advising
Canadians to forgo unessential travel to the capital. Now people want the President and Army Chief to resign, saying they are to blame for the demonstrations, rioting and looting.

You asked what it is like to work in this environment. You go ahead with the basic work in case the plans can actually materialize. Then you cancel, replan and retry. Nothing is real until it actually happens. You spend a lot of time listening to the news, communicating with others by email or phone. This is where the support comes in—by talking with others and keeping up to date. It also means a lot of planning ahead for all the contingencies. Are there enough food, water, and gas in the house so that you can all stay if you have to or gas in the car to be mobile? Do you have enough money in the house so that you can leave with the staff if you have to go quickly? Is your bag packed and all your important papers, etc. ready to go? Is the work as updated as possible so that someone else can move in easily etc. etc. etc. It’s not too bad and certainly challenging to keep on top of it all. I am constantly dragging around passport, money and other vital things—my computer, address book and references are rarely out of sight. As long as the telephone lines are working, we are ok.

It is also reassuring to have good national contacts and friends. The reasons to stop working are only coming from ourselves—one woman is leaving but the rest of us are determined to carry on if we can. How is the Board of Health stuff? There seems to be so many problems in the health field that never seem to be resolved. They need someone who is experienced. Love, Constance

November 22nd, 1998

Dear Gail.

All is not lost. I have a meeting in the capital November 30 to meet the development agency monitors who will be with us for two weeks. Although things are quieter after last weekend, the student demonstrations are going to continue until after the elections in May. Also the arrest of ten
activists who the government are claiming to be inciters of the rioters may provoke lots of trouble.

I’d be pleased to be part of your thesis although at the moment I am not directly working in the health area, there are still relationships with the health sector. On a practical level, my health care background is used constantly in providing advice (for what it is worth) to expatriates and locals. I will be happy to participate as much as I can. See you in Toronto at Christmas. Love, Constance

Constance and I met for lunch at an Italian restaurant on Bloor Street, downtown in Toronto on January 2nd, 1999. She describes how reform is manifested in her adopted country and in her work.

The new President is considered the same as the ousted President so there’s no real improvement socially or politically. The reform we were supposed to see has not happened. There is not more openness or democracy. There is the same nepotism and corruption. People are very angry about this and more willing to speak out than in the past. Their expectations were raised by talk of reform and they are not seeing any promises materialize. It is interesting to watch how language is being used by each party to shape perceptions and reality. For instance, the media talks about students shooting at police but the Army and police are the only ones with guns so when students are shot in the demonstrations you know who did it. We can’t go to the capital at night and if we go during the day, we’re picked up at the airport and driven straight through to our hotel. At home in the province I feel much safer with my housekeeper, driver and guard. I stopped shopping in markets and food stores about a year and a half ago, when the economic situation worsened, so the housekeeper does the shopping now.

Right now my partner in the government is in name only. He stole the equivalent of thousands of dollars from the Ministry budget so there is no money to implement programs. I need a counterpart who is a partner and will help move the plans into action. This is one of the major
frustrations of my work. I met a few weeks ago with the Ambassador. He reported driving through calm streets and seeing business as usual. He was in an armed motorcade. My supervisor invited me to share my provincial perspective with the Ambassador. I sat there and thought, do I take the risk and tell the truth while everyone else is pretending? My national colleagues only come to work two or three times a week because they cannot afford the gas. I know about the stolen millions, padded project budgets, and people are starving. What do you do when you know of corrupt and illegal practices in both government and development agencies? We need food subsidies and without money, there is no health care. A couple came to my colleague’s gates with a letter from their village chief testifying to their need for money. Their son was in hospital with seizures and they have to buy the intravenous tubing, drugs and pay a fee for his stay and the administration of his drugs. I encouraged my colleague to give as much as she could because without money, the child will not be treated and will be allowed to die. I do not know what ultimately happened to this child. There are attempts in the villages to have women healers replaced by nurse midwives. The healers are being blamed for high maternal death rates and are being punished. But they work in a system where there is no health promotion or illness prevention and there are not enough nurse-midwives yet so the healers are still needed. The nurse midwives tend to be young and from outside the community. They are controlled by physicians in that they are dependent on the doctors for orders to take action—it is very medical model.

I have come to believe that one person can make a difference within their own sphere, one person or action at a time. This keeps me from feeling hopeless about the whole thing. And I can’t imagine coming back to Toronto and not working. My work is over here with my team.

February 2nd, 1999

Dear Gail,
I am settled back—as if I never left (groan). While you have been having snow, we have been having unremitting rain. Flooding of streets and houses has been very common. The roads are a mess as they are breaking up and potholes have appeared everywhere. There have been 41 riots in the country since Christmas. Yesterday election rhetoric started so I expect ongoing escalation of conflict. The government is strategically manipulating provincial issues. They have provided arms and training to antiseparatist civilians and sent them out to wreak havoc. There are daily reports of terrible killings etc as a result. It is a most hateful place now. The Ambassador is coming back for a visit this week. Talk with you soon.

Love. Constance

March 11th, 1999

Dear Gail,

I am busy and challenged and sinking under the weight of constant project redesign, clarification, etc. We have just undergone a month-long series of monitors, consultants, and constant meetings. There is indeed no time to get the work done. We are still not sure we are doing the right thing, whether it is useful, desired or possible, what can and should be done for the next two years of the project.

Meanwhile the country is in serious trouble. The Christian schools were pelted today by rock throwing students and since then all the schools have been closed. My bag is constantly packed and I hope that I will not need to use it. Love. Constance

March 21st, 1999

Dear Gail,

We have reached a new milestone in our project work. Having been monitored and advised almost to death in the past three months, we sat down last week and rewrote and clarified our goal, objectives, monitoring framework, defined terminology specifically and are now set to redo all our annual reporting formats and do the plan. This has been very complex work in so very many ways.
I finally have a government counterpart to leave something to. This move was very accidental—a great man who has gone back to school, looking for work, interested in the gender field, hard working and bright. The project agreed I could take him on as an “attachment”. The only thing going for us right now. Our most immediate provincial crisis was averted at the last moment—tomorrow, who knows? Love, Constance

March 23rd, 1999

Dear Gail,

I hope all stays quiet. There are now reports of massacres on a neighbouring island. Every week a new area starts to run amok! Trivial incidents start all reports—a bump on the arm, a dispute about the price of a fare. I have no interesting news. My life is pretty dull and quiet—work, come home, work on the computer, eat, work some more, watch TV and go to sleep. Hope I can keep it up! Love, Constance

May 9th, 1999

Dear Gail.

I am leaving on May 28th, before the elections. I’ll call you once I am in Toronto. I am fine. It is ok on the surface here in the city. Christians are being harassed still and students are demonstrating about almost everything, however, as long as there are no riots, our life goes on. We are preparing for the worst though and except for the house guard, the rest of us are returning to our home bases until the elections are over and the dust settles. The problems around the country are serious and a “balkanization” model is very accurate. I’ll call you when I get back from the capital.

Love, Constance

Constance was home for a month in the summer of 1999 and we met twice to catch up in person. Over lunch in Yorkville, she explained to me that her work involves the concept of gender mainstreaming which is from the Beijing conference on Women. Gender mainstreaming means everything is looked at with a gender analysis; examining the gap between men and women across many social indicators, such as, wages, health, land ownership, and mortality. She elaborates further:
Programs are planned to address the gender gap at a system level. Gender is also a class and a race issue. It gets transmuted by government language into programs to improve the quality of women as if it is the individual women who need to be fixed. System structures are thereby unexamined. So for example an income generating project to make women more productive is not gender work. Gender work includes men and women-specific projects don't. Gender work is social reconstruction that redresses stereotyping and discrimination.

One of the tensions in doing gender work is that it is seen as Western and Feminist, not Asian. It is so important to get men into training and consulting on gender issues; a gender balanced pair are the most effective teachers. This is human rights work. A year ago, gender work could only be framed as fairness or balance or partnership. It is difficult and dangerous work. I have the advantages of being white, educated, older, funded, literate in the local language, living in the community, and working with grassroots activists and organizations. The essence of my work is facilitating face to face linkages between people who wouldn't normally meet and talk. There are no preconditions in the social environment for this gender work so creating the conditions necessary for dialogue and change is part of what I do. Personal relationships are everything in this work; they are the basis for working together and so my recreation, social, and homelife intersect with my worklife. What I do is help people build stories about how to live that includes a gender point of view.

January 29, 2000

Dear Gail,

Your thesis is compelling and moving reading. I could hardly wait to get to the next page! It was so informative and personal, written in such a readable style that my attention was held throughout. I had some difficulty with some of the words early on which you explained later on i.e. liminality. You are asking some very important questions here—
personally and professionally. Who are we, the nurses? How do we influence the system—reform based or otherwise? I was particularly interested in the male nurse encounter and responses. This gender factor is too all a part of our dilemmas.

At this point in my life I can say, though, that the preparation that nursing has given me, has been invaluable in dealing with this “new” life of mine—the dealing with difficult situations, the sensitivity for others, the planning and organizing skills, have all made such a big difference to my work here. I see the difference in my new colleague (non-nurse) who doesn’t exhibit many of the above characteristics. She is in a grave situation. Nursing prepares you for anything—especially getting through things that are tough to handle. We had to do so much of that. I remember how I hated the operating room and couldn’t wait to be finished with the experience. Although I vomited every morning for two months, I got through it!

Please keep sending me your materials. It is the most interesting stuff I have read in a long time! I’m off for a meeting in the capital this afternoon. Back on Tuesday, Talk to you then, Love, Constance.

February 12, 2000

Dear Gail.

Sorry to be so long answering but it has been a very busy time. The annual workplan is due for review after the international conference. And they want a new organization to replace the non-viable (structurally and functionally) team that is in place and not sustainable. We need to ensure provincial gender mainstreaming in a financially secure way with knowledgeable staff. This is a gigantic piece of work on top of everything else. On top of this my local colleague has been given an ultimatum by her husband. She used to wear traditional clothing and have short hair under her scarf. She is wearing western clothing, including dresses, and is wearing make-up. They are fighting all the time which affects her ability to work on the project. The project has changed her fundamentally and she
said she can no longer tolerate what used to be normal. It is very difficult for a divorced woman here as the woman is blamed for the failure of marriage and there is no sympathy for women’s roles outside the traditional.

I am relating all this as my reaction to your thesis and as another example of how very difficult it is to separate gender issues from nursing realities. If you substitute the word gender for nurse, we are looking at a social construction embedded in historical contexts, defined by social conventions and settings. When we think of nursing relations we are examining gender relations. The basic issue in gender relations is power and we are fighting here to have women involved in decision-making—the point where power is expressed. This all links to personal burdens and the country’s development in terms of human rights.

Reading your latest documents, I felt moved and saying to myself. yes! Yes! The expression of personal experience is so revealing and affirming. You are giving me lots of food for thought. Many thanks for sharing this with me!

Love. Constance
February 23rd, 2000

Hi Gail.

I have tried so hard to conceal my urge to control and spell out all the details for everyone. Sometimes the concealment works and then again it doesn’t. Years of trying later, I am still always aware of my impulses and have perfected a cover. All those measures add to my need to seek an outlet—nail biting, smoking?!? Anyway the struggle goes on.

I’m still planning to be back in Canada by the new year. There is a lot of uncertainty in the development community right now.

Love. Constance
April 8, 2000

Dear Gail,
Weather is great—went snorkeling last week-end. It was glorious.
I came out of the water all wrinkled and salt-encrusted. Wonderful!

It has been a busy two weeks. Staff changes, advisor leaving, project troubles—lots to think about. I am going ahead with my plans to leave by the end of the year but new things are happening that must be dealt with. And, my landlord is putting in a new patio. It all feels unreal.

Hope you have a wonderful day.

Love, Constance

For Constance, reform is language that is used by government to create a perception of change while holding on to old practices that are being interrupted by civilian unrest in the form of shootings, burning objects, and raping women. Having been evacuated once to another country when her adopted city erupted into violence, Constance knows that openness and democracy are not going to happen quickly or easily. She is always prepared to leave, in the midst of hard work with agencies and government, on a moment’s notice. She feels the daily tension of telling the truth or pretending everything is alright so officials will not have pressure to change. Constance has decided that in reform, nothing is real until it actually happens. She embraces the idea born of her experience that creating the conditions necessary for dialogue on a personal and daily basis is the way meaningful change will happen. Real reform for Constance is social reconstruction through work with many other people, including gender, class and race considerations.

Kathie: A View from Health Policy: Nurses as Intellectual Resources

We met in Kathie’s office at the Ministry of Health. The space was about ten feet square and is full, almost to bursting with a desk, two chairs, computer, cabinets, books, and papers. The afternoon sun was shining in the window and reflected off of Kathie’s glasses. When she became animated and moved her head, I could see her eyes and the energy she brought to issues about nursing and her career. Her phone rang several times while we met and her pager beeped. Her time seems very full and I was aware that she had promised to meet in 20 minutes with the person who called and paged her in the middle of our conversation.
Reform has been going on for awhile, at least since the mid 1980s. If you think back to some of the changes that have been taking place in hospitals and the community, patients have shorter hospital stays, hospitals are no longer able to apply for funding to make up deficits and practice has been influenced by the way that health care is funded. Most recently my clinical work was in the community and I saw an increase in acutely ill, complex patients. A decade ago a nurse might do a wound dressing. Now there are people whose bedrooms are intensive care units with ventilators or dialysis. The landscape where care takes place has changed a lot. I was grateful everyday for the education I had and for the twenty-five years of experience I had. You never know what it is you are going to encounter when you go into a home. It is not a controlled environment.

I have two graduate degrees, a master of nursing and of anthropology. I am currently working on a doctorate in clinical investigation. What strikes me is how much preparation you really need to function effectively. In the community you don’t have the luxury of ready access to consultation. It’s the same in the hospital where flattened organizations have eliminated a lot of resources that nurses had to help them in their clinical practice. Assistant and head nurses and teachers aren’t there anymore. I think this is good.

What has always struck me is that we had antiquated systems in place that were holdovers from when nursing students gave most of the hands-on care. Then you needed policy and procedure manuals, you needed resource people to go to and they have hung around long after they were needed. When you go to all Registered Nurse staffing, you don’t need to keep nurses in an infantile relationship with the system. We have to support nurses as professional practitioners who make decisions. Many nurses are still functioning with a cookbook approach, like, “Show me a procedure and then I’ll do it”. So I think the changes are going to be very
good for nursing if we change the practice environment to liberate the essence of nurses’ practice in different ways.

I’m more and more convinced that the person on the front-line needs to be well educated. What has always been perverse about nursing is that the more education you have the further you move away from the patient. You don’t see that in other health disciplines. In nursing we say we have four domains: practice, education, administration, and research. You need advanced education for all of them but practice and it’s a practice discipline. You need a certain ratio of nurses in a technologically sophisticated country and it works out to be 78 – 80,000 employed nurses for Ontario’s eleven million people. We have that, but these nurses need to be better educated.

Right now, we have the largest number of nurses who have been in the profession for the longest period of time. We have antique structures in place that were set up for a work force of student and novice nurses who did not stay longer than five years in practice. It’s a recent phenomenon that people are making a lifelong career of nursing and we are the first generation who has to pay for nursing services. Many nurses in practice now have learned a lot with 20 or 30 years of experience. What I am worried about is novice nurses coming into the system without all of the supports. I think one of the reasons we’ve been able to undertake the reforms we have and still be able to deliver health care is because we have this huge cadre of experienced nurses. We need to recognize their value in the system. I’m really worried about when they are gone.

New nurses, who have multiple part-time or casual jobs, who have never had a structured practice environment and no mentorship, are coming into a setting where they are expected to be job-ready. This is even more reason why we need to educate nurses to be independent and to find their own information. Throughout the 1980s when I was a clinical educator, I felt like I was tying together bits and pieces of information in a digestible format for my nursing colleagues. I never felt that I did a good
job because in a practice setting, education was low on the totem pole of priorities. We were lucky if we got 15 minutes of sustained time and I’m not sure how much the nurses took in. I’d like to see education out of acute care and be handed over to educators. And I’m convinced that when you take people out of a clinical setting and put them in a learning situation, you get better outcomes.

There are problems with portability of education from employers and a lack of academic credit and no quality control. So, even though hospitals got out of the education business for economic reasons, it’s a good thing because hospitals are not centres primarily for teaching specialized nursing. I think nurses should come out of their basic degree program and go to the community colleges for oncology or critical care programs. So when you look for employment, you are virtually job-ready. The resources aren’t there anymore anyway and colleagues don’t have time to nurture you along. We’re the only practice discipline that I know of that’s expected to get two weeks of orientation and be up and running. Typically the way I describe that to people is that we have not taken into account the fact that nurses can kill people. Another discipline might do something that slows down recovery or impairs function to a degree, but nothing like what a nurse can potentially do.

So reform is delayering management structures which creates fiscal pressures, increased acuity in the community, and responding to technological changes in medical care. Patient’s care requires a different way of thinking, for instance, even though the outside wound is smaller, surgery has occurred inside. I find people minimize the impact of surgery now because the wound is smaller. We have to teach nurses differently about assessing people. They aren’t going to have the same signs and symptoms of something going wrong on the surface so how do we reconceptualize what has happened internally?

This has application in my health policy work. In the Ministry of Health I have worked in a number of roles, in the bureaucracy and as a
political advisor. There are many former nurses in government but they are not professionally identified or linked to practice. They are also about two decades behind in the practice perspectives they bring to policy making. Organized nursing externally had a poor relationship with the Ministry in that when a committee had to be put together, we didn’t know who to call. The Ministry had a sense of a fragmented group and didn’t know who did what. Often when you want to dismiss a group, and you don’t really know how to deal with their problems, one of the ways out is to say that they don’t have a united voice. Then you don’t have to respond. The external nursing organizations have recently had more consensus opinions to offer which helps. There is more of a sense that nursing does not have to be homogeneous but there are consistent, persistent, coherent key messages. I think the most important thing has been to coordinate the right person with the right expertise on committees. So nursing can shape reform by being on these committees, by having a broad perspective and being articulate.

I think the profession’s issues are also health care system issues so it is in the government’s interests to address these issues. And nurses need to understand that the government is not their employer the way it is for physicians. Doctors negotiate directly with the government and nurses negotiate with health agency employers. The government is arm’s length from decisions about how hospitals allocate their budgets, for instance, how they staff, and how they organize nursing services. These are administrative choices, like having an all Registered Nurse staff or using unregulated workers to give nursing care. What is frustrating to me is that we don’t hold employers accountable for decisions that have a negative impact or potentially a negative impact on patient care.

The role of nursing leadership in organizations has all but disappeared. Where it does exist, it tends to be a position of influence rather than having line authority with budget and staff. Not only is there a lack of mentorship for new nurses, there is no nursing voice or presence at
senior decision-making tables. How does this impact reform in organizations?

I think it's a problem that nurses are not consulted about reform. We don't see any abatement of the medical voice so you see decisions being made that do not recognize how nursing and medicine work hand in glove. I don't believe you can have first rate medical care without first rate nursing care. Cheapskate nursing care compromises good clinical results. Unfortunately, nursing's contribution to patient outcomes is not always recognized. I hate to say it's a gender issue but nursing work is viewed as women's work and that a bit of education is gravy. We're just putting a bunch of women to do domestic work and that is historically unpaid work. In the discussions I'm in about the level of education for nurses, the feeling is that it is non-intellectual, technical functions, assembly line, factory work. So then it becomes alright to divide the tasks and employ unregulated workers. Even the workload measurement tools do not capture the intellectual work of nursing. Kate McPherson (1996), an historian of women's labour, writes about nursing as quintessentially women's work. So having nurses in policy and decision-making roles is a turnaround in thinking. No one would dream of making health policy without consulting the medical profession, but not nursing. Now we are being consulted (even if it is to keep us quiet so we won't complain so much). The only way that we are going to get rid of these patriarchal structures is revolution. Like any revolution, there is a period of confusion and ambivalence. We don't have the replacement structures yet.

To some degree, nurses are being affected by rather than affecting reform. The Ministry often acknowledges in letters that, of any group, nurses are most affected by reform to date and have had the least positive gains. Reform makes a lot of problems for nurses and we haven't seen the positives. Part of it is educating nurses beyond 'doing' to a way of thinking. For example, I was oriented by a fabulous nurse when I worked in the community. We are still friends. She was working part-time on her
baccalaureate. She was an intuitive practitioner and did everything right. But if you asked her why she chose an intervention she couldn’t explain it. This is a handicap in terms of advocating for patients. We saw a palliative care patient on an initial visit and talked with him about his symptoms and management. He never used the word ‘pain.’ He talked about aggravation. When we got around to talking about his family, he said his son was an aggravation. Because of the way I am educated and think about text and subtext, what stood out for me immediately was that he used the same word to describe his son and his terminal cancer pain.

My colleague came away from the visit saying, “There is something wrong between the father and son. I can’t put my finger on it but there is tension between them.” I asked her what should be done about it and she said she would continue to assess it on subsequent visits. So for her there was a need for additional data collection. When I pointed out what I had observed, lights went on and she was able to move to an intervention right away. This reminds me of homecare research done at the Nursing Research Unit where patients with degree-prepared nurses were found to be twice as likely to get a better outcome in fewer visits. This is the difference between someone with my level of education doing an assessment and pulling the pieces together in a way that I can explain to someone else what it means, and someone like my colleague who will pick something up but be fuzzy about the supporting details and be unable to articulate what the patient needs. We can’t do things as we have done them for 30 years. Let’s try this and see if it works, let’s try this other thing and see if it works. Now you don’t have that kind of time and you better be able to identify the problem, select the intervention from research-based evidence where it exists, and get positive results.

I think inevitably we are going to create an environment where nurses are going to be liberated to think, just by virtue of the fact that the structures are breaking down. All the things that kept the lid on nursing are breaking down. We need to educate nurses differently and then the
practice ghetto will come down. We have a caste system operating where educators, administrators, and researchers pat practitioners on the head and really don’t listen to them and don’t value practice. One of the ways you gain status is to move away from practice and yet it is the cornerstone of our discipline. I think we’ll see more graduate nurses choose clinical practice and that will change the way the interdisciplinary team and nurses interact. I think all of us should be committed to doing a minimum of a week-end a month of clinical practice. But this is very difficult in the current environment.

And practice cannot be in isolation or decontextualized. All the domains or elements are blended in an experienced nurse’s practice. The biggest problem we have in the profession right now is the ghettoization of practice. There is a lack of ownership and valuing of the practice in our discipline. There is cognitive dissonance for those of us who leave hands-on practice. I’ve never been able to stay away and yet when I’m in practice, I hear we’ve always done it this way. The manager doesn’t always take kindly to challenging practice so you fall into prescriptive roles and practices which can be dangerous. Or, you do wonderful things in secret and never tell anybody so there is no shared benefit of the experience.

We have to make expert nursing visible. As we gain momentum with describing the theory of the discipline and elevating it to the status it should have, there will be more nurses on key decision-making bodies. We don’t recognize expert or specialized nursing or fund nursing services except as a fringe thing. I don’t blame the public for being confused. We have a fuzzy continuum or menu of nursing services available. Everything from three months of preparation for a personal support worker to advanced practice nurses with six or more years of university. I think people need to understand that this title goes with this education and a particular kind of care.
Some nurses won’t like that responsibility or certainty. They like to be able to say the manager told me to do it this way. Or I did it like the procedure manual said to do it. On the other hand, I think we have a lot of nurses who are dying to be liberated. You have to be bright to be a nurse, intellectually gifted. I wouldn’t be in health policy if I couldn’t have an impact on the practice of the profession. I think nursing has huge untapped, wasted intellectual resources, one of the biggest sins—the socially wasted intellectual capital of nurses. It’s no different than primitive societies that don’t educate girls. We are doing a disservice to the health care system to so undereducate and underutilize nurses. I love clinical practice and for me it is a sacrifice to be here.

For Kathie, reform started in the mid-1980s with no more money to cover hospital deficits. The funding changes influenced professional practice and so patients stayed in hospital for less time and went home with increasingly acute conditions and concomitant complexity of technological support. Restructuring in hospitals has removed layers between nurses and senior administration and Kathie hopes that will take nurses out of an infantile relationship with the healthcare system. Kathie points out that the reform that has happened so far is only possible because experienced and senior nurses have been in the system to hold things together. New nurses are not getting the mentoring they need and have to be job ready, often with multiple employers. Kathie feels that nurses need education and experience to reconceptualize what they do with clients and to play a role in shaping reform itself. She is concerned about the lack of senior nursing positions in most healthcare organizations that continues the dominance of the medical perspective in policy-making. Kathie recognizes part of her work is explaining to government that nursing is intellectual work, that the factory model of technical workers does not capture what nurses do. Nursing, for Kathie, is a way of thinking that nurses in her experience have difficulty articulating. Reform is breaking down structures and offering nurses the opportunity to articulate the research-based evidence for their interventions. In her terms, the lid is coming off the practice ghetto and clinical practice is being liberated. Nursing is a wasted public resource if reform efforts do not include making expert nursing visible.
More Thinking Narratively

These stories of nurses show the relationships between people, events, and places that constitute the professional knowledge landscape for nurses. This could be further elaborated by including patients’ voices. I leave that for subsequent inquiry. Each participant point of view enlarges, contextualizes and shows the texture of the landscape. John Dewey (1933/1998) describes reflective thinking as a “process of detecting relations” (p. 77). I like the notion of defining nursing as seeing relationships between people, events, things, and as discerning patterns. So reflecting on the relationship between reform and nursing involves showing the thinking of nurses and the part they play in constructing as well as experiencing restructuring. From the perspective of co-participants in chapter four, this is often stated to be invisible to nurses themselves. And yet, I observe each nurse keenly aware of her own situational circumstances and thinking about how to be a nurse in a changing world.

Several of the participants spoke of how reconstructing experience matters to them as nurses. Sara, Helen, and Kathie suggest that finding the words to describe our experiences, to be able to say what we do and the contribution we make will be facilitated by nurses’ reconstruction of experience. The significance to Ginny of reconstructing her experience as a nurse relates to story and choices. “Telling our evolving stories is a way to increase awareness and break out of institutionalized patterns; a way to see our place and choices in the big picture.” Ginny’s analysis, echoed by Kathie, suggests that the conditions of reform are shaping nurses to reform themselves and their practice; new ways of thinking and living nursing emerge. Constance, reading her own composite and several of my draft thesis chapters, says she is drawn into the stories, finds them relevant to her projects of social reconstruction, and likes the questions of ‘Who are we as nurses?’ and, ‘How do we influence the system?’ Constance moves into her own experience of life’s seamlessness where recreation and personal life intersect with work: as it does for her work-mate whose gender work is complicating her homelife and marriage. “Nurse is a social construction, embedded in historical contexts and is defined by social convention and settings,” Constance elaborates. She feels sharing personal and professional experience reveals and affirms the meaning of one’s work and life. As
Cassandra points out, continuous engagement with seeing and acting make a study of our lives—telling the story of our lives in the mission we have fulfilled.

Florence, Helen, and Sara discuss aspects of the business model which has been adopted in healthcare restructuring. This model is evident in the American nursing literature because of the nature of healthcare third party reimbursement but increasingly is seen in Canada with the introduction of private or partially funded services. Nurses are encouraged to negotiate partnerships with patients in health care systems so that “expectations can be compatible and realistic” (Wolf, Boland, & Aukerman, 1994, p.56) in the context of managing costs. Compatible with what? Realistic for whom? Are nurses who implement these partnerships asking such questions? Or are they too tired and busy “training and supervising their own replacements?” (Baer & Gordon, 1994, p.38). Baer, Fagin, and Gordon (1996) explicitly link American profit-motive health care to patient abandonment. Historically, Canadians have a more universal and accessible health care system but American style management and patient care systems are readily adopted here. even before there is evidence of success or even after the United States has discontinued a practice. Almost on a daily basis, the newspapers present further evidence of privatization of health services or two-tiered access to care in Canada.

Being able to care for vulnerable people in a business/corporate paradigm is an enormous tension as Helen and Florence describe it (5). When nurses as employees in healthcare organizations are seen as human capital with “skills, knowledge and information effectively channelled into products and services” (Gilmartin, 1998, p. 78) patients are constructed as consumers with health services as a commodity. For me. this begs the question “are you (nurses) embracing downsizing and cost-cutting more quickly than theory-guided (nursing) practice frameworks?” (Cody, 1997, p. 65).

Constructing knowledge through a business paradigm leaves out the nurse and patient as people and what they do as relationship. In this business plotline. I wonder if “nurses and the environments in which they work (are) in the same canoe but paddling in opposite directions?” (O’Brien-Pallas & Baumann, 1992, p. 15). When I hear colleagues talk about customers or consumers instead of patients or even clients, I am afraid that our language is making people invisible in their particular circumstances. Business language assumes a market place relationship between care providers and patients and assumes that
health care activities are commodifiable objects. Who wants to buy diabetes or leukemia, who purchases units of health care, who is left out or made invisible by this way of looking at human experience? I feel we lose a sense of what is actually happening to and between people and we live as if the jargon and rhetoric are a world we can inhabit. As Helen points out, it might sound like more patients per nurse increases efficiency and productivity but in human terms, it means less care for each and perhaps poor care for all.

Nurses in chapter four encounter tensions related to continuity over time and construction of knowledge and identity. Restructuring interrupts places and temporal consistency of client assignment. As nurses work in multiple settings on a part-time or casual basis, their care becomes episodic or on a shift by shift basis. Given experienced clinical and administrative nurses are reduced in numbers or absent, front-line nurses have an opportunity to directly articulate their knowledge to others. The conversations can bring nurses face to face, in unmediated contact, with other disciplines, community members, and senior management. How do they do this and who listens? If identity and knowledge for nurses are constructed in relationships with people, places, and events, how does it matter that these relationships are created in a context of system restructuring?

This question is addressed in chapter four as nurses take situationally specific actions to respond to calls for involvement in a complex and uncertain daily environment. How healthcare restructuring is understood and conceptualized depends on who a nurse is, experientially and temporally, where she/he is located in place and how roles and tasks are enacted. Restructuring is not only an external landscape; it is also internal and temporal for nurses. Restructuring of the healthcare system informs nursing identity and knowledge. And, how it is experienced and interpreted by a nurse is reform from-the-inside-out. Reflecting on and reconstructing experience within healthcare reform is a nurse’s education—reforming identity, knowledge, and, therefore, actions in social situations.

I now conceptualize the healthcare landscape as a multi-faceted crystal. The surfaces or faces of the crystal are nurses’ stories of relationships with other people, events, and places. The light that shines on a nurse and the colour emitted depend on who and where a nurse is on the landscape. To continue the metaphor, the light that
illuminates the colours is reconstruction of experience and what shines from the crystal is interpreted meanings and new actions in a nurse’s life. To pursue this thinking and my inquiry further, we turn to the prelude to chapter five. Afterwards, we meet Sasha as she explores her experiences with healthcare restructuring as a nurse in clinical practice and with the curriculum revolution as a Post-RN BScN student. In chapter five, she retells her story to live by, showing us how she constructs knowledge and identity which reveals her learning and future possibilities. In our co-inquirer relationship, some of the significance of narrative inquiry to curriculum and teaching-learning is also revealed.
Chapter Four Endnotes

1. Meeting dates with co-participants in chapter four:
Sara June 22, 1998
Florence July 15, 1998
Helen October 15, 1998
Ginny December 10, 1998
Maggie September 28, 1998
Constance June 2, 1998 - April 8, 2000 (email)
Kathie September 1, 1998

Consent Letter for co-participants
I, [name], have discussed with Gail Lindsay what it means to be a co-participant in her doctoral research, a narrative inquiry into nurses’ stories of experience on a reform landscape. I understand that the reform landscape includes stories of healthcare and nursing education reform.
I consent to the collection and confidential use of personal writings and conversations for the purposes of understanding my environments including, people, places and events. I understand confidentiality will be safeguarded through the use of pseudonyms for people and places, that I will have access to all written materials pertaining to me in the research and that I can withdraw from the inquiry at any time. In such an event, my stories of experience are also withdrawn from the research.
I understand that the research will be published in a thesis/dissertation format and that any other use of my stories will be separately negotiated.
I voluntarily consent to be a co-participant in this narrative inquiry with Gail Lindsay.
Signed: [Name]. Please print name and date ____________________.

2. Cassandra’s Lament is constructed from Nightingale’s own words. The reference is Cassandra by Florence Nightingale, in Cassandra and Other Selections from Suggestions for Thought. M. Poovey (Ed). 1993. New York: New York University Press. (205-239). The quotes are from pages 205, 206, 215, 216, 218, 219, 227, 228. Cassandra is a mythological character who could correctly prophecy about the future and was doomed by one of the gods to never be believed.

3. At the April 6, 1998 Board of Health meeting, the Medical Officer of Health Dr. Sheela Basrur announced that the provincial government will again cost-share 50% of public health budgets—what this means in terms of real dollars, level of support and for what is not yet known.

4. Now the hospital is called: Sunnybrook and Women’s College Health Science Centre

5. For literature related to nurses and the corporatization of practice, see Balik, 1998; Corey-Lisle et al., 1999; and, Pillar & Jarjoura, 1999.
Prelude to Chapter Five

Taking Stock

Revisiting my April 1998 thesis proposal two and a half years later, I find tucked into the red binder cover a letter from Veronica Ellis that she wrote following my February 1998 presentation at Works-in-Progress. Veronica is a dear colleague at the Centre for Teacher Development at OISE who replied to the first four versions of my family-centred care story and gave me permission to quote her here. She writes “it is not that hindsight is so much clearer; it is more that we are able to reconstruct the story so that it incorporates our new experiences...with each narration the audience is forced to rethink its conclusions” (February 19, 1998, personal communication). Veronica's comments evoke my curiosity about how you, dear reader, are encountering my inquiry. What assumptions and conclusions have been called into question for you? What experiences are you drawn to reflect upon in connection to the nurses' stories told thus far? Perhaps this is a good place to take stock – to reconstruct the purpose of my inquiry, to show how I am learning to think narratively about experience and restructuring my thinking. Proposing to explore relationships between experience and education in nursing with my co-participant Sasha and imagining the end-in-sight of my inquiry complete this prelude to chapter five.

Reconstructing the Purpose of My Inquiry

A central purpose of my inquiry is to explore and describe the healthcare reform or restructuring landscape as constructed by retelling and reliving our experiences as Registered Nurses. The professional knowledge landscape of nurses is conceptualized as their relationships with people, places, and events. Wondering how nurses shape and are shaped by their social situations, I wanted to show how it matters to nursing practice and to nursing education that nurses undertake an approach of inquiry to their own lives. This is a perspective missing in the healthcare reform and nursing literature. Questioning how identity and knowledge are constructed through narrative inquiry, I wanted to reveal how my experience and other nurses' experience is the basis for stories to live by; to show possibilities for being a nurse that unfold through thinking narratively, reconstructing experience in times of change, living in liminal, in-between space. By now, what is
emerging for me is how my inquiry shows reform is very personal, it is inside-out work that is embedded in daily life.

Learning to Think Narratively About Experience

Rereading my work to this point reveals how some of what I intended to do is accomplished and invites deeper reflection and reconstruction. Reviewing nursing education literature and research as a source of stories to live by reveals that reflection on practice and story-telling are part of professional expectations and education for nurses. The difference between these terms in the nursing literature and in narrative inquiry is how experience is viewed in the latter as embedded in a person’s life—with dimensions of backward and forward, inward and outward, and place. In contrast to top-down administrative strategies or psychological interventions in healthcare restructuring, narrative inquiry illustrates how a nurse is a knowledge-maker. A theory-practice dialectic is shown in my stories of becoming a nurse and staying in nursing. The differences and similarities between narrative inquiry and interpretive phenomenology have been presented such that the contribution of narrative inquiry to nursing education and research is highlighted. Researchers in narrative inquiry are co-participants, as I was with Karly in the second family-centred care story. I am necessarily and explicitly part of the social situation being explored. In my inquiry, attention is paid to layers of stories—what can be told publicly, what happens in classrooms or at a bedside, what is mandated, and what happens in the liminal space between stories.

How narrative inquiry matters to my life as a nurse-teacher, especially from the perspective of identity and knowledge formation, has been shown largely in chapter three. I can see movement in my life from a frozen, passive position to involvement and awareness through the plotlines evident in retelling my San Diego and family-centred care stories. Telling myself to avoid administrative work in the future, that I’ll only make mistakes, I began to write my experience and thinking. My stories show how this story to live by excused me from responsibility as I lived on the margins of situations to keep myself out of the messiness of daily life. Thinking about myself as separate from social situations, I waited for the perfect nursing opportunity to come along—I watched the parade and waved at the people going by, but kept myself apart on the roadside curb.
This way of thinking about how to live my life resonates with my father’s description of me in childhood—the rose in the outhouse. It was important to me to be seen as without fault, allied with my parents as my siblings’ babysitter. Understanding how I construct hierarchical situations with others, my awareness allows me to behave differently—to pay attention to each person’s perspective, as well as my own, to resist the impulse to tamp down dissenting opinions. Hearing a generalization or noticing my inclination to suppress a conflict are now my narrative triggers to pay attention deeply in a situation. In this way, I am open to more of what is happening than if my past plotlines constrict the possibilities. My own stories of being frozen and conflicted about being a nurse, retold over time and intersected with new experiences as I learn to tolerate the uncertainty of not knowing, is my education. How I am a person and a nurse-teacher now is my own personal reform of nursing education and practice. Holding the paradox of experience and awareness, I am in my daily life in new ways.

The professional knowledge landscape for nurses is shown as cycling through rhythms of shortages and surpluses of resources, including nurses as a human resource. Beginning with an overview of twelve years of healthcare policy documents (1988-2000), the landscape is further illuminated by seven nurse co-participants’ stories. They are specific people, with narrative histories, interacting in particular social situations that also have ongoing stories. Florence, Sara, and the others describe how they understand what is going on in healthcare restructuring from their perspective, in particular settings, and the part they play in its unfolding. In exquisite detail, they portray the situational tensions and their capacity to learn and change. The healthcare restructuring landscape emerges for me as a multi-faceted crystal; how it is understood depends on personal perspective and location over time. An interesting point to remember is that the colour spectrum that our human eyes can see is a fraction of the total electromagnetic spectrum. Ultra-violet, infrared, radio, cosmic, and x-rays are all outside of visibility (Page, 1994). Dear reader, as you continue through chapter five (and six), ask yourself, “What can be directly apprehended in this situation?” And, “What is the relationship of the unseen to what can be directly apprehended?” Making sense of narrative intersections creates a story to live by—an identity based on epistemological and ontological considerations of lived experience. Helen’s story of becoming a nurse in the 1950s, leaving nursing to raise her
children, and returning to clinical nursing practice in the 1980s shows how new choices are grounded in daily life experience. Nurses who are my co-participants and I show how we have choices beyond fitting in or leaving situations.

Reconstructing Thinking

Rereading and thinking about earlier chapters to discern what we know so far about the professional knowledge landscape, I ask questions about how relationships are constructed, what fosters and what impedes them? These questions arise from Dewey's (1933/1998) point that all reflective thinking is a process of detecting relations and Clandinin and Connelly's (1995) definition of landscape as relationships between people, events, and places. Three rather large issues that emerge from holding these questions as I reread earlier chapters are: restructuring, theory and paradigm dominance, and identity-education. For each of these three landscape issues, we turn to thinking about how what is revealed so far in my inquiry fosters and impedes relationships for nurses.

Restructuring issues are illuminated by Florence and Sara as they notice, from positions of bedside nurse and nursing administrator respectively, how resources are reduced in acute and community care resulting in a shortage of nurses and little time for nurses to know their clients. They see in their daily lives how these elements of organizational restructuring create safety issues for people in hospitals and residential/homecare. When a nurse does not know who a person is, as when Florence worked on a casual shift-by-shift basis, it can be dangerous when giving out medications. When nurses do not spend time to know a person before giving care, patients and families sometimes react with suspicion or express feeling unsafe or uncared for. As an administrator, Sara was called into situations of conflict that seemed based in people not knowing one another. These examples challenge the notion that it takes too much time to get to know someone so it is acceptable to only do task-based nursing. The time it takes to unravel conflicts and to deal with people once they are fearful or self-defensively resistant is at least equal to the time spent in establishing and nurturing relationships in nursing practice. Relationships are fostered in restructuring, as Ginny points out, when new nurses are recruited into the profession with attitudes of entrepreneurship towards knowledge and their practice. With layers of management and supervision reduced and new care delivery models being implemented, nurses in clinical practice have
opportunities to directly communicate what they do and to show the intellectual work of nursing. Ginny values how the contribution of nursing and interdependence with others is made visible through the application of transferable skills to clinical situations. Florence is concerned that too many senior nurses have been removed from the system as she actively searches for experienced nurses in her apprenticeship. Kathie reminds us that nurses have intellectual capacities that have not been appreciated historically. She suggests that restructuring gives nurses the opportunity to more clearly define their own roles and responsibilities in specific situations to maximize time with clients.

Opportunities to be with clients are enhanced as other departments also restructure, and nurses take on non-nursing care.

Relationships are interrupted as a result of restructuring, illustrated by the policy review in my prologue that shows experienced nurses took themselves out of healthcare in the late 1980s, were laid-off in the mid-1990s, and are again in high demand in the new millennium. Retention strategies are mostly limited to the acute care, curative system as public attention is drawn to emergency room back-ups, not enough beds, and surgical waiting lists. Although the current provincial and federal governments are giving money back to the healthcare system, sufficient full-time positions in nursing have yet to be established. As Florence’s experience shows, nurses continue to work on a multiple part-time and casual basis or consider going out of the country at graduation. Helen comments that nurses’ work continues to be divided and allocated more cheaply to less educated workers as the thinking and critical assessment skills of nurses are not articulated and valued. Ginny sees that as private and for-profit organizations establish themselves in our healthcare system, issues of professional practice, access, and continuity of care for clients must be addressed. Yet, Florence points out how nurses feel the tension between going along with agency policies and being the face of the organization, or speaking out to advocate for patient care and utilization of their education. She feels the loss of experienced nurses to teach her how to be a nurse and to mentor her development as a professional. Leaderless at senior levels, nursing is also vulnerable to devolution of other departments’ work.

Now I understand that healthcare restructuring is situational; how it is described depends on a person’s perspective and location. Reconstruction cannot be explored
except related to specific people, events, places, and time. It matters what situation my co-participants and I are in for discernment of what is going on and what the possibilities are. Exploring what facilitates and what impedes relationships shows different facets of a crystal. Who and where you are and what is happening at a certain point in time determine the colour a person will experience from the crystal and the colour a person will add to the landscape. Using this metaphor, restructuring can be viewed as fostering or impeding relationships.

Theory and paradigm dominance refers to the pan-professional and institutional movements to evidence-based practice that privilege theory and are biomedical in nature; and to the corporate/business model for organizational relationships. Nursing literature and research contribute to impeding relationships as theoretical word castles are presented as more real than actual experience. As Constance points out, perceptions of change can be created using ‘reform’ language while the usual practices continue, albeit with fewer people to carry on. Nurses are seen as human capital and clients are buyers and consumers of care in language and models underpinning Kathie’s policy environment. In the past, she points out, nurses were unpaid or lowly paid labour that malleably fit healthcare system needs. It is a struggle to introduce to the allopathic system how nurses can provide alternatives in terms of the care they offer as Nurse Practitioners or in terms of their knowledge about nursing science and healing practices.

However, as Maggie shows in her community development work, relationships are fostered as the inadequacies of theory and corporate paradigm dominance creates space for alternatives, for new ways of relating which change how things are done. Nurses can create theory from practice and be informed by relevant practice theories in the literature—creating a theory-practice dialectic that enriches clinical practice with persons needing care. The conditions necessary for dialogue and change are grounded in practice and in daily life experience as shown with Maggie’s pregnant client. She comes into the office looking for Maggie’s assistance, bypassing the centralized intake systems which overlook personal relationships. Retelling her experience, Maggie shows me how diligent she must be to stay aware and present to individual people in a system that is population oriented. How nurses use language to purposefully reflect on and reconstruct experience, as Constance and Maggie do, enables reform from the inside-out.
Education and identity issues related to becoming a nurse can also be impeded or fostered on the healthcare landscape. As systems break down and barriers fall, if educators teach as we were taught with little reflection and change on our part, then students will learn from out-of-date curriculum. If I stay in my first story of family-centred care, my teaching-learning with students is limited to what I understood in 1991. Students themselves may have out-dated views of what a nurse is and does and, therefore, what constitutes nursing practice and education. The student in my leadership class who confessed her own feelings of failure as a director in long term care shares her understanding of how reflection and reconstruction of my experience in class showed her it is possible to practice in a way congruent with her personal development and to overcome dated views of becoming a nurse. I still wonder about more educated nurses moving away from clinical practice and not self-identifying as nurses. If the connection of nurse-teachers to clinical practice settings is marginal, the possibilities for influencing practice attenuated. Personal issues around how nurses understand themselves as people and as nurses, as well as our competencies related to listening to one another, giving and asking for help and speaking out about resources needed to care for people in the healthcare system, can be implicated in impeding relationships. Florence worries that the conditions of restructuring alienate nurses from one another and exacerbate competition.

The connections between education and identity are fostered in several ways on the landscape. A focus on the intellectual work of nursing encourages a stance of inquiry and allows the possibility that there are different ways to practice nursing. Kathie reports her days are filled with examples of interpreting to policy makers that nurses are thinking and doing in their practice, that we are research oriented and knowledge building, that there are serious implications for people in how we practice. As Constance illustrates, a nursing career can have multiple threads and directions. She has left North American healthcare situations for social reconstruction work in southeast Asia that is calling upon her relational and planning skills as a nurse and her love of travel. Ginny models how choosing clinical foci or settings that fit her changing circumstances makes sense and broadens our understanding that people, regardless of geographic setting, need nursing care for their health needs. Nurses have the opportunity on the professional knowledge landscape to bring their knowledge and skills to social situations, to value relationships,
to make thoughtful choices, to take responsibility for the consequences of our actions—this is a personal way of being that interrupts received identities, habits, and routines. In all our stories, the plotline of bringing who we are to our practice, inward and outward, across time, and from many places shows how everything is personal in nursing.

From my own stories and the stories of other nurses, I have shown how being/becoming a nurse and knowing cannot be separated from each other. And, these two cannot be separated from the context of social relationships. The stories we reveal as we tell each other of our experiences have meaning in terms of what we do with other people. Narrative inquiry has meaning for nursing practice as nurses live, tell, retell, and relive their experiences. A central accomplishment of my inquiry so far is to show through narrative inquiry how being a nurse is autobiographically meaningful and socially significant. Stated another way, personal experience, reconstructed to create identity and knowledge, informs professional actions in social situations and, therefore, has implications for the daily work of nurses with people needing care.

**Exploring Relationships Between Experience and Education in Nursing**

Chapter five illuminates how healthcare landscape stories of reform and restructuring are based on life experience, and since curriculum is life experience, exploring nurses' lives in the landscape is their curriculum. The link between my co-participant Sasha's experience in healthcare restructuring, education as life, and her BScN curriculum is explicated through landscape issues of restructuring, theory and paradigm dominance, and education-identity. How these relational issues play out for Sasha in clinical practice and at school are theorized to be reform that is inside-out, grounded in a daily life. Healthcare restructuring in my terms can only be meaningfully presented if peopled in situ. This is one of the reasons to share the experiences of Sasha; to show how she constructs identity and knowledge by reflection and reconstruction, how she makes choices and how this is her education.

**The End-in-Sight**

My inquiry contributes to nursing education by showing how autobiographically, narratively exploring experience, through reflection and reconstruction of stories in a professional landscape, is education that is foundational for nurses' teaching-learning and clinical practices. Sharing the nuanced specifics of one nurse's experience over time in
home, school, and work settings shows how narrative inquiry matters—in the classroom and to clinical nursing practice. I want my readers to see this point of view with Sasha to answer potential critique that this is only my story. While many interpretations are possible with any story, in chapter five Sasha's experiences and their reconstruction add to our understanding of restructuring on the professional knowledge landscape and to how narrative inquiry matters to nursing education and practice.
Chapter Five

Sasha: A Nurse in Clinical Practice and BScN Education

In this chapter, we see Sasha’s professional knowledge landscape of nursing practice and BScN curriculum through the lens of restructuring, theory-paradigm dominance, and relationship issues of identity and education. As we think narratively with Sasha about experience and education in nursing, relationships between people, events, and places are storied and reconstructed to reveal new possibilities for daily life. Before turning to the three lenses of landscape issues, we meet Sasha and hear how our research relationship was formed.

Meeting Sasha

Sasha is a Registered Nurse with almost 20 years of clinical practice experience who works full-time as a critical care nurse. Pursuing her baccalaureate in nursing, Sasha is also the single parent of two children. As a nurse-teacher, I first met Sasha in a winter 1997 communication class when filling in for an ill colleague. Sasha stood out for me because of her appearance and deportment. Beautifully groomed with dark wavy hair and bright red lipstick, Sasha was the spokesperson for her small work group. They had concerns about the absence of one member who failed repeatedly to contribute promised work.

What caught my attention was the clear and organized way that Sasha presented the issues and the group recommendations without making assumptions or judgments about her peer. Learning this was Sasha’s first course in the Post-RN BScN program, I was intrigued about her because she expressed such clarity about how things ought to be. We met again in a fall 1997 leadership course. This course was largely case study analysis based in nursing, leadership, management, and feminist theories. What I brought to the nursing classroom at that time was influenced by my concurrent doctoral courses in narrative and curriculum with Dr. Connelly and by the educational philosophy of Dewey. How nurses shape and are shaped by their life experience emerged for me as a salient curriculum question. It makes sense to me that nurses are educated to be as self-aware as possible, given they engage in practices that are both intimate and full of potential consequences for the health of clients. What I did not know at the time of this teaching
was how this belief arose out of my own unresolved experiences. I did not understand this about my teaching-learning until reflecting on my family-centred care stories in chapter three of my thesis. Thus, what is true of the student is true of the teacher—self-awareness is foundational for education and practice.

Each week I read a short piece of my own writing to the Registered Nurses in class (Wendy’s Face, Family-centred Care) and invited them to write about their daily lives. I knew from my own experience as a student that life writing (Clandinin & Connelly, 1994) invites critical reflection which would build a body of work toward their final scholarly paper. At the end of the course, Sasha spoke to me about the powerful connections she had been able to make between her personal family experience and her nursing practice. I recognized her as a colleague with whom I would like to talk more.

This chapter introduces you to Sasha, dear reader, as she shows us her professional knowledge landscape through exploration and reconstruction of her experiences. We will see how Sasha’s construction of identity and knowledge, which changes her relationships and actions in social situations, is her education.

**Negotiating Entry Into Research**

After the marks were submitted for the leadership course and assignments returned, I called Sasha to ask if she would participate in my narrative inquiry about Registered Nurses’ experience in reform. She readily agreed and with her permission, using her chosen pseudonym, I draw on Sasha’s writings and on our conversations. Each time we met, I asked Sasha to tell me about her experiences in healthcare reform. This is commonplace language for restructuring and down-sizing in nursing so ‘reform’ is the term I use in this chapter. After checking the volume on the tape-recorder and seeing that the tape was turning, I could be in conversation with her instead of worrying about exact recall of our words. The planning I did before our meetings, and my observations during our time together, were written as field notes immediately before and after each conversation. In this way, information that would not be on the tape was included in my field texts. An example of field text data follows:

I felt empty, hollow as I drove to Sasha’s place for our first meeting.

Starting something very important to me, something that was uncertain, I felt fear. Parking my car on the street in front of Sasha’s home, I saw she
was in the yard shoveling snow. Sasha lives in a pretty neighbourhood with established gardens, mature trees, and well-kept homes. She welcomed me warmly and initiated a hug which surprised and pleased me.

I had wondered what it would be like to connect after last seeing one another in a classroom one month ago (December 1997). Her home is simply and pleasantly furnished without a lot of bric-a-brac. The light coming through large living room windows enhance the glow of her well-polished furniture. The kitchen, open to the dining room through a doorway and to the living room through a window-like opening, was pristine with nothing on the counter tops except some bananas. Looking at the plainness and noticing the contrast with my own penchant for countertop adornments, my body tensed in a sensation of anxiety. I did not know what it meant to have such unadorned counter tops. Was it a decorating choice, a lack of equipment or financial resources, or something I did not yet know about Sasha that led to such simplicity?

After our conversation which lasted about 90 minutes, I drove a short distance and then pulled over to make notes. I was moved by Sasha's tearfulness and sharing with me. I also shared with her from my life about marital separation and single parenthood and being a nurse. I didn't want to talk too much or make interpretations so that she was free to explore her experiences. I tried to stay in an inquiring and narrative place in myself and not to be analytical or caught up in explaining things to reify what I take for granted to be true. I was also very aware of how Sasha's time is valuable and contested. It touched me that she was generous about seeing me in her home and that she agreed to meet several more times. (January 19, 1998, Field note)

Sasha also gave me copies of her writing assignments from our leadership course, including auto/biographical writing, family stories, memory boxes, letters, journaling, imaging, and conversations (Clandinin & Connelly, 1994). These reflection tools are a way to "think back" and come to understand ourselves, a method for making the embodied, tacit nature of personal practical knowledge explicit (Connelly & Clandinin,
Texts created using reflection tools make critical thinking about experience possible. Education, after all, is intimately related to actual experience (Dewey, 1938).

We met six times from January 1998, and after each conversation Sasha received from me a typed transcription for her review. (1) Noticing how we returned to certain topics in each conversation that were more revealing of Sasha’s experience and thinking, I then created a composite written and shaped by us as if they were spoken with a beginning, middle, and end. Sasha and I met in April 2000 to discuss the composite, to ensure accuracy and anonymity, and also to explore how this experience of narrative inquiry mattered to her personally and in her nursing practice. This composite, her writing, our conversations, my field notes, and personal journals are the sources for sharing Sasha’s experience with restructuring in chapter five. Thinking of the healthcare restructuring landscape as a multi-faceted crystal, remember the facets of the crystal are Sasha’s stories of experience which illuminate narrative tensions and plotlines. We begin with Sasha’s experience as a nurse and her workday.

Sasha worked on a medical unit for three years after graduating from a community college diploma program in nursing, in a Recovery Room for 10 years, and is now in the Intensive Care Unit (ICU) of a large, urban teaching hospital. She works 12 hour shifts that divide the day and night at 7:30 a.m. and 7:30 p.m. She is concurrently in a Post-RN BScN program at a university near her workplace. We begin with her worklife.

**Sasha’s Worklife**

Whether it’s days or nights, I get my patient in ICU by 7:15 and by 7:35 I read the chart because I like to know a little more about the person. By 8 o’clock I have to be up and running. I have a strip of paper that I write down all these things I have to do and then the issues to talk about with the team and then you do all your stuff and by 8:30 you start charting on the computer. You start planning your breaks because breaks are three hours to use efficiently—it’s when I do my homework and go to the hospital library. So then I come back from my first break and the doctors do rounds. It is so relaxed compared to the floor where you run around with your head cut off.
I feel confident in what I am doing in ICU and it is not stressful any more which is good. You look after your patient all day or night, talk with the family, try to incorporate them a little more, and by 7:15 you give report. We get people with respiratory failure who are dependent on respirators, have transplants, and multiple organ failures.

At work, we have mothering in common. We talk about how that affects our work. If an ambulance is booked for a patient at change of shift, I cannot stay because of my arrangements for my daughters. And, if I go with the patient on a transfer then I am away from my car which I need to get home. The charge nurse in the ICU factors in the common role as a parent with responsibilities at home which is a change from the past. Before you had to go regardless, it didn’t matter what was happening at home. You’d be threatened with patient abandonment and losing your license if you said you had to get home at the end of the shift. It was mandatory overtime.

ICU is very different than Recovery Room where the goal of recovery is focused and your aim is to do it in an hour, two hours at most. If everybody goes along alright, it’s a nice little package, you’ve done the work, you’ve accomplished a certain thing from beginning to end. We’ve recovered this patient from their anaesthetic, that’s all we do but with the Intensive Care Unit it’s an ongoing thing, patients can be in for months.

I notice how paperwork of various kinds is primary in Sasha’s work. The chart, the list of things to do, the library work for school all involve engagement with written text. Nurses in the ICU are at a person’s bedside constantly charting vital signs, technological and biomedical measurements, healthcare team and family visits. Sasha is with her patient all shift and the evidence of her care is written documentation. Tensions about what to write, who will read it, and how it could be used inform Sasha’s reporting and relationships. Place is fixed for Sasha over her shift—at her patient’s bedside except for breaks when she chooses to be in the library. Any change in place must be negotiated with colleagues so the patient is safely cared for. If the patient is transferred, the nurse goes too, or that is how it was before for Sasha. Now her charge nurse plans for patient
movement taking into account Sasha's family responsibilities. Issues of temporality arise in Sasha's workday. The patients in ICU can be in for a long time in contrast to hourly turnover in the Recovery Room. Also, the 12 hour shifts have a rhythm of caring for a patient, consulting with and reporting to others about the patient, and interlacing schoolwork into breaks. The relationship with the patient and nurse happens intensely for three to four 12 hour shifts and then they may not see one another for three to four days. Relationships in ICU are very direct as nurses work with one patient and family and are included in rounds with the interdisciplinary team. Work, homelife, and school all impinge on one another in Sasha's day. Now we turn to landscape issues identified in earlier chapters as significant to understanding construction of identity and knowledge: namely, restructuring, theory-paradigm dominance, and identity-education.

**Restructuring**

Sasha's story of healthcare reform connects to her anorexia. Sasha considers her work, her personal life, and her past as connected to reform. The landscape as multi-faceted crystal is illuminated by her stories of experience and their interpreted meanings.

Health care reform is all loose ends—it challenges everything we know. When I voted for the Conservatives at the last election, I thought, "I hope I don't regret this." It could impact my job, it's a double-edged sword. But if they do make changes, maybe this will jumpstart me to make changes in my life. I remember marking the ballot and I still believe in reform after more than two years even though it affects me.

In order to reform something, you have to analyze the old and introduce the new and re-evaluate. so from my point of view, there will always be eyes watching you. It's a problem if you look resistant or like you are lagging behind—all those things will be judged on a daily basis. We're in pilot projects all the time, constantly challenged and on display. It's not just going in to work and leaving, it's constant pressure on outcomes.

Reform includes needing a degree to work as a nurse, lay-offs, and a glut of good nurses on the market so it really makes you think. I knew that I needed to change my approach, none of this change is a bad thing—
going back to school will elevate the profession beyond being task-oriented workers and nurses will feel better about their jobs. Therapists and nutritionists have degrees and nurses were getting by. The public were always surprised that I graduated from a community college and it became embarrassing to admit that. Even with friends, they couldn’t understand how nurses from colleges and universities write the same RN exams. It felt weird so I never felt good about that.

When I voted the Premier into office I knew there would be cuts in health care. I wanted to be kicked into changing things, a little kick start. I wanted to resolve my eating issues and my work issues that are about having control in my life. Work and eating are all about judgement and at least with eating, it is something I can control. In a world where people try to control everything you do, I can have success. I can lose weight which is a hard thing to do. It’s a weird way of thinking—no one will like me unless I am thin. If I don’t have a good day, I feel fat and it gets in my way, drags me down. When I’m thin I can put up with the rest of the world and have the energy to deal with the rest of my life.

In the past, no one knew I had an eating disorder. My family didn’t and my ex-husband didn’t. I kept that hidden for over twenty years. My boyfriend Darryl knows all my dark everything. Isn’t that so liberating? He said I didn’t have to tell him, that it didn’t matter. I told him it does matter, it matters to me that you understand me and where I am coming from. I don’t have to keep track of anyone’s secrets. It’s just all out there. My ex-husband still doesn’t know about my eating disorder. To me he wasn’t worthy of knowing that, he wasn’t trustworthy. He could use it against me and I never had that closeness with him.

When I went to my family doctor after my marriage broke up and talked about my eating disorder, that was the first time he knew and I had been seeing him since I was 12. I lost my period as a teenager because I wasn’t eating. When I was a child I was heavy and then in grade 11 I started to control my weight. I was a smart kid and I knew from biology
class that body fat was important to metabolism. I went to the library to read more. I figured because I didn't abuse laxatives or make myself throw up that I was ok. But, I'd lose my hair, had dry skin, was very constipated. I was very cold all the time. I used to hate that but it wouldn't change my behaviour with food.

When I lost weight which demanded great will and restraint, I visually could see my success. People would compliment me and I'd feel good. But this is short-term and it doesn't deal with my feelings. So then I'd lose more weight to get more attention. It's a vicious circle because after a couple of months, everyone is used to my weight. So I would lose more weight, get more attention to build up my self-esteem and that's how your looks become so important—it's the only way to get self-esteem and feel in control. I never dealt with why my self-esteem was so low and why I felt so out of control. When I am feeling wonky, hyper, and disorganized, not eating but thinking about food all the time, I know something is bothering me. I try to figure out what is going on when I am upset and before I take the first bite. I always walk a fine line because I want to be healthy and that has kept me in check compared to others who have gone to far extremes, to near death. I control what I eat—taboo foods never enter my mouth, like butter, desserts. When I was in nursing school we had nutrition courses so I knew what I should be doing.

I told the ICU nurses that I needed time off on Tuesdays. I said my therapy on Tuesdays was about my marriage break-up, they didn't need to know about my eating disorder. But we have an eating disorder clinic at work and sometimes the conversation comes up about an anorexic patient and how they are this and they are that and my daughter did a paper on that for school. I'm listening to all this stuff and I'm thinking, I hope they don't find out that I am anorexic. Could they tell from what I am eating? I don't think they'd understand so I don't share that fact about me with them. They feel like my parents, they wouldn't handle it and couldn't understand it.
My father would go berserk if we took too long to eat dinner, or clean a floor, or get ready for bed. It was all on a time schedule and a judgement—how well I did at school, how well I cleaned my plate, how well I cleaned my room. If you are a good kid, you do it now and you do it fast—in your parents’ timeframe. So now I know that I have these reservations about reform and change because of when I was a kid. I like things to go smoothly. I don’t like my balance of life upset. I react to change so rigidly. I have an extreme reaction emotionally.

I get disappointed if things don’t go as planned and anxious about finishing, like my degree. I cross off courses as I take them. If I learn, it’s a bonus. I want everything to be in place, with nothing hanging loose. It makes me nervous. I’d go nuts writing a paper like you are doing with all the loose ends—all these different people you are interviewing and all these strings flapping in the wind. I want it all closed in, neatly packaged, and placed somewhere. So all the changes at work are terrifying. But patients are individuals and you have to be flexible. I have to talk myself into being flexible because I know I need to chill out and put everything into perspective. My performance appraisals always say I’m extremely flexible and I’m not but I work on it.

When Sasha mentioned her eating disorder in our first conversation, I felt a mild shock course though my body—this was another place where Sasha and I connected. Exploring this issue in a field note, I wrote:

I asked Sasha how it mattered to her that I am fat when being thin is such an issue for her. She said it didn’t matter because she had been fat as a teen-ager, 155 pounds, four feet eight wearing size 20 dresses and 40 waist pants. Now she looks about size two. I don’t feel we are done with this issue yet. I am aware of myself in the conversation with her as a body which is not my usual awareness. What we are sharing reminds me that I am a body, not only a head or personality. Sasha also told me that she had talked with her therapist about the personal experience writing that she did in the course she took with me. Sasha said that she thinks in terms of
separations (black/white, school/therapy) but the writing brought things together. I recognized what she was describing because I compartmentalize in my life too. For me, this is a way to keep a sense of order and to surf the chaos instead of drowning in it. A sense of amazement at our connections, even at this first meeting, pervaded my awareness and I wondered what else would be revealed in our conversations (January 19, 1998).

Reflecting on Sasha’s anorexia. I pause in sharing our conversations. Purposefully avoiding psychological literature about anorexia, I value Sasha as expert on her own health and quality of life (Parse, 1998) and accept her definition of meaning related to triturated eating as a way to gain acceptance and to feel in control of overwhelming emotions. Thinking about anorexia as a narrative sign, I wonder how it relates to her nursing identity, knowledge, and enactment. I see anorexia as withholding nutrition which is a source of fuel and pleasure, purging and controlling body responses to nourishment, silencing body needs, and feeling successful and in control on the surface. Inside is a different story as Sasha is aware of her body as something to be controlled, its desires in conflict with her ideas of how to be and live. Body is denied material reality as if its desires and needs are an object to the mind. How does this affect relationships with others who are also bodies—especially when so much of nursing work is embodied contact? How to be embodied is not only Sasha’s issue as one of my field notes shows:

As I type the transcript of our meeting, I am struck by how aimless I seem to be here, almost like a cheerleader/mother/teacher, not finding the right note of how to be with Sasha. I was struggling to find myself in conversation with her, in my experience of this moment with her. This was partly a function of my writing group’s demise and a phone call from the person who left the group the night before. She suggested that we get together. I was vulnerable and confused but trying not to bring that to my time with Sasha. Yet, my teachery persona was coming to hand all too readily. I was aware of the struggle at the time and tried to ground myself, to centre in my body, to meet Sasha as we talked instead of floating around somewhere above our heads. I wonder if she is aware of any of
this? I wondered at the time if she is going to feel I am wasting her time when she isn’t feeling well and has to study (April 1, 1998).

Reflecting on my experience, I too did not bring who I was into my work as a nursing director. It was a role and a cover story that protected me from exposure at work as someone in difficulty. While I generalized my experience in family-centred care to thinking reform is only negative for nurses, for Sasha, reform is necessary because it is a kickstart for changes in her life. However, there is a tension between reform at a distance in the system and reform that touches a person in a daily life. We begin to see the daily contradictions in Sasha’s life. She holds the apparent contradiction of stirring things up in her life with a job change, therapy, and school, and, at the same time, wanting everything neatly packaged and contained. She works on her flexibility with others, knowing how inflexible she is inside, and she also sees healthcare reform as necessary and as personally challenging. We also see how secrets inform public life—Sasha’s eating issues are her way to have control and success. Her family, ex-husband, family doctor, and colleagues at work do not know about this central feature of her life. Her choice of what to disclose and what to keep to herself is only relieved with Darryl, her new boyfriend. She has decided that if she is to have a relationship with him that matters, she will share who she is and how she is on a daily basis.

Sasha Explains why Healthcare Reform Matters

My first job in nursing was on a medical floor. Sometimes I worked a month of nights and other people got all day shift. It was a huge mess and I was fed up with living my life that way. After three years, I was burned out. It was such a busy floor, two RNs for 31 patients. People went nuts on nights and never slept. Also, you’d call the doctors to come and see someone and they’d deny you had called. I looked around at the nurses who had been there for years and thought if I don’t go now, I’ll never go. The position in the Recovery Room came up and I went for it. I worked part-time in RR and had my children, Stacey and Amanda. When my Head Nurse asked for my goals as part of my performance appraisal, I said to have another baby. I didn’t want to work. work, work like my husband—my family was my life.
While I was in the Recovery Room, there was a debate about which of three hospitals to keep open and which services should be at which site. I think there are too many hospitals and that services should be shared. I couldn’t stand the pressure anymore of wondering if my site would close so I jumped over to the ICU in the largest part of our amalgamated hospital. I have always felt that in health care there is money wasted. In health care, if they wanted it, they got it because eventually the government paid for it. Then one year the bailouts stopped. I thought this is going to be interesting, this is going to cause a lot of trouble because hospitals waste, waste, waste. They build a landscape park and three months later, they tear it apart and build a new building. Opening trays to take out one item, wastefulness, disposal of garbage haphazardly, not considering the environment.

My Dad’s favourite expression is cash on the barrel. If you don’t have the money, you don’t buy it. That’s one of the things my father instilled in us. Look at this, it is two inches long. I always use my pencils right to the end. I always liked these little pencils because it was hard to get a new pencil from my parents. You can’t ask them for money. I always had that instilled in me. you use everything right to the end, be very conscientious. And, hospitals aren’t, so I always thought they were going to be in trouble some day.

It wasn’t a surprise to me that reform needs to happen. It was exciting. Then they started laying off people and I wasn’t upset by that because they started with departments like housekeeping and to me they weren’t doing their jobs anyway. I was a student working in a kitchen in a hospital so I saw the waste that happens there. People would finish their job two hours in advance and hide in corners, pretending to do other work, what a waste. I liked to be busy so I would offer to help somebody. This one woman yelled at me for doing this because then they’d see the work could be done in two hours instead of four. She was afraid they would increase her load. I thought this was wrong. So, with reform, I figured they
would get rid of the loafers and the health care system will be more efficient.

Sasha sees reform as an efficiency measure. Human and material resources will not be wasted. This is reform at a distance related to her hospital. Sasha has choices of where to work because of her seniority and the need for nurses with her knowledge of critical care. However, reform from-the-inside-out is something Sasha is seeking and this is reform that is personal and concurrent with reform at work. One of the reform plotlines that Sasha brings with her to work relates to families and to being believed.

**Being Reported; Being Believed?**

I knew that in ICU you have families to deal with, which is different than in the Recovery Room, so I thought it would be a challenge for me. I thought it was good not to avoid it any longer and to face up to my fear. I hated it on the medical ward because of the nasty frills—the family. For 10 years in the Recovery Room, I avoided it. Families are complicated things. Their emotions come into play and they are irrational, demanding, and time consuming. I also feel that even though some of them are appreciative, the good doesn’t outweigh the bad. I hate being judged and to feel like I don’t measure up. I always feel like I’m being judged and that comes from my family and my father.

As the eldest daughter who keeps the house clean and the family fed under her father’s surveillance and judgement, Sasha’s story of herself as a nurse confuses with her family story. The overlay of past story on the present situation interferes with relationships and application of knowledge. How can a nurse be present to a patient if the situation calls up experience that has not been reflected on or reconstructed for learning?

And what has happened? A family in the ICU has reported me to the College of Nurses for not answering a call bell when I did go to the patient. It’s embarrassing because the Director of the unit and the physician involved met with the family. They didn’t even know who I was because I had just started in the Unit and that concerned me. They would take the family complaints on an even playing field. If you know a person’s character, you might know it’s not in her nature to do what she is
accused of. If you are on an even plane, you are almost found guilty before, like now it’s my duty to prove my innocence.

This is the thing about going back to school. Now what I hear is the patient is not just the patient, the patient is more global than we used to see before. Just like the nurse is more than a nurse. So now I am more positive about the family because all these other factors affect or hurt the patient are part of the package, and that is why I have to change my thinking. Now I try to talk with the family a little bit more. I am starting to see that what they tell us at school is true, it does impact on the patient. I know when I was in the hospital, you feel so vulnerable and when families come in they mean so much to you. And so these people coming in mean a lot to the patient. They are not what I used to think, families as furniture.

But, I don’t want another life learning experience. I have been challenged enough. This family’s accusations were false and the Head Nurse supported me. I was orienting a new RN that day and she is my witness that I responded to the call bell. The doctors were supportive too, yet at the same time I thought there are people out there that can make irrational statements, lies, and what if somebody believes them? I felt like I was called into the school office, like my whole existence is questioned. It was left that the family could call the College of Nurses but no one has ever called me about a complaint.

Sasha is comfortable to present herself with challenges to her flexibility and way of being in the world, but resists the world giving her new opportunities to learn. There is enough to cope with in what she sets herself to do; outside challenges reawaken childhood experiences. She does not have faith that she will be believed and wonders on what basis someone would hear her side of the story. This apparent contradiction in Sasha’s stories shows up again when she talks about working for only the money or just wanting to complete her education and if she learns, “it’s a bonus.” Sasha’s wariness of how she will be judged in her work as the system restructures is a narrative plotline that she continues to explore.
The way I interpreted it was that I always have to prove myself. I never feel like I am competent or that people will believe me. It’s a self-esteem issue. In my family, you’d hear a big rumble from downstairs and my father would come and hit first and ask questions later. You had to give him the right answer, it was always like defending yourself because he’d say, “Why should I believe you over your brother?” So I always feel like why should someone believe me especially if they don’t know me. They don’t know my integrity. That worries me—that I won’t be believed. You know I went to argue a parking ticket and I thought why should the judge believe me? But I put myself in that position where I can argue my point. I feel like I was wronged so I will take it to court—but it’s almost like I believe people won’t give me credit.

For Sasha, being believed requires the other person in a relationship to listen. More is required than having a voice to speak—someone to hear and attend to what is being shared is necessary.

**Being Listened to**

I stand up for myself so I’ll get the confidence that someone listened. it’s a listening issue. It’s a recognition that I count. My daughter will say, “Just listen, Mommy. You need to listen.” All she wants is to be acknowledged, to give her a minute with 100% focus on her.

That’s what I struggle with and what nurses struggle with—we just want you to listen to us. Hear our concerns, acknowledge their validity. For instance, we had two lounges at work but one was taken for the pharmacy. We complained about it and two nurses did speak to the chief physician and a memo came out saying they’d look into it. But what are they going to do? The space has already been renovated. They aren’t going to give it back to us. There’s over 100 staff in the ICU and we have a 9 by 10 foot room with three couches. It’s really squished in there. I think this is interesting because last time you asked me if nurses have a safe place to talk. We have to watch what we say in the cafeteria because it’s more public space.
To make matters worse, our lounge was recently moved to a different floor than our nursing unit is on. This means the family waiting room will also move to the same place—away from the unit. Families get lost now so what do you think will happen with them being on a different floor? They’ll be on the elevators and hanging out in hallways. This tells them they are not a priority for the hospital. Our vision says they are, but they are not. Behaviour is everything—it counts more than words.

This conversation about the lounge comes up everyday because people are so unhappy. The nurses take it as a sign of respect, being treated as a human being. They closed the bigger lounge and left us with the tiny one. We don’t feel like a priority or like we are listened to. That’s how the hospital functions—we are low on the priority list. You don’t have to say in words how you value nurses.

They have a shortage of critical care nurses in the hospital and they are going to put new RNs through a critical care certificate program and pay their salary and tuition. So that’s 15 weeks costing about $10,000.00. I already work there and I paid for the courses myself. So this brings new nurses in but how does it support the nurses who are already here? I think its great for the new nurses, but the hospital is only doing it to suit their needs because they need staff. Why not also look at keeping people? We want to stay, but if you don’t treat people in a certain way and maintain their enthusiasm, you’ll end up recruiting and recruiting and recruiting. I don’t think they understand that yet.

Sasha notices how behaviour and words are not congruent. She values the behaviour as a source of knowledge over the words. When a memo says a situation is open to review but the evidence of construction of one lounge into a pharmacy means the space is gone, Sasha pays attention to the message in the behaviour. She and her colleagues interpret this action to mean the nurses do not matter because they are not heard, reinforced by what is perceived as preferential treatment of new nurses.

What concerns Sasha reminds me of Schwab’s observation that theory removed from “the concrete enquiry which gave birth to it” (Schwab, 1971, p. 512) is what
Clandinin and Connelly (1995) call "stripped-down knowledge claims... (Schwab's) rhetoric of conclusions" (p.8). These empty claims, coming from hierarchical heights at her workplace, are sacred stories, information for staff that is supposed to direct their actions but is so removed from their daily experience as to be meaningless. Clandinin and Connelly conclude that such communication is no longer about substantive issues involving people and moral choices, but rather becomes an issue of obedience and power. In the paradox of experience (we'll look at the issue/the pharmacy is built), nurses in this situation continue to talk about how they feel they are not valued or listened to. This discussion leads us to examine the dominance on the healthcare landscape of theory over practice, organizational hierarchy, corporate practices, and biomedical care over nursing science care.

Theory-Paradigm Dominance

Clandinin and Connelly's (1995) conceptualization of landscape includes sacred, cover, and secret stories. The sacred stories are based on the belief that theory drives practice, that theory is real and that practice must fit into an idea about experience. Cover stories are how people express themselves in public, the stories they tell shaped to show themselves in a positive light. Secret stories are closer to actual experience—they include aspects of struggle, emotion, people's histories, where the teller is part of the story. Sasha's stories of how she eats (or not) and what it means to her daily life at work and home are secret until she is in a relationship with Darryl. My early family-centred care stories are cover stories for example and the later versions are secret stories, told for the first time and they still evoke deep complicated responses when I reread them. Part of the sacred story for nurses is that we implement physician's orders and administrative policies with patients and families. The cover story of competence and certainty allows us to be agents of the hierarchically powerful. But as I am learning in narrative inquiry, it is the secret stories about what happens with patients and their families and with other health team members that are grounding and life-giving. Let's continue with Sasha's stories of relationship.

How Relationships with Physicians and Administrators Matter

In my reading for school I saw that Nightingale came from the military and nurses were supposed to be obedient to doctors. Being
Portuguese you are so obedient to the father. I felt quite comfortable accepting the role so I didn’t go beyond it. I couldn’t see myself as peers with the health team, even though at school they kept saying you are a co-worker. I didn’t feel it, I didn’t believe it. And now I do. What made the switch for me was working in Recovery Room and ICU where nurses are more respected.

On the medical-surgical ward there was no respect for nurses. A doctor could question everything, make derogatory comments, partly because you are new and make silly mistakes or you don’t ask the right questions or you appear unconfident which you are. It’s from that they have this attitude towards you. Only with time and experience, you assert yourself. I found nurses on the ward weren’t confident, their knowledge base was less, and, therefore, not respected. Often a ward is where you go when you come out of school and so you are new. You tend to get younger nurses and the work is not specialized.

But as soon as I went to the Recovery Room, it was a whole different level. All of a sudden they respected you because you were there in the specialty of critical care and you had experience. The physicians didn’t question what I was saying and I could tell them my opinion and they’d take it and agree with it. It was very different. So now I’m in the ICU and the way it is set up they do rounds and they want to know your opinion. You are part of the team and they seek you out. They don’t just go by you, if you are not there or at break, they wait for you because you are considered relevant to the whole health team and that’s huge, this acceptance.

One time my observations were different from what the resident noticed, and the staff doctor said the two of us had to figure it out. He didn’t take sides which is fair. What we decided would make a difference in the patient’s treatment. I thought it was neat because the staff doctor didn’t take the resident’s opinion on faith. It is respectful that they wait
and they want your opinion. They invite you to speak and they listen, it’s like an invitation, it’s very nice and it wasn’t like that in the old days.

Sasha illustrates how where a nurse is situated in the healthcare system largely determines how she is seen and included in relationship and decision-making by physicians. Nurses’ knowledge is more visible when the relationship is more direct—which changes how a nurse stories her identity as anonymous or as unique. Being heard again is affirmed as equally important to speaking out.

The week before this conversation with Sasha, a community college colleague and I were invited to speak at a staff meeting at the same hospital where Sasha works. Here is what happened at that meeting:

We were able to sit at the back of the room and watch the meeting unfold, as Mary and I were later on the agenda. The room was windowless, the door seemed to be locked as people continued to knock to get in, and the lights were dimmed except at the front of the room where speakers waited their turn. The program director, who is a physician, gave some general announcements and then began to talk about money and staffing. He said everyone is so busy and the government is not giving enough money. Then he said, “Nurse managers, I want to remind you that you report to me and I don’t want to hear that you have gone to other VPs or to the president without me.” He told us that he plays tennis with the president and during their last game they agreed that how the hospital has been run by them is fine and they want it to continue. The physician then told the nurse managers that by now they should have their budgets and to get medical directors to sign off because the budgets are adequate.

I was looking at my community college partner and she mouthed silently “power.” I was in a story in my head about male medical oppression of female nurses and then I realized, that’s an old story of mine and doesn’t necessarily apply here at all. This thinking released in me the possibility of understanding why the nurse managers work around him. And if he thinks speaking to them this way will get them on board, loyal to him, and silent
with other doctors and administrators, he is, as Sasha called him, “a silly man.” I told Sasha this story for several reasons but what happened next is one of them. A large woman who wore surgical scrubs and a jacket spoke up. I assumed she was a nurse manager. She asked the physician what he was going to do about the impending and spreading nursing shortage. He didn’t mention any retention measures at all. He agreed there was a shortage and that the system had been part of creating it and that it is a problem. He acknowledged that some nurses and physicians don’t want to work at this hospital.

Then he introduced the impending merger with another smaller hospital and how ‘we’ should all support the staff coming onboard. It was quite clear that they were joining an established place that was not changing—it was only the newcomers with adjustments to make. I flashed back to my San Diego AERA story about how others with differences can join existing groups so that their issues can be addressed. The established members of the group can carry on undisturbed. But as my story of Ariel leaving our writing group shows, every member is implicated in social changes.

Sasha found this interesting she said because nurses at the hospital are concerned about adjustment on both sides, potential seniority and bumping issues, being devalued for being the “old” staff, not being the new kid on the block. In Sasha’s experience, the nurses see how everyone is involved in the organizational changes. Sasha continues:

It would be an overwhelming task to try to change that doctor’s way of thinking. I’ve seen people go underground to get their work done or they get fed up and say, that’s all I have, that’s all I’m going to do, that’s all I’m giving you.

For all the chitter-chattering we did to stop the layoffs, they still happened and nurses are carrying out the lay-offs. Our Vice-President and Director of Education, both nurses, introduced using health care aides instead of nurses and expected the outgoing nurses to orient the aides before leaving. Those women represent everything in nursing I always
hated. They do what the boss says without question because in the end that’s what he wants. But let’s not tell the staff what is going on—what an insult to my intelligence! Do they think I am stupid? Don’t lie to me. I don’t feel an alliance or an allegiance to these women. They are puppets and in the end they were both fired. It angers me, these submissive women in high positions representing nursing.

Listening to Sasha’s experience of betrayal with nursing administrators, I heard her words filtered through an awareness of my family-centred care stories. What stories to live by were her Vice-President and Director of Education telling themselves; how did they make sense of replacing nurses with aides and expecting the nurses to teach the aides on their way out the door? Bearing witness to the impact of female nursing administration on nursing staff, I refocused on Sasha as she continues to explore gender and power plotlines.

I have seen nurse managers lose their job if they protest how the system works. There is no union for nurse managers to hold administration back. They have managers over a barrel unless they are rich or don’t need their jobs. Here’s how I look at administration. There are projects for people to have a job and to look visibly busy. At my hospital they have been cutting for years and introducing new crap. You are so used to it being introduced and then it goes away. Like introducing a nursing theory, one theorist, for the nursing department. It’s not useful information for me. I just ignored it and nothing ever came of it. Now I don’t get stressed out—when they introduced case management and we wrote hundreds and hundreds of care plans—they are in a filing cabinet. No one ever implemented it because there was such a revolt. The nurses didn’t want to do it so it didn’t happen. And then the woman coordinating the project got fired. Maybe it’s more about who you are than gender and power issues? I ask why there are so many women in nursing—are women more compassionate? Are women more willing to put up with the working conditions? Maybe it’s a mothering thing where when one is a child and sick, they tend to go to a mother. Why the mother—because she is more
likely home? So all of these societal things come back. It comes naturally to me to be a nurse. It’s not that hard to be nice to people.

I like having male nurses on the unit. I wish there were more. I think it’s too bad how the division happens—male nurses get male patients and female nurses get female patients. I feel bad for male nurses who are scorned by patients and say they don’t want a male nurse but guess what the doctor is? So a man can be a doctor but not a nurse? Then you are rejected solely by your gender and I don’t have time for that. I think patients should be assigned a nurse and get used to it. Although, some people and children are afraid of men. My daughter has all female teachers and she freaked out when she had a male swimming instructor. Why is this fearful for her?

Again, the apparent contradictions emerge between Sasha’s disdain for patient preference based on gender and her experience with her daughter’s fear. Holding both points of view, Sasha continues to think out loud.

On my street I’ve seen one man who has stayed home with his children. He plays with them, hugs and kisses them, takes them for walks and so he’s doing the same thing as the stay-at-home mothers except he has more testosterone in his body. Is he a different kind of male than other guys? I think our gender impacts how our patients respond to us. I’ve never experienced the bias men do with patients and their families. It’s almost like the public wants nurses to be women.

When I ask male nurses about their experience, they say some patients aren’t that receptive to them because they are men. They find it harder to connect on a certain level. Yesterday, I had a male patient who was dying. Another female nurse and I were taking care of him, listening to him, holding his hand. I wonder if a male nurse would be comfortable doing that? Would they have the same sort of emotional connection? I don’t think so because of how society views men. Our vision of what a nurse is is a female who is compassionate, with motherly instincts. But is
that what we want? Is that what nursing is? Maybe having more men infiltrate nursing will put a spin on how society sees nurses.

Gender categories are not helpful to my understanding of the healthcare reform landscape. Physicians and nurses cannot be stereotyped as only male and female roles as more of both genders enter both professions. In 1989 when I began teaching there might be one man per nursing class. Currently, I have 10 male students in a class. Leaving my old story of generalizations about men and women, I realize life is more complicated.

There are social stories at work, historical factors, organizational issues and that gender, power, oppression frameworks are potential lenses for analysis; they are not THE story. Looking at the young men in my classroom now, I wonder how it is for them to be at nursing school, in a curriculum that is taught almost exclusively by women. Power and gender issues are understood differently when explored narratively as part of our experience as people. Sasha continues:

Our program director is a physician and he gets upset if we have a drink on a table at the patient’s bedside or if we sit down. He makes a comment if he sees us sitting down. What is his image of what nurses are? He’s older and from a country where women are not valued so nursing has all of these influences that can’t be ignored. That’s why its so difficult to change. Its not just our job description we are changing—it’s a whole way of life and a way of thinking. Sometimes it feels too overwhelming to think about. Think about how many years it took for the slaves not to be slaves anymore. How much death along the way? That’s why I make the comment that I’m in this job for the money. I want to deal with the stress of my life, get fulfillment from that, because I’m not into tackling someone else’s mess.

I always resisted labeling me as a nurse. I don’t think of myself as a nurse—I’m not a compassionate person because I am a nurse. I’m compassionate because I am a human being. Why live if you are not going to live? I think people respond to laughter and happiness. You cannot separate who you are at home from who you are at work. I don’t think nurses in general think about this but I believe it.
One of my colleagues and I were taking care of a man together. We rolled him on his side to clean his bottom and she said, “Ok booboo, this is going to feel cold on your skin.” and then she laughed. She said to us, “I just can’t get out of the habit because this is what I do with my baby.” And she cleaned him up with a certain diaper technique that works.

You cannot separate home and work. It just instinctively comes out—who you are. Some nurses wear little earrings and lipstick and have their pens a certain way and are so meticulous. And if you’re a slob at home, then you are a slob at work. Who can ever separate it?

As Sasha questions her knowledge, and her identity shifts, the sacred stories of marriage, parenting, working as a nurse, relationships to power all change. Possibilities that are grounded in Sasha’s learning from reconstructing her experiences emerge as she decides what she will do, what is purposeful for her, interrupting stereotyped relationships and opening genuine connection. She also has the autonomy to decide what she will not do. This is a departure from the story of nurses as healthcare housewives and physician handmaidens. Relationship with people in her care are changed in light of her reflections and movement in knowledge and identity. As restructuring is changing the social situations in healthcare, external structures, and directives for Sasha lessen. As Sasha constructs an identity built on self-awareness that challenges traditional notions of how to live her life, space is open for reform—from-the-inside-out as she becomes more aware of how to navigate through the narrative tensions between stories to live by.

**How the Gender and Power Story has Shifted for Sasha**

My relationship with my father has matured as well. I don’t take everything he says on faith, I see it as his perspective. It’s similar in that with doctors you don’t just take it because he says so. There’s a process you go through now, you have more confidence in yourself, more experience, your knowledge base is different, you’re in a better position to question. I question everything now about the motives of my father. Why does he demand things from me? Why does everything have to be so black and white? It comes from his life and where he comes from so I have to put that into perspective. But as a kid all you want to do is please your
father. What he was telling me wasn't bad advice, but it was too extreme. He told me the duty things, but I didn't get a sense of what I was capable of doing.

It was always duties to perform, very task focused and it's the same in nursing. What in nursing can I physically do—I was quick, efficient, neat, everyone looked all spic and span, dressings done. details were taken care of. But the knowledge behind it, the application, the thinking about what would be best for this person, that's the biggest revolution in nursing for me—what more can I do for this patient beyond the physical things. I think it is the same with my father, looking deeper into the relationship as opposed to what I can do to please my father or trying to understand him. It is more abstract.

Identity and Education

Having considered the landscape-as-crystal through stories of restructuring and the dominance of theory in Sasha's experience, we next consider identity and knowledge construction related to education. Education includes life experience and formal Post RN BScN curriculum for Sasha. She is in a program that allows her to structure the order and number of her courses to fit in with her work schedule and parenting. I asked her to tell me how she got into nursing in the first place.

Sasha's Identity and Knowledge on the Healthcare Landscape

When I was in grade 13 I didn't know what I wanted to do. I thought about being a teacher. My brother was dating a girl who was taking nursing at a community college and he thought it was a great profession. I wanted to do a college program quickly and get on with my life.

I hated the first year and I wanted to quit, but I never quit anything. I said it has to be better because who would stay in the profession? We were taking care of old people—I was 19 and these old people would try to hit me. It was only in 1983, my second year, that I felt like we were doing something important, something worthwhile. I like to do dressings.
You know I like things in order and I used to take pride in puffing them up and completing all the little tasks.

When they say nursing is task-oriented its never bothered me because wasn't my life all tasks? I had to do tasks for my family all the time and that gave me a sense of satisfaction. My sister and I cleaned the house once a week and cooked the dinner every night. So it's all tasks that I had to do and they had to be done a certain way so nursing is sort of the same thing.

It was sort of an accident how I got into nursing but now I like the work. You could never admit this on a school or job application. You have to say something like you wanted to help people. This is how we lie about why we are in nursing. It's not a profession I chose, there was nothing better to do. I knew I couldn't say that in my letter of application. It would be interesting to reread that now. Until I went into my first course in my degree program, I didn't think anything about being a nurse.

Now I think nursing is a reverent profession—very biblical and proper, like royalty. People remember nurses with white starchy collars. It's very proper. The picture or image of myself in nursing is one of a shadowy figure looking in on the intimate and private lives of others. I've often felt nursing has afforded me a place in people's lives at a time when people are emotionally and physically the most vulnerable. It amazes me the impact we have on people's lives and how willing people are to share their innermost thoughts. Difficult moments as well as times of elation are shared—the dying patient or the mother giving birth. The image of myself as a shadowy figure in the background represents to me my continued struggle to respect the private lives of people who are for the most part stripped of their control in their lives during hospitalization. It's a balance I strive for between caring and interference. The image of a shadowy figure gives me a safe feeling—a place where I cannot be judged so harshly perhaps.
Sasha notices how patients are stripped of control in their lives, an issue of personal importance to her. Her presence as a shadowy figure is in response to fear of judgement, yet she also recognizes the impact of being in an intimate situation with a patient. Both nurse and patient come together with narrative threads intersecting. Sasha’s awareness of how this matters influences how she is in relationship with patients, balancing care with intervention. She was also a shadowy figure in her marriage.

**Sasha’s Story of Marriage Connects to Her Nursing Identity**

When I first found out that my husband, Juan, was cheating, we’d been married three years. I would cry at work and the nurses were wonderful. Then I found out about the second woman but it became like old news. Why don’t you leave him? What’s holding you? What is it about him that you love? I didn’t want to answer those questions and I thought if I’m not willing to leave him, then I won’t talk about it anymore. You lose credibility with your colleagues and with yourself when you can’t make a decision. So you choose not to disclose. You know, why complain about it if you are not willing to change it. People are sympathetic up to a point.

One girl I knew was really supportive. She said people don’t know until they are in a situation how they would act. She told me not to be hard on myself, that I would know when it is time to leave him. I struggled for so long to keep something together that I felt I needed to. The image of family and togetherness at all costs. Time and time again my parents reinforced the idea that there were ups and downs in marriage—as if pain and suffering was an evolutionary process of a marriage. No one could see what I could feel. Who was I without Juan? My life had become his life.

When I lost my marriage, I lost my identity. I was the most confused person. I decided at the same time to deal with my eating disorder. So all of that happened at the same time. The psychiatrist who met with me for an initial consultation asked me, “What is your next step?” I sat in the chair facing him and said, “I don’t know. My head is absolutely blank.” It was the strangest feeling, to not even know if you want to be happy or if you want to be sad. Could I even feel that anymore?
I was a blank page, empty, nothing. So I knew I had to be proactive. Let’s try changing jobs, go back to school, do therapy, and it’s gotta be something different.

I read an article by Nunes (2) who said that Portuguese women feel hardship is just one of life’s afflictions, to be endured for the sake of the family. My own marriage reflected that belief. I set aside my own values and opinions to live my life through my ex-husband’s desires. My inability to make healthy choices for myself was rooted in my family experiences with past successes and failures and family role expectations. My sense of negative self-worth evolved over time in a family structure that valued control and respect to a male, either a father or a husband.

I wasn’t ready at first but finally when the decision was made that Juan was going, I didn’t feel nervous. I was excited. It’s actually going to happen, a new life. I felt badly for my kids but not for me. My Head Nurse in the Recovery Room was very supportive. I felt comfortable with her and she gave me the time off that I needed for appointments. I told her what was going on. I was so beaten. I was just surviving—I’d lost my spirit. I’d cry for little things. Then the Head Nurse was moved out and I was devastated. I couldn’t tell my new manager what was going on and that’s when I transferred to ICU.

What I am saying is that I can have some say in what happens and can be proactive in what happens. For me to say that takes a lot because sometimes I don’t believe it and I break down. I wanted a chance to show them I can make it and there were all these factors against me—part-time work, not at school, layoffs at the hospital, getting Juan out of my life. The entire unit at that time got a letter saying we could be bumped. I couldn’t deal with that, I cried and cried. The Head Nurse explained that doesn’t mean you will lose your job but someone could bump you into other work. I felt like a victim because I was the lowest in seniority in the part-time pool in the Recovery Room with 13 years experience. I hated feeling so vulnerable so I moved to ICU before the axe could fall.
My image of myself has since changed. I have made changes in my life that have helped me to value myself. I am no longer married to a controlling male who did not respect me and my value as a person. I have changed my views of nursing and my role in nursing. I see nurses in a collaborative role and as an essential part of a health institution with other health professionals with equal talents to offer.

Similar to my family-centred care stories, Sasha reveals stories within stories as she explores how she embraced healthcare reform. We first learned of her transfer to ICU as her choice to end the uncertainty of hospital mergers and units closing. Next we learned of her challenge to herself to deal with patients' families. Synchronous with Sasha leaving marriage, starting therapy, and going back to school, her supportive manager left the Recovery Room. Now we see how a breakdown in relationships affected Sasha in her own family as well as at work in healthcare.

My mother was devastated when I broke up with Juan because everyone loved him. Mom always used to ask me why I was breaking my head studying when a man would be looking after me. Isn’t that funny? She thought Juan was wonderful because he used to fix things up around the house. She worried about who would do that for me now. I said you should be angry for how he treated your daughter, how he cheated on me and had secret bank accounts and other women. You should be mad at him for all those reasons yet you choose to turn a blind eye. My parents thought because he didn’t beat me we should stay together. What’s love my father said. I was physically ill from this. They didn’t know about my eating disorder. I was throwing up four or five times a day at this point. I stopped the yo-yo when I was pregnant because I wanted to give my children the right start then I would go back to my old ways. In the last three years of my marriage I was bulimic. I would induce vomiting in myself. I had overwhelming hunger by bedtime from not eating, so I would binge and then I would vomit after every meal. I couldn’t physically take any more. It took a year and a half before my parents accepted my marriage breakup, although they still aren’t happy about it.
I borrowed money from my dad to buy my ex-husband out of this house and I pay my father back religiously. He’s thrilled that I have a full-time job because that was the other thing about breaking up my marriage—you don’t even have a real job, where are you going to find a job, they aren’t hiring nurses, look at the market. All his fears, thinking about himself, he’s not going to sleep at night worrying about me. That’s partly why I stayed so long with Juan because I knew his mother and my parents would go nuts. They make it very hard.

My Dad wasn’t going to lend me the money at first—he was finding fault, very doom and gloom, almost like punishing me. There’s never any positive about my going to school. I’m not stupid and I’m a good worker. I have good credentials. But it’s like no trust in me and my abilities. They believe its fate when bad things happen, there’s this magical force that happens that you have no control over. You know, in 1979 I went back with my father to Portugal. 20 years after he came to Canada, and not much had changed in my dad’s previous home. There was still no running water or electricity and I saw the land we would have been expected to take over and grow crops. My life would have been different if my mom and dad stayed. I always admire him for the courage it took to drop everything he knew and loved and try to improve himself in a scary foreign place. His sense of risk and adventure is a side of him I’ve never seen again.

As Sasha told me her story of married life, I wondered at her learning the devastating news of Juan’s affairs and then spending 10 more years with him trying to make her version of family life a reality. And, at the same time, she kept her secret of anorexia from everyone. How does feeling I must stay and make the best of it change how I experience daily life? The tenacity and accommodations required to fit that social story and not to reveal what is actually happening are awesome tasks. I wonder if nurses have that script at work as well as at home. How are possibilities for change held open if the overarching belief is that one must endure? How does this fixed position affect relationships? Pilkington (2000) writes about persisting while wanting to change. She
argues that “persistence and change are two sides of a single rhythm” (p. 10). Based on Sasha’s retelling of her experience, I wonder if she knew she wanted to change but lacked the material and emotional resources to do so or if, as she said earlier, she did not know what would make her happy or who she was outside of her marriage and so did not know what to do. Until she could imagine a life without Juan, a life that did not bring true the doom and gloom of her father’s prophecies, she stayed. This has resonance in her nursing practice.

**Staying With Patients**

I was looking after a lady for five days who had a lung transplant and she was not doing well after being in the unit for a long time. Her sister had put her life on hold and was with the patient everyday. The patient was moved out of a room with a window and a TV into a room with no window. This woman was becoming very depressed and for two days I tried to get her moved back. I explained to them, I wrote it in my report, I spoke to the nurse in charge—like now she’s depressed so it’s a medical reason we should move her. Patient preference isn’t reason enough to move her. That’s how it works and I felt like I failed this woman. She did move on the third day but it weighed on my mind—I felt weighed down with their problems. I personalize too much.

When I explained the delay to the patient and her sister, I felt like I was trying to dismiss the blame. I don’t want the blame on me or for them to think I don’t care or haven’t done anything about it. In one way I’m trying to explain the reasons and I can’t do any more than ask for the move. I don’t know if it’s right to explain the delay to the family either because some people say patients and families aren’t supposed to get involved with hospital politics. The hospital sometimes comes across as unorganized or uncaring. You don’t want to talk badly about something you work for. But how can you not explain your behaviour? I don’t want people thinking badly about me. I don’t want them to think I’m not sensitive to what they are seeing or what they are seeing isn’t valid.
For Sasha, her identity and the hospital’s identity come together in problematic ways. As front-line staff, nurses are the face of the organization as they explain organizational policies, procedures, and physician orders. This conflation of identity is a tension for Sasha as her intentions and actions on behalf of her patient put her in conflict with organizational norms about what information can be shared with patients and their families.

Just as in my life, I want things to go smoothly. I don’t like bad things to happen and just because they do doesn’t mean you were the cause. I take on too much, it’s too much of a burden. It spills into my work—other people didn’t care if that patient had a window or TV. It runs off their backs but I personalize everything. I want to make it better for everyone. That’s directly where I come from in my family—I’ve always had to make everybody’s day better. They all come to me as the eldest daughter. Sometimes I am just tired of that. I feel sorry for myself and tired of worrying about everybody else. I can’t keep up the façade of being perfect. You alone can’t please everybody else.

Again, Sasha refers to the apparent contradictions between her public self which is created out of perfectionism and self-control, and her private self beset by worry and fear of judgment. How is Sasha in relationship with others when pleasing them is a narrative plotline that supercedes her own human needs?

*A Story of Relationships with Patients, Families, and Nurses*

Recently, I was the resource nurse, which means I don’t have assigned patients but oversee the functioning of the unit. There was a man who decided this was the day he was going to die. He was waiting for the rest of his family to arrive. I remember thinking, he is a DNR [do not resuscitate], he’s going to die soon, are we going to stop caring for him like that nurse in my ethics class said? He is a human being and I want to treat him the way I would want to be treated. Another nurse and I went in and rubbed his back, pulled him up in bed on pillows, and gave him a drink.
He had been on dialysis for years and was admitted with extremely low blood pressure and he was so weak he could hardly move. He talked it over with his family and treatment isn't tolerable anymore. He said he had gone on for so many years and he appreciated what the doctors had done for him but they could play golf and travel. He said he had had enough. I thought he made sense. His family was phenomenal; they were wonderful with him. They were teasing and gentle and the father said to his son, "I just want to tell you that I love you." He was just an amazing man and I was in that room so often just wanting to be with him too. I was freaking out too because this man was smiling and was happy about being able to choose to die. He had peace with himself and I thought he was so brave. I learned a lot from him. It was a privilege to have known him in that short period of time.

Another family was going through a similar thing but very differently that same day. A man with a transplant and a short illness was dying. He was swearing and his family was pleading with him not to die. There was a lot of heartbreaking commotion going on. There was a desperate cling-on, cling-on, I love you Dad as if they hadn't had a chance to say that all their lives. They were walking all over the unit, going where they shouldn't, and not calling ahead before entering the unit. The nurses felt they lost control of their space I think. They wanted me to tell the family where they could be and I said, "Come on, this family is in terrible grief. They don't deserve some person flipping out about what room they are in. Their father is dying." And I was proud of myself because in the past I would think it was my duty to tell them the rules and I wonder if I'm wimping out but let's be compassionate for this family. Why should I treat the first family nicer than the second? This second family ran out of time and the man was past hearing them. I know people have different ways of grieving. But I did avoid them. I didn't talk with the second family as much as the first.
Sasha’s awareness of how control can impede relationships led her to hold back on censoring the second family. These two patient stories show how Sasha is drawn into situations—because of personal resonances with professional duty. Sasha is showing us how a nurse’s relationships in the healthcare landscape are shadow-boxing with personal history which complicates being present to patients and others.

**Being a BScN Student**

What I’m trying to do is to be independent and confident and not to fear risk and to accept change, no separating. The theme is my fear of inflexibility, it’s my personal fear of not measuring up. If I don’t fit in, where do I fit? Some people choose to be clueless and that’s not a bad thing but I’m in school and therapy and I look at what’s going on around and I pay attention. In the end I’m not so different from everyone else, but now I pay attention a lot more to what is going on. I never paid attention to the connections until I wrote my personal experience. It’s opening so many more questions that I would never have given the time of day. Everything is interwoven—how you feel about your work, about your homelife, impacts on your mothering and your career. How come we separate it so easily?

A lot of nurses think I am going to school so I can be an administrator. I don’t have any desire to be an administrator. But patient care coordinator positions already require a degree. It sets up two classes of RN. So it’s a threat to nurses who are not financially prepared or don’t want to go to school. What do you think will happen to the nurses without degrees after this? They are not going to be nice about it, at least in my opinion. Nurses without their degree say they can’t fire all of us, but that’s like ostriches with their heads in the sand. They can fire you, they will do it in many ways. They’ll close hospitals, units, without your degree you can’t get back on. They won’t open doors, you’ll be stuck in a job, or they can take away your responsibility like RPNs who have more education than they are allowed to practice with. I’m too young to allow that to happen. I need to be marketable.
There's a nurse at work and she is angry all the time—she's the most angry person I ever met. She yells at the top of her lungs at people and says things like, "What kind of stupid question is that?" When I explain why I asked something, she'll say she's sorry, she made a different assumption. Another nurse said that she thought it was only her who provoked this angry nurse. I'm just beginning to learn about this one—she thinks every patient is a hassle. It's as if she hates being at work. But what's making her hate being there? She must be like that at home too. I'm wondering what's wrong with this woman for her to blow off steam like that? She thinks my friend who works in community nursing is not in real nursing. And she is so against any of us going to school, the angry nurse, the evil nurse. It's the same kind of personality I used to come up against when they would discourage you from going to school because they don't want to go. This is what nurses do to nurses.

Currently, I go into work seven times in a two-week period. Six of those times are a 12 hour shift and the remaining one is an eight-hour shift. I have school for four days in that two weeks so that leaves me with three days off in 14. That's why I have this attitude about school—a teacher annoys me if my time is wasted. I want the path of least resistance because I am busy and I don't have patience for people who waste my time.

I'm not mean about it because I recognize a teacher is a person too and I know how it would feel if someone was telling me what to do, but if she asks I'm going to tell her how she could teach in a different manner. I always think in terms of right and wrong—what's the answer. So when there is no answer I want to know that ahead of time. People can debate, but I want to know the answer. I have never liked courses where there are no answers. I like things to be neat and tidy. Maybe that's part of the problem—I never liked artsy-fartsy courses but I have to be more positive.

I have a specialty certificate and almost half my degree credits completed—isn't that wonderful? I will be finished my degree in the
spring of 2001. I’m dancing about it. At the same time if learning happens, that’s cool. I think in black and white—what is the end? How many courses do I need to complete? In high school, I would have a calendar where I’d mark an X each day and I could visually see it going away and that’s what the degree credits are like. If I learn something in-between, that’s a bonus.

I didn’t start my degree to learn something, I started to obtain completion, a degree so I can continue working. There are certain ideas that are introduced that are interesting, like feminism, looking at the patient in a different way, bringing the family into it. I think about people and it’s like an experiment. God knows if they notice that they are guinea pigs. I decide to talk to a family, like a planned thing, what am I going to talk about, and in the end its never as bad as I thought it would be. That’s also reform—that nursing will have a different face. We will be more valued by the public and by our co-workers if we have degrees, not for the credential but because of a different attitude.

My first university teacher in a communication class asked me to write a self-reflective paper and I went. “What are you talking about?” I couldn’t understand that. She wanted a paper about something that happened to me? I was laughing but it was terrifying at the same time. I was crying so much. It was too fresh for me to talk about something that changed my life. I couldn’t deal with it because I wasn’t dealing with it in my life. It was my eating disorder that I wanted to write about but I couldn’t put it down on paper. In the first class of my first course, when we introduced ourselves, I had tears in my eyes. It meant so much to me, it meant the beginning of change in everything, needing to be different and being different.

It wasn’t until our leadership course that I wrote out the worst experience, about when Juan said he wanted a divorce. My girlfriend dropped by the day I was writing that and I was crying. She was worried about me but it was a good thing. I read it to her and she was crying. I’ve
never put it on paper before and it was seeing it in writing, seeing my life back then. When I worked in RR, people were aware of my marriage problems with Juan. They’d say Sasha you’re an open book but that’s not true. People only show others what they want. It’s hard to put that stuff down on paper and people don’t want to put in the work to find out and know. If you had said we didn’t need to do the writing I wouldn’t have done it. It’s the path of least resistance. But I was curious because you said it may just show something. I had never heard of this before and your stories were so moving. Let’s see what I can write up.

In the leadership class, I was hearing different stuff about being a nurse and thinking about how my work matters. Two of my work friends took the course after me and they came to me about the personal writing and asked what I thought. They said they weren’t going to write a personal paper and couldn’t get over a teacher reading moving and personal stuff. I told them you wouldn’t ask them to do something that you wouldn’t do yourself, it’s confidential, no one else reads it. When I first started writing for that course, I didn’t understand what it was leading to but writing it out made sense because I could see these events in my life and how they related to my nursing. It made a difference. It’s a body of work like you said where I could see my life, how I am. I could connect my life and articles we read and my nursing practice. I have fears about who is going to read this—it leaves you vulnerable if you are 100% honest. That’s why I think diaries are a farce because whatever you write, you have to be prepared for someone to read. Some of my stories that I wrote for your class might hurt someone to read but I can’t bring myself to rip them up. It’s too important to me so I have hidden them away.

So on one hand I’m open but also not. I wonder what people are afraid of about sharing their experience? Is that part of the problem of their resistance? I was really surprised by the reactions of the nurses in your class when asked to write about their personal experiences. They said I can’t do this, it is really emotional. Reading our papers must have been
emotional for you. It would be like reading someone’s diary in world war two. Did you realize the impact of those papers at the time? I think its hard for people. They don’t analyze why they do what they do or why they feel the way they feel. I remember in my first classes, with you and Regina, being asked to reflect, reflect, reflect. I thought it was something new since I finished my diploma education. I was all choked up about it. It is so much work, realizing I have frailties and things I have to work through. I thought my work was separate but it is not. The life patterns I have are reinforced at work—the women are still submissive.

Right from the time I was young, if a teacher or my father assigned something to me, it’s in the back of my head. I actually feel pressure in the back of my head. If I wanted to go for a bike ride or watch TV, I think about it. I’d know I have that thing to do, it’s always there. So to me it’s a means to an end. I know I have to do it. I’ll never be negligent and not do it. I’ll not be flippant about it because I have expectations of myself and I’ll do it thoroughly but if I didn’t have to do it, I’d never do it. It’s not something I would seek out.

When I was reading this composite, I saw your interest is more ‘gee, I enjoy doing this’ and I’m more ‘it’s a means to an end.’ I only do it because it has to be done. I just did this community health evaluation assignment and it really showed us community development and how it actually occurs. The nurse’s role is to facilitate and guide and the community members do the work. So I thought that’s really interesting—something that nurses have done has worked out in the real workplace.

The articles were interesting so that’s the bonus that I talk about, but if I never had to do that assignment, I would never do it. I would never go and seek that information out. So an assignment is just a means to an end, just to get that credit, is that bad? I know that sounds bad.

I want a teacher who is going to go home and think how am I going to encourage these people to learn because if you have a teacher who is just there to make her money that comes through to the student.
Depending on where the student is in their life matters as well because I’ve been in classes where some people have a halo around their heads. They just love it, they just say, “Wow, what a course.”, and I notice women with their children grown up who have gone back to school because they want to stimulate themselves and they come from a different place.

Remember I came from a place where I thought I’m going to lose my job. I’m a single parent. I need food on the table for these kids and I need not to feel afraid of not having money. So that was my motivation plus it takes me away from my priority which is my family. But having said all that, if I have learned something from you, something from the way you presented, that’s totally cool don’t you think? I mean you actually made your goal, it doesn’t matter how I approach it, or where my motivation is at the start. The beautiful thing is I actually learned something and it was ok.

Sasha explains how she is moving beyond the certainty and habit of education as cultivation. She holds the uncertainty of being between stories to live by—in liminal space where paradox resides. The discernment is not in choosing one side or the other of apparent contradiction but is in holding both. and living open to possibilities and engagement in relationships. Parse (1998), a nursing theorist, frames paradox as the “unity of apparent opposites; two dimensions of one rhythm” (p. 98). Paradox is identified by Parse as part of our human condition expressed in daily life as revealing-concealing and connecting-separating. Sasha describes inward knowing about her inflexibility which is concealed and her public presentation that reveals an opposite way of being.

Dewey (1938) suggests that we “go to a level deeper and more inclusive than is represented by the practices and ideas of the contending parties” (p. 5). Reflection on apparent contradictions and reconstruction of experience allows education as awakening and transformation. As Sasha explores and reconstructs her experience as a nurse, as a student, as an ex-wife and mother, possibilities for change emerge. A new identity is shaped by Sasha as she deepens her understanding of how to hold paradox in-between stories.
If you bring knowledge to the surface then it opens up the idea that things could be different so let me look at that too. That’s why I tried to do the case study thing in the leadership course. I thought, “I don’t want to do this,” but that’s just me saying that and my usual way of saying this, so let’s think openly and try it out. right? So you’re right, you have to know how you learn things and it brings it to the surface. Nurses who have all these resistances, I think they can’t physically and emotionally deal with it.

I think you have to realize not everyone is going to follow the same bandwagon. That’s a given. You’ll capture those like me who try it even if we don’t want to and we will learn something. Then you’ll have those who think its great. Then there will be students who are resistant and if a student isn’t prepared to write about it, don’t put it down on paper. People I know as students lie about what they are writing about in self-reflective papers—they lie and elaborate on it. I mean, for example, this chronic paper. I wondered what to write about and my girlfriend said I could write about her because she is diabetic. So I said, “I guess I could write about you, but you know what? That would be weird.” It would be like I was watching a movie. I wasn’t really there. She could tell me what happens but I wasn’t really there to share how I would feel, so it won’t come out right.

We can only fit a form if we know who we are, not the other way around. If you expect nursing to give your life form, you will always be let down—there’s nothing concrete to support you if you don’t have a sense of who you are first. With all the restructuring that’s going on with people in the wrong places, if you are not happy or knowledgeable about yourself, there is no way you won’t be setting yourself up for disappointment. There will be change, there will be things you have no control over. So you have to know who you are as a person in your life. It’s like when there is a new Head Nurse and you present your principles to her. And if she is
wonderful, you share your life with her. And if she is horrible, you keep asserting your principles and not giving in. It is emotionally draining and it chews away at you, always having to reestablish who you are and what you will do and not do. Otherwise, you give up on your ideas, who you are, and just coast.

I changed my life all at once. It was very hard and I thought it was too much—my head is going to explode. But I also questioned if I was giving up with the excuse that life was too busy. So I am reforming my life and while its being reformed in health care, I’m going along riding the wave, surfing it. It came at a time when I needed to change. I’m not fighting the system so much anymore. If this happened seven years before, I’d be fighting the system—why are you going back to school? Are you nuts? You know you won’t make anymore money. That’s how people talked and now it’s different. I’m riding the wave—now I hear. “Oh you’re back at school, how wonderful. It’ll open more doors for you.” I feel that now is a good time, it is exciting. It’s something I needed to do anyway and now it’s supported at work.

*What’s Next for Sasha*

I want to finish school. I don’t want to think about anything else until then. Once I’m done it will be more about me again and the girls. My boyfriend and I are talking about marriage and another baby. There’s no guarantee with the reversal of the tubes, and my age, I’m 38. I have all these concerns so I need to get going. I figure if I feel fine on the outside, my insides must reflect what is on the outside, so I have a total shot at this. I would have the surgery after we’re married. I’m not going through this and having somebody change their mind. But then I’m thinking why would he change his mind? I have this feeling that I want it all. So, I don’t want to think about marriage and stuff until I’m finished school and he is thinking he’d like to move in next March. My girls don’t want to move from this house. I have my referral letter to see the doctor, it’s a six month
wait so I want to start getting information now and then my boyfriend and I will talk and we'll take it from there.

I eat and I still go once every two weeks to my therapist. My boyfriend and I talk about stuff, stuff meaning stuff that comes up. How I feel, how image is still important, I can’t get it out of my head. Being thin is more successful, but yet then I can’t do it the way I used to be able to do it. I used to be able to not eat all day and I can’t do it. I have to eat every five hours. Does this mean I’ve lost my will-power? My therapist said I have my hunger cues back because I am more regular in my eating but I still have to talk my way into eating.

Sasha talks her way into the eating like she counsels herself to be flexible—without this awareness imagine what she would bring to her relationships and daily life. Her secret stories are now in the open and guide her life in ways unimagined when she told the psychiatrist she did not have any idea what makes her happy or sad.

**How Does it Matter to Reflect on and Reconstruct Experience in Healthcare Restructuring?**

When I read this composite, I thought it was pretty good. I thought wow, its my life. I laughed because I thought I was an angry woman back then. I thought I was sort of angry. I sometimes laugh about how I put certain things and how I talked about that angry nurse, it is so funny. I actually said that. “She must be like that at home.” I actually said that—that was my gut instinct. In my diploma education, I learned not to listen to my gut instinct. The teacher made it seem as if, you know whenever you’d write tests and you’d have a gut feeling because you take into account everything you have learned and you want to put it in, but in nursing, you can’t do that. It had to have a scientific reason why.

I remember that my teacher, Regina, talked about intuition in my first degree program course. I’m thinking wait a minute. in this article I’m reading, is this what I think they are saying, this is totally wrong. I’m confused, I don’t understand it so when I asked Regina, she’s like intuition is what’s on, so I’m thinking if I hadn’t been at school I wouldn’t know
this. But everybody back there who hasn’t been to school is still thinking the way I think, so now we’re supposed to think this other way? How are they going to get to know this? I think everything in my life is very orderly, that people know what I know and vice versa. I don’t realize that this nurse is trained differently. I’m only starting to realize that this group was trained differently than this group, everyone is trained different, when I thought that a nurse is a nurse, that it is all uniform.

I think that’s what held my confidence level back. I’d have to double-check with someone to verify and that to me meant we were taking liberties, like doing something before the doctor gave you an order. That was how I can parallel it. I knew it was the right thing to do but I had to get that order first even if I knew the patient needed it. So I would do it and then get the order and I felt guilty about doing that, it’s bad and it’s not scientifically based. Now I know it is ok. I have the ability to know intuitively, but that’s kind of sad because somebody had to say, “Sasha, nurses’ intuitive experiences are valid,” therefore, it is ok to use. Now I’m thinking, ok I can use it. I should have been a stronger person and say bullshit. It should have been like the kid with the Emperor’s clothes—you are not wearing anything. I always believed in rules, everything was rules, right and wrong. I can’t do just anything that I want. I had to be guided by this, this, and this. So now that I know intuition is fine, I can pay attention to it again. But that goes back to how I was brought up with rules and regulations.

And this also goes back to nursing education that does not recognize the experience and knowledge students bring to the nursing curriculum. The traditional view held that students had to be filled up with the content that would make them safe practitioners. Sasha is learning there are many ways to know, including embodied, intuitive intelligence.

There was one question on my exam for my winter course, what does self-reflection do for self-care and for your professional development—give two examples. And basically I am saying that it forces
you to bring to the surface things that are there so you can learn and change, to look at how things are done. It forces you to bring to surface things that are dormant and if you address them you grow as a person. You recognize things that need to change, things that are right for you, even why your actions are the way they are. Depending on where you are in your life, that can be the best thing to do. It so coincided that at the time I was in therapy, I was also in school and it forced me to think about all this stuff. Reform in nursing, everything fell into place. Did it fall into place because there was always reform in nursing or did it fall into place because now I was actually paying attention to it? Did I notice that nursing is changing a lot? I changed jobs because I had money problems but at the same time this changing the job mimics changes in nursing and changes in my life. I don’t think I would have seen the connection unless someone pointed it out. For me, it was just changing the job to make more money, more marketability, the upfront thing.

At school, it carries through the same themes as therapy. Let’s evaluate, let’s figure out why we are doing what we are doing. That’s not how we were taught in my first nursing program. By putting it in writing, it makes you think about how is everything connected. It brings to surface what is inside of you, question why do I do what I do? It makes you evaluate and when you see it happening in front of you, it makes you think about it, not just dismiss it. Even now, my mom’s been ill for two years and one doctor shakes my mom’s hand and speaks to her. I noticed and I wouldn’t have picked up on that stuff before but I see that this is important. It makes my mom feel valid as a person. It is not speaking to me about my mother’s disease in her presence and telling me what to do. The doctor addresses my mother directly and isn’t that what we should do? I wouldn’t have picked that up before.

But I’m thinking, because of what I am learning at school, it makes you think about your actions. Patients are people, and I thought at the time, this is different for me, I thought about it right at the time with my
mother and her doctor. I think it is this degree thing happening in my head because I just did this paper on chronicity and how to treat people. We lose sight of who they are.

All through nursing they said don't label the person and refer to them by diagnosis or organ or like the gall bladder in room 12, but you know even though they said it, it never was practiced. Maybe it's the ICU setting but now they ask patients to bring in pictures of themselves and you get a whole collage of their life before you. I think that is important. I had one nurse say to me that she didn't like the pictures and when I asked why she said it could get in the way, we could lose them, it's just clutter. But I thought I really like it. cuz look, he used to go swimming this guy, look at him with his wife at a cottage, he's so vital, he's old but vital. Look at him now, he's old period. I love it when they bring pictures in. It makes me feel as if they are more human, you talk to them a different way.

It makes me re-evaluate how you say things and I've changed, maybe I'm different than other people because I'm in therapy and thinking about stuff like that. That's who I am and that's how I see things. I talk about it enough that others will listen and then they'll start the ball rolling and it'll make them think. They'll ask what I'm doing and I'll tell them about my chronicity paper about the patient who lived in the unit for two years. There was an interesting thing about stigma. I remember we didn't like the patient assignment or going into his room. We thought his wife was really aggressive and she had to have her way. Well, there's theories about why that happens.

I started telling them about it and how we all like structure and are fighting the clock and never sit down and hospitals are paternalistic and like things done a certain way. We don't like things messy and I'm like that as a person anyway, from my father. I don't want conflict, I don't like conflict, so I talked to them about some of the things in my paper. They said, "Oh, that's really good," and that's how actually I got the idea of
doing a presentation because they don’t know about that stuff. This one essay had to be 12 pages and I had so much material on it I couldn’t fit it all in—so I have more material I could fill in a presentation. Some people need that theory confirmation. That’s how we were educated to believe, that your experience is nothing. We are going to teach you how to be a nurse, before you came into the program, what is that, it’s nothing. You are taught what nursing is, none of your experience before matters, you are not a nurse.

It will be interesting to see what difference 20 years makes because we still have all those people taught in my age group and will eventually retire. Once everyone is degree prepared I wonder how different it will be? We were talking about this at breakfast yesterday, Darryl and two other nurses who both have degrees. My boyfriend’s position was that somehow degree nurses have a lot more knowledge apart from nursing that impacts the whole picture. You are more well-developed as a person, you’re not just one focus. His ex-wife was a nurse and his mother is a nurse. So that’s his perspective.

My friend who went and had back surgery, she was telling me she asked to go home a day early because of the nursing care. She called on the call bell to go to the bathroom and she was left for half an hour. She’s tough and she said to the nurse, “What took you so long? I have to go to the bathroom.” And the nurse said, “You are not the most important person here. There are other people on this unit and their problems are more important.” So I said, “She actually said that?” She said, “I could have fainted and I don’t want you as my nurse anymore, I want a new nurse.”

But they never changed nurses or dealt with the problem and that’s pretty typical because we’ve had families where they want another nurse and they don’t want the family to have that control so they’d rather resolve the matter and just let them know that the patient assignment won’t be changed. I just think there has to be a better way. Why should this woman
have to go through this? This is sad. That’s why I don’t want to tell people I’m a nurse, but if you know me you’d probably think I wouldn’t be like that.

People feel like a factory item, they are out the door, there’s no caring and no one listens, why is that happening? People shouldn’t have to deal with how my friend was talked to. She’s not the easiest person to talk to but why did she have to wait half an hour and then being told she wasn’t important!! Being honest about why you are late is so much better. It goes so much farther. They talk in articles about how patient care delivery impacts on recovery-- did my friend’s nurse miss that lesson at school? What happened there? And if she is an older nurse, she would have missed it because I never heard about it until I read these papers in the last four months. How people are cared for and listened to impacts on how well they progress. They feel better sooner.

It would be interesting to have that situation taped and have the two people involved watch it and say, what’s happening here? Sit down and really think ‘why did I say that to her?’ and, ‘why did that patient have a knee-jerk reaction? What’s been going on in her life?’ Remember she’s bringing in her life and she’s had a hard life. How she talks is a total reflection of that and if this nurse understood that she’d understand that reaction and would she have dealt with it differently?

It’s a whole different approach, but instead you have one dissatisfied client and one angry nurse who says what a bitch patient and life goes on. The only time we get a patient’s life history is when social workers meet with patients and families and interview them before they have a transplant. There is no way with regular patients for the nurse to learn about alcoholic fathers and mothers who leave. When I was a nursing student, I took care of my friend’s sister. She was Portuguese and my age. I had never seen anyone Portuguese who went crazy and why did she go crazy-- because of the stuff I was going through. Father doesn’t let her out, not allowed to date, can’t have friends, come home right after
school, sleeping on the floor, confusion all the time. This is what this girl grew up with. There is no room in the system for us to know all that, that she has never had any proper love. Her mother was dealing with her own thing. Such tough women, no soft edges, and she brings that with her into the hospital and the nurse brings her life with her.

The patient has a valid point. Why wasn’t the nurse there in half an hour? Why couldn’t she say, “I am so sorry, I can understand how you must have felt. I didn’t answer that bell right away for these reasons and I’m here now to help you.” I would acknowledge that this woman has been waiting for half an hour, for crying out loud, to urinate or defecate in the bathroom. Can she think what it is like? It doesn’t make her wrong for not being there for half an hour, nor does it make my friend right for yelling at the nurse. Just explain why it happened the way it did, it’s a really simple solution, but somehow people just don’t get it.

As I re-read this research text, I notice Sasha is speaking very specifically about individuals in particular situations. This is what narrative inquiry encourages—consideration of people in their daily lives instead of generalization or homogenization. Everything is personal—actions in relationships with events, people, and places are narrative signs with situated meaning. No time to know a patient erodes the relationship that underpins safe, effective, and connected nursing care. When relationship is pressured and contracted, there is nothing personal to shape what happens between two people who have, theoretically, a social contract to care.

Beginning my inquiry, I agreed with Chopoorian (1990) that “the world of clinical practice and education, while parallel are distinct...they are different worlds” (p. 25). “Perhaps the most problematic aspect of the separate worlds of education and practice,” Chopoorian goes on to say, “is that the everyday life of both is closed from each other; it is not a shared world” (p. 31). In the sense Chopoorian means, this separation was real for me too. However, in my inquiry with Sasha I have come to understand this compartmentalization is a cognitive device that obscures the connections between education and clinical practice. Reflecting on Sasha’s stories, the disconnection seems more related to the interruptions of restructuring and the dominance of theory as
received wisdom. Identity and education are intimately related as Sasha’s plotlines converge with those of her patients and co-workers. The different places on the landscape are physically separate and yet linked in practical terms—the connections are deeply embedded in our narrative histories and our ability to entertain multiple perspectives in a situation. Conversations with Sasha reawaken my questions about what sense a nurse makes of her experience in healthcare reform, especially in terms of how experience, identity, and knowledge connect to her education.

Sasha encounters her school curriculum as inviting her into liminal space—in-between what she knew about being a nurse and being a student and what might emerge from considering personal experience. She pays attention to her responses of resistance to the change in pedagogical approach and weighs them in light of her awareness that she was purposefully challenging herself in response to social changes. Her identity was not fixed: no longer Juan’s wife, beginning to move forward from having no idea what would make her happy, Sasha explores her relationships narratively. Her awareness about how her body is a template for the meaning life holds shows how embodied knowing, personal practical knowledge, is foundational for education. Becoming aware of personal practical knowledge makes it available for reflection and, in the context of our relationships as teacher and student, then later as co-participants, reconstruction of experience is possible. Exploring assumptions about how to be a nurse and about education of nurses reveals what we deny ourselves and how we shape relationships.

**Relationships in the Nursing Landscape**

“Paradoxes are not problems to be solved or eliminated, but are natural rhythms of life” (Parse, 1998, p. 34), the apparent opposites in a situation take turns being foreground and background and occur together. Liminal space is the place to hold paradox, uncertainty, the inquiry—life is not choosing one side or the other, it is how to hold both while we consider possible actions and their consequences in the context of our relationships. Stories of identity, knowledge and education are all facets of the landscape as a crystal —what have we learned about the landscape through Sasha’s stories of experience? The title of my thesis, ‘Nothing Personal?’, is refuted in Sasha’s experience. She illustrates how her family history, marriage, children, beliefs about her body and eating all inform her work with patients, their families, and other healthcare providers.
Restructuring her identity by leaving her marriage, going back to school, and starting therapy for her anorexia changes how Sasha understands situations and that knowledge allows for possibilities of living never before imagined by her. Autobiographically, narratively exploring experience (which includes many ways of knowing) through reflection and reconstruction is Sasha’s education. She embraces how relational nursing work is based on how school, work, personal life, and her own way of being are connected—her ontology and epistemology come together in her actions.

As a narrative researcher, I ask what I am learning from Sasha, what is revealed by her stories that wasn’t known in earlier chapters? You too, dear reader, may have questions arising from reading Sasha’s reconstruction of experience. For me, the complexity of contemporary clinical nursing is revealed in the minute by minute choices a nurse makes about how to be involved with patients and their families. Sasha chooses how to act based on her knowledge about the woman who was moved to a windowless room, or to restrict the family whose father was unexpectedly dying. Her decision is informed by the intersection of her personal experiences with observations about patients in the common human situations of fear, loss of control, and wanting to be affirmed. This is the basis of empathy and relationship in her nursing practices.

Thinking of Peplau’s (1952) notion about who a person is matters a great deal to who they will be as a nurse, I notice Sasha feels who she is gives shape to her nursing. Nursing, she observes, is somewhat content-free and is a form that is filled by a person. So, who you are and what you bring to a nursing situation matter to how you will behave as a nurse. Reflecting in this way about how we become nurses requires seeing that ‘a nurse is a nurse is a pair of hands’ is problematic. A nurse is not generalizable or interchangeable, as patients are not room numbers or disease labels. Perhaps it is place that determines how uniquely a nurse is regarded. As Sasha points out, nurses on the general medical unit where she worked after graduation were homogenized, seen as similar and often found lacking. It is in the critical care areas that who Sasha is and what she knows is in sharp relief with patients, families, and the interdisciplinary team.

Sasha’s cover story of flexibility and openness with families is presented socially while her private story is the sacred story—pleasing father/husband/doctors. As her secret story of herself emerges into her daily life, Sasha’s education is claiming her own story
which is created in liminal space between convention and new stories to live by. Conceptualizing the landscape as a multi-faceted crystal, Sasha’s light shines in liminal space where paradox resides and as she considers the contradictions, her own story of being grounded in a daily life is illuminated. Her identity, knowledge, and actions are charged with new possibilities.

A plotline of avoiding mess and loose ends creates a position of passive observer, merrily checking off the lists of tasks and duties completed. Reconstruction of Sasha’s experience in our co-participant relationship allows acknowledgement of our personal authority, to see what matters and how our acts have consequences. With reflection, we came to see how our stories shape our actions. We looked into experience itself: opening our ideas and assumptions about what happened to inquiry. Many tensions and possibilities are revealed in thinking narratively about our lives. Identity is a both-and creation; inner-outer, personal-professional, backward-forward, all are dialectically related. A position of inquiry about life experience changes our identities and what we know in a dynamic, ongoing, converging manner. Static notions about fixed identities and correct knowledge are shattered.

Now disagreeing with Chopoorian (1990), I conceptualize Sasha and I as sharing a world. Coming from different places on the landscape, we meet in classrooms and our homes, revealing to ourselves shared plotlines and problematic assumptions. While our public roles and identities may appear disparate, our secret and personal stories converge. The autobiographical meaning of being a nurse and thinking narratively weaves us in threads of temporality, place, and relationships. Contextualizing what is happening to us within a social world of healthcare reform, through multiple perspectives, shows how being a nurse who is relevant is connected to our education. Together, we interrupt the idea that epistemology and ontology are in conflict in nursing by exploring how identity and knowledge construction are experientially based and interconnected.

Given the social environment is always changing, so must our sense of how to be a nurse and what knowledge and skills we bring to relationships and events. Restructuring and theory-paradigm dominance are landscape features and so are internal constructions of identity and knowledge. Sasha and I can mediate what is externally received to shape our actions in congruence with what we consider moral choices. I
began my inquiry seeing reform as doom and gloom and Sasha sees reform as a way to kickstart the changes she desires in her life. She still believes in the intentions of reform and the problematic plotlines have to do with how nurses are treated in a workplace—are they listened to, respected, included? These are more salient questions for Sasha than whether or not reform is a good thing. I now see reform as situational and open to interpretation, lifted out of a plotline where generalizations excuse non-involvement in daily life. To see our part in mutually shaping healthcare situations and to discern the consequences of our actions is a maturing force. We have both called forth learning in our lives through reflection on and reconstruction of experience. Everything is personal.

The End-in-Sight

The end-in-sight is further explored in chapter six. While I can speculate about ‘who cares?’ and ‘how my research matters to nursing education,’ actual responses from nurse-teachers make sense to me. In August 2000, I hosted a reading luncheon with three colleagues. Through dialogue with these nurse-teacher colleagues, the social significance of my inquiry is described. How learning, change, and involvement of nurses in social situations matters to identity, knowledge, and actions is revealed. Chapter six explores how my inquiry matters to nurse-teachers and to our teaching-learning practices.
Chapter Five Endnotes:

1. Timeline with Sasha
Met in April of Winter 1997 course
In class together Fall 1997 semester
January 19, 1998 met for explanation and consent
February 23, 1998 conversation
  Transcript mailed March 1, 1998
March 23, 1998 conversation
  Transcript mailed April 1, 1998
May 1, 1998 conversation
  Transcript mailed
September 8, 1998 update letter sent
October 6, 1998 send her RWE presentation “Including women’s stories in the curriculum of caring professions: post-secondary social services and nursing education”
September 28, 1998 conversation
  Transcript mailed
March 6, 2000 composite mailed
April 10, 2000 conversation about composite
  Transcript mailed April 11, 2000
August 24, 2000 revised composite mailed
January 31, 2001 chapter five mailed to Sasha

Chapter Six
How my Inquiry Matters to my Colleagues who are Nurse-Teachers

In May 1997, I bought Clandinin and Connelly’s 1995 book, Teachers’ Professional Knowledge Landscapes. My comprehensive examinations were successfully completed and my thoughts turned to thesis proposal development. In response to reading about landscapes, I wrote my questions inside the front cover of the book: What are the stories of the healthcare landscape? What relationships play out on the landscape for nurses? What difference would it make if I lived both-and, in contrast to either/or? What is troubling me about how to be a nurse?

Three and a half years later I write my last chapter and understand my inquiry as embodied in my daily life, manifesting some answers to my earlier questions. The discovery process of research brings me to completion for now on the question of ‘how shall I live?’ As a nurse-teacher writing to my colleagues in nursing education, I pulled forward from earlier chapters what has been learned about nurses’ relationships on the healthcare landscape in the prelude to chapter five. The landscape (Clandinin & Connelly, 1995) is conceptualized in my research as “the interface of theory and practice in teachers’ lives,” (p. 4) ...“composed of relationships among people, places, and things,” (p. 5) wherein dilemmas are defined as “conflicting claims of theory and practice,” (p. 6). My inquiry explores how this conceptualization applies in nursing education as I turned to actual experience of myself as a teacher and to Sasha who is in clinical practice and concurrently a BScN student. As we take Dewey’s advice to deepen and be more inclusive when faced with apparent contradictions (my notion of both-and), we go autobiographically inward and contextually outward over time in different places, holding the paradox of daily life in-between stories to live by. This liminal space, which is a place of letting go of certainty and embracing learning, holds different kinds of stories of experience.

Cover stories are found in nurses’ experience with restructuring. Like my first FCC story, the cover story describes literally what happened from my viewpoint as central to the story. The dilemmas are superficially presented in preformed theories of gender oppression. The sacred story is found in relationship issues of theory-practice dominance. The healthcare system and its administration tell staff and patients what will

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happen, what should happen, what the rules are. The physician administrator at Sasha's workplace tells the nurse managers that they are to consider their budgets adequate and that they must get the relevant physicians to sign off without challenging the plotline of having enough resources. The third kind of story is the secret story where education occurs and identity and knowledge are constructed. This is the deepest of the three kinds of stories where paradox is held in liminal space and reform is from the inside-out in the context of healthcare situations. This is what matters about my thesis—nothing personal is a problem and what is personal in narrative terms is what matters to relationships on the healthcare landscape.

Thinking about the social significance of my inquiry and wondering how it matters to my audience of nurse-teachers, I developed an idea suggested by my friend Regina. She proposed that I write a synopsis of my thesis and ask nursing leaders to read and comment on how understanding the experience of Registered Nurses in healthcare reform matters. As my research text emerged from the conversations with nurses, reading research and literature, and discussions with colleagues and my supervisor, a meeting with nurse-teachers, who are my audience, evolved into a read-and-lunch event, similar to a works-in-progress course I had taken at OISE (1). Having approached six nurse-teachers, each of whom bring different theoretical perspectives to their work. I emailed the following letter to them on July 24, 2000 about the idea of coming together.

Dear Friends,

I hope this finds you having a good summer and that whatever sustains you is part of it all! I have been writing my thesis full-time and am so grateful for this time (and that my stamina is holding up). I have a proposal for you as nurse-teacher colleagues and welcome your response to it.

I have written a prologue that gives a snapshot of the last twelve years in terms of government healthcare and fiscal policies, healthcare organization restructuring and nursing policy, chapter one on my phenomenon and inquiry purpose, chapter two on thinking narratively and nursing education phenomenological research in comparison to narrative inquiry from curriculum studies, chapter three which is my own
autobiographically reconstructed stories of experience, chapter four which are seven co-participant stories of experience with healthcare reform and then a composite for my co-participant from clinical practice, Sasha, who is also a BScN student. The last chapter is the “so what” piece and is not written.

My audience is nurse teachers and so I wondered if you would agree to read one chapter, have lunch and talk about how it matters to nursing education, faculty development, curriculum teaching-learning that such an inquiry is being done (in my thesis!). With your agreement, I would tape our lunch conversation. The conversation we have at lunch would inform the “so what?” chapter because you are an embodiment of my intended audience. It also speaks to the significance and relevance of my research in anticipation of oral defense questions.

My idea is to invite you to my place for Thursday August 17, 2000 at 10 a.m. to read a chapter in the comfort of my yard or house and then to have a discussion about your responses and the “so what” over a delectable lunch which I will prepare while you read. Please let me know how the date and idea sit with you. If you prefer to read ahead and come for lunch at noon, that’s another option. I welcome your participation and hope that you are willing/able. If this conflicts with holiday plans, no problem, I will miss you but holidays come first!!

Take care and I look forward to your response.

Affectionately, Gail

Two of the invited nurse-teachers were on holidays and one was immersed in her own doctoral writing. However, three colleagues, Regina, Mina, and Brenda came together on August 17th, arriving promptly at my home at 10 a.m. It was a beautiful sunny summer day and the house felt cool from our new air conditioner. We sat in my living room, the scene of many conversations that are the basis of chapter four. Presenting an overview of my research, a copy of the letter to nurse-teachers that begins my thesis, a consent form (2), and a page with three questions on it (3), I also expressed my gratitude that they were giving me the gift of their time and attention. The prologue and chapters
one to four were written and are substantively what you have read, dear reader. Chapter five was a composite of my meetings with Sasha and did not include research text. The final chapter, the “so what?”, was only a small binder of notes, articles, and saved bits of writing. Each of my colleagues chose a chapter to read based on what appealed to them from the overview of my thesis. Be open, dear reader, to how what they chose to read and what they reveal at lunch are narratively connected. Mina chose chapter two. Regina chapter three, and Brenda read the prologue, chapters one and four, and took chapters two and three with her to read at the end of the afternoon. Each one signed a consent and indicated which name they would be comfortable with in chapter six. They agreed to review this chapter for accuracy and confidentiality.

Mina coordinates all the student practicums in clinical sites for years three and four of our Collaborative BScN program. At the time of our lunch, she was accepted into OISE for a doctoral program in evaluation and measurement and planned to teach a third year research course in the fall. Also at the time of our lunch, Regina had accepted a position as an Assistant Professor in the Collaborative Program. She has a diverse clinical practice history over three decades of nursing and an integrative and expressive arts therapy practice. The theorist she espouses is Margaret Newman (1994) who conceptualizes health as expanding consciousness. Brenda is a doctoral student and teaching assistant in an American university nursing program whom I met at a Research on Women in Education conference. She embraces the nursing theorist Parse, and has a clinical background in critical care nursing. When she wrote to tell me of her holiday plans in the Toronto area, I invited her to be part of my thesis luncheon. Curious and a bit nervous about how they would respond to narrative inquiry and to my research, I poured coffee and left them to read.

Mina took her chapter to the family room at the back of the house where she sat in a wing chair, expressing pleasure at the footstool and the sunshine coming in the window. Regina sat in the living room and Brenda started on a chair in the same room and then read, lying on her stomach on the floor with her feet in the air. Krisst, my little brown cat, came and went over the morning—visiting each one of us in turn. I left them all to their reading by 10:15 a.m. and went to the kitchen to prepare our luncheon.
In this chapter, in-between the dialogue at lunch and the leisurely eating, I bring forward stories of experience and narrative threads which intermingle with our contemporary conversation and with my ongoing life events. As this research text is written in the new year of 2001, we move inward and outward, backward and forward, and visit many places.

While I cooked, chopping and dicing, cleaning and mixing on that beautiful August morning, my son Paul cooked the rainbow trout on the barbecue. He then retired to his studio downstairs, having little interest in fish and mango gazpacho. I had the table set with a green cloth, white and gold china that had been my Mom’s, silver cutlery, and candles. The setting and ambiance were important for me to honour my colleagues and my writing. My love of cooking and my pleasure at sharing my home and my work with colleagues, as well as my anxiety about how they would respond, shimmered inside me.

At noon, we met each other in the dining room. I put the tape recorder on a small table near us and pressed record/start. Our conversation ensued while we ate. Our dialogue is interspersed with the recipes from our luncheon much as Kilbourn (1998) presented dinner preparation as counterpoint to the teacher conversation of Laura and Paul in his book For the Love of Teaching. My voice as researcher-narrator is included within a box format. We open with soup and the question: How does this research matter to nursing education and to your teaching-learning practice?

Spicy Mango Gazpacho
Preparation time: 10 minutes; makes 12 half-cup servings
3 large very ripe mangoes (peel and slice)
1 red pepper (clean and cut into strips)
1 to 2 jalapeno or hot banana peppers (optional) [I excluded them]
½ English cucumber (wash and sliced in chunks)
4 green onions (mostly the white part, sliced)
2 large garlic cloves (coarsely chopped)
½ cup fresh coriander leaves
Grated peel and juice of two limes
10 oz. of chicken broth
¼ tsp Tabasco

Put all ingredients in a food processor and pulse until everything is coarsely chopped. Cover and refrigerate for at least two hours before serving. Will keep well for two days.

Mina: It matters. The research helps you to understand yourself and your life history. That is not something that has been part of nursing education. It needs the support of nursing educators. I was very struck by the example of students being empty and having to be filled up. I was comfortable reading your work although I was emotional. With my background in mental health, I understand that it is important to understand yourself before working with others.

Brenda: Your work is explicating what Parse’s theory says about what it means to be human. I see everything in the world through Parse’s theory—that’s how I understand reality to be. Your work in very excquisitely descriptive ways spells out the meaning of the first principle of Parse’s theory which is all about structuring meaning multidimensionally and co-creating reality. Parse’s theory assumes the nurse has an understanding of herself already through a broad liberal education and reflective processes. Parse assumes nurses are fully formed and ready to be present with others. Your work is a very important piece to help educators to create the kinds of people we need in order to practice that way and to understand how it matters. Your work makes it clear and specific, makes explicit, how one comes to that point.

Gail: Recovering my own historical dullness in situations, going along, doing what is expected. I now see what it means to be aware in a situation, perceiving on many levels. Seeing that what is going on is different for every person in that moment, so the story each of us could tell coming together today, having lunch, would come out of our own narrative histories. I never understood that before. I thought people listened to authority and did what they were told. Writing and rereading my own stories, I’d ask where were you? Wake up! It seems so common sense once it is uncovered but before that I was unaware, doing the best I could.
As Brenda notes, contemporary nursing practice theories assume a nurse is self-reflective, able to be in relationship empathetically, present and listening to a patient's expression of their lived experiences, without saying how it is that nurses become this way. As both Sasha and my stories show, we have much unreflected upon experience in life that can be a source of education but can also just be undigested raw materials. As nurses, all of us have years of experience in clinical practice, and it is possible to do the same thing over and over rather than reflecting and changing what we do with others. In an article that explores "Who is there?" as a question of an individual's identity and relationships with a social world. Rev. Karl (1992) suggests that we need "a language that overlaps inside and outside, individual and environment, who and there, into a between: ...the more the practitioner is rooted in sources that animate the practitioner's being, the greater the capacity to be there" (p. 5) In other words, who we are and what we know are what we bring to nursing practice so attention to this allows the possibility of relationships and healing. Narrative as a process of inquiry, in education and in clinical practice, deepens that capacity in nurses.

Brenda: Well, there is so much meaning in each situation. You can always go back and discover, recreate other meanings that were not as visible before.

Regina: Look at environments which make knowing dangerous—sometimes I have underestimated the wisdom and knowledge of people in certain contexts but they do know and they judge it dangerous—extremely dangerous—to reveal their knowledge.

Brenda: That the meaning of the situation is to not know or not to reveal what you know.

Regina: But also within ourselves, not to really experience or accept what we know. For example, "Oh, I don’t want to know this, it’s going to be very painful," or "I’ll be hurt or threatened or I’ll see what the real dynamic is here," or "I’m disenfranchised or unprotected or not valued." That process served me as a nurse as a defense mechanism for a very long time.
Dear reader, think back to my family-centred care stories and how much I did not know when telling that first version of the story to my students. I had not thought to make the connections between my personal life and my nursing practice as an administrator. Similarly, Sasha lived her life before voting for the Conservatives as if her work was just a job and her family life, held together by sheer will, was a picture of perfection. We tell ourselves cover and sacred stories in order to live each day the way we think we should be living.

Mina: Give me an example of a nurse not knowing.

Regina: Choosing to not know some minor thing that would give you a clue about the dynamics of the situation that is too painful to experience.

Mina: As a nurse?

Brenda: It is a knowing but it is not a reflective knowing—there is an awareness but I think there is knowing that is immediately apparent and available to us and there is knowing at a deeper level but it is still there and buried. I think much of what happens in the world around us is like that. Of course we choose how we relate to the world and how we choose meaning in situations. That is a way of being, when things are very very painful and hard to face. We choose not to be in that awareness.

Mina: What I find about the knowing piece in my personal life. I am different as a nurse. I’m different at York in my role. I’m different at home. I’m different in each case because I can’t be myself, I can’t reveal who I am.

Regina: So you know but bringing it to a working or shared experience…

Mina: To the surface, I know I’m not being true to myself in being different personalities in different places.

Regina: But maybe you could be but you judge the situation as being one where your capability to deal with it, because you don’t have support or comfort or whatever, you have to proceed in a certain way which is alienating in itself but maybe in certain situations is necessary.

Brenda: There is also choosing how to relate to others because of how others are and it’s a co-creation. When I spend time with my father and his wife, I couldn’t be
Brenda—the-nurse because I have a world of meaning that they can't begin to understand. I am this shadow person who they don't understand, who presents to them a side of who they want me to be. They can't begin to enter into who I am because they have no sense whatsoever about what being a nurse means—they are stuck back in the 1930s or I don't know where they are stuck but their view of being a nurse is someone who helps the doctor do his work, his work. They have absolutely no understanding whatsoever that what I would be teaching students is not medical tasks and there is no way of me finding the language to relate because they don't understand the words and the language.

Brenda, like Sasha, has an image of herself as a shadow person. For Brenda, the shadow is in her personal life; for Sasha, it is in her work life. For both, the lives of family or patients seem more real than their own; not to be interrupted by themselves fully in the situation. Paradoxically, both are aware of this presentation—Sasha, in awe of the intimacy of what patients share and her desire not to be intrusive and not to be judged; Brenda, out of respect for her father's beliefs and values. How does it matter to their identity and knowledge that their secret stories construct them as shadows? This image reminds me of paradox—apparent contradictions of dark and light or of foreground and background—both sides of the paradox co-exist and are held in liminal space in a situation. Both the personal and social, being and knowing are present in situations for nurses so their education and research methods need to be able to hold the paradox of life experience, paying attention to ontological and epistemological concerns. As we reconstruct our life stories, integrating new experiences, deeper meanings are apparent and new actions emerge.

Regina: And that's a consciously chosen presentation?
Brenda: Yes. for all sorts of reasons.
Regina: That doesn't mean you are not knowing, that is your way of dealing with the consciousness you have.

**Tantalizing Thai Salad**
Preparation: 20 minutes; makes: 12 servings
**Dressing:**
2 tbsp minced or grated fresh ginger
2 large garlic cloves, minced
2 tbsp brown sugar
1 tbsp oyster sauce
2 tbsp sesame oil
Freshly squeezed juice of large lime, about 3 tbsp.
2 tsp hot sauce (I used Tobasco)

[The recipe also calls for 1/3 cup vegetable oil but I never add it]

Greens:
2 mangoes or 2 lb. Asparagus or snow peas [I use mangoes and one green choice which I
blanche briefly in boiling water]
1 head leafy lettuce
1 head romaine [I use two kinds of leafy lettuce]
1 bag spinach (optional)
1 small head of radicchio (optional)
1 red pepper
1 yellow pepper
2 cups fresh bean sprouts (optional)
1 bunch green onions
2 bunches fresh coriander [I never use this much—more like 1/2 cup]

Prepare dressing one day ahead and refrigerate. Clean and julienne vegetables, toss
together with lettuce and dressing in a big bowl.

Brenda: I had a very real experience with that myself that made me understand how
powerful that phenomenon is. When I was working in Africa, my sister was
diagnosed with breast cancer and she wrote me a letter that described in very
graphic details her mastectomy. She was a nurse herself and she described it
very graphically—about her incision and what had taken place. Anyway, I read
the letter and I was so profoundly shocked, first of all that my sister had cancer
and was so seriously ill, and secondly that I was so far away and couldn’t go to
her, what I did was put the letter in a drawer, and it was as if I had never read it.
It wasn’t until weeks, maybe several months later, that I came across the letter
and it was like I had never seen it before. I opened it up and I felt the shock all
over again. It was as if the situation had happened and yet I had forgotten I had
read the letter. But I knew I had read it because the letter was open and I had this
déjà vu memory of having read it before. That’s how I know that you can choose
not to face the truth because it was too painful for me to come face to face with
it and it is this most remarkable thing.
Regina: I think I am a pretty reflective person and I’m shocked at what is under my nose and then God only knows what permutations happen. What conditions make knowing ok? That was an encounter between you and your sister and a letter. How about between you and a colleague? Or, a patient? How about us? It is rich. I think Gail the risk-taking you are making is an act in itself of exposing your consciousness and also not putting closure—leaving room in ways that other theorists have not done—allowing that more consciousness may evolve. For example, you know that your work is being informed by your life even to the extent that we are sitting here having a meal and talking. What I notice is hospitality seems to be a great theme in your life and a necessary self-expression.

Gail: How do you mean ‘leaving it open?’

Regina: I noticed that your theorizing and meaning making is not finished, it’s still open. I like that because there is still room for people to say, “Have you thought of…” “What about….” And I don’t see that in very much writing. It’s more like, “Oh, now I understand, this meant that.” It’s all tidied up. Again, this reminds me of desert practices of hospitality. I’m thinking of my time on the border of Afghanistan in the tribal regions. Even if you are an enemy, the law of hospitality displaces every other law which allows every potential for relationship.

Gail: I don’t know who read it, but at the end of chapter three, my personal stories. I used finding seashells on the beach in Florida as my metaphor for what was happening for me in narrative inquiry. It bothered me how to tell my own stories without hearing, “Oh, I don’t need to know that,” and “Why is she saying that?”

Brenda: People will say that, there will be some, but many more will say this is incredibly useful and important work.

Gail: Finding the seashells helped me understand—I was looking for beautiful intact ones and then I realized that they are in a spiral and the broken open ones were beautiful too and there is still more spiral inside. In fact I don’t have to disclose beyond what I am comfortable with and people who read it don’t have to go any more deeply into it than they want to, so there is that element of both openness
and at the same time closedness. Whatever you are ready for, do, and I feel that with students too. I want to offer them the opportunity and also the safety that if they don't care to disclose they can write about their meaning-making piece of it without actually disclosing the event as long as in their private writing they have investigated their experience. So that's how I'm hearing what you are talking about. And when I meet with Michael will he see this as I'm not done? So it encourages me to hear you say that it has meaning as written— with openness. There will be no tidying up of experience. Even at the end of the 'so what?' chapter, I'm at the beginning of another part of my life with a group I value highly and the adventure is just beginning.

I am interested in my own position at this point in time—feeling grounded through narrative inquiry in my role as nurse-teacher and, at the same time, aware that thinking narratively means situations are open to forward movement through the uncertainty I call liminal space. Bringing this awareness to classroom relationships, I agree with Dewey (1938) that, “teaching-learning is a continuous process of reconstruction of experience (p.87)…getting at the significance of our everyday experiences of the world in which we live” (p.88). Think again of my multi-faceted crystal metaphor for the healthcare reform landscape—each facet is a story of identity, knowledge, and education casting light on a situation. “By insisting on a political, historically located positional self, we reground knowing in the real world, where we are indeed different and things can and do change…people tell their own stories. Simply by doing so, they begin the process of change” (Minnich, 1990, p. 164-5). Sasha illustrates this when she moves in her conversations from generalizations about nurses to telling stories of relationship between specific people in particular situations. There is no fixed identity or certain knowledge if we conceptualize the multi-faceted crystal as illuminating different places on the landscape, displaying a rainbow of possible colours. In the liminal space where learning occurs, we can appreciate each colour and ponder which of many choices to make in each circumstance.

Mina: How will you finish it—what is the last chapter?
Gail: For me, it ends with how does it matter to nursing education and practice that this kind of inquiry is being done, the subject of our lunch. How do you connect with it or not, what fruitfulness might it have for thinking about your own teaching-learning and your own becoming a nurse-teacher? How would it intersect with your own research which Brenda alluded to by saying her response is in the context of being a Parse scholar—it’s an ongoing process of becoming that is never done.

Mina: What I find—my take on life is that it is a journey, you meet people along the way, serendipitously. When I was reading chapter two, it was affirming of that. It’s a give and take and some people give more and it is not the same person you’ll get from or give to.

Brenda: You’ve mirrored what I experienced of life in a remarkably detailed and insightful way. You’ve laid bare what remains unspoken, known but not spoken in so many lives, so you’ve laid it all out there and it’s all very powerful. I found it was disturbingly powerful because of what it brought to the surface for me. I started at the beginning. I’m a methodical person. I started with the prologue and the first chapter and chapter two and three were in circulation so I read chapter four. It laid bare for me the sense that often wells up in my life of the frustration and helplessness of being able to see things but not being able to fix them and having to be satisfied with only understanding things as they are. Not being able to alter them—at least getting that far is progress because there are possibilities for action. There are possibilities for shaping and choosing how you want to move in the situation. That’s how I understood it and that’s what I see many nurses haven’t gotten that far—they just close down and choose to deal on the surface and not get involved.

Mina: But looking at nurses lives, nurses are feelers, caring, nurturers and in our personal lives, we have a lot to carry so sometimes when you go to work, you just want to go to work and then go home. This introspection is too much work because it brings up the sadness and realities of your life and do you want to do that? It’s like a whole equilibrium, there has to be balance and if you bring it up you take away my skill or my cage or whatever it is I am living in—what are you going
to give back to me? You’ve taken away something from me, you have to give something back. Well how many of us educators in the classroom when we have opened up the wounds or opened up the past because it’s the thing to do, introspection and meaning making, when that student leaves the classroom, they go crying, like what happens? I don’t know if you are aware there was one woman that was devastated by the first day of the caring-healing conference. She was crying and the next day, she was in a crisis at her hotel and it brought out so much stuff and she paged one of the people at the second day who had to leave to be with the first person. So again, it is much the same, it is valuable because it moves you to a different level but again you have to be there and impress on students, you are there as a support system.

Gail: I think that is why it is important to offer choices and to build into that what I’m doing as a teacher—space for the student not to do it my way and not to do it as a have-to. They have to have a choice about the level of disclosure. It’s a given for me that if who you are as a person is who you are as a nurse, you have to be reflective so that part I don’t move on but there is a choice about how you choose to show your reflection or show your knowledge. That’s why it’s important to build choices in and offer levels of disclosure and I also think it is important to share my own work. Regina and I co-taught together in the past and we regularly talked about opening people’s awareness if in fact being closed down is protective for them and how do we allow them to stay there if that’s their choice?

Brenda: I firmly believe you can’t open people’s awareness—it’s a personal choice to be open or not to be open and people who choose not to be open just don’t engage. We see those students all the time who choose to not engage because they don’t want to, they cannot. So the person at the conference—the conference didn’t cause her to feel the stress—the distress is there already, the conference made an opportunity for her to bring to the surface what was already there. It’s a choice to block. I still believe firmly that was a way to choose to not deal with the situation and when I felt ready to face it again, I found the letter so I feel like sometimes we give ourselves too much power to think we have that much
control over students' lives that we inflict upon them pain and suffering—we can provide opportunities for them to think, to grow, and to explore but it is up to them ultimately to take that invitation.

Nurses can undertake an approach of inquiry to their lives and practices. As Sasha reflected with me in conversation about her experiences at school, she named her first courses as opportunities to write what is inside her and not yet shared. She realized how important the place of school was to her, it meant space to go backwards to her childhood anorexia and her marriage and to come forward into her new life as a student, single mother, and nurse. She knows she likes things tied down and tidied up, but took the opportunity in the leadership course to write her life experience to see what she could learn. As she told her friend, “It is alright for me to cry. I am finally writing about what matters.” Sasha responded to the invitation to reconstruct her experience as inside-out reform, changing her identity, knowledge, and, therefore, her nursing practices. Narrative inquiry, for Sasha and me is autobiographically meaningful and socially significant.

Regina: Nurses need to ask themselves, “What are you in this business for?”—this business of nursing is a lot about difficulty, awareness, choices, and advocacy. I ask my students this question a lot.

Mina: What answers do the students give?

Regina: I've heard, “It's a good way to make some money.” So I ask the class is this a lucrative occupation? Reflection is fundamental. Nurses refusing to learn how to reflect is like an artist saying, “I don’t want to think about colours.”

Brenda: It is too much trouble, too stressful.

Regina: Yes, I don’t need to do that. I don’t know why I should know what each colour evokes in me—why should I? I don’t want to know what it means to me.

Mina: That's a good way to think of it.

Brenda: This is what nursing is about so they need to realize that nursing is about human lives.

Mina: And emotions and experiences.

Regina: And most people, whether they know it or not, come to it as an autobiographical task. For example, my own story is one of service before I can turn to my art.
Brenda: My sense of helplessness and frustration is with how nursing has co-created impotency as a profession and with how the system has pushed nursing in the direction that we are going today and the sense of not being able to alter that process as a single person. I wish I could take over the government for a day or a year and make it alright for nursing, but of course that's not an option.

Regina: It might be Brenda, you might be the President's nurse.

Brenda: I read the prologue and that was enough to get me going about the social political context of what is happening. It is the same in the United States—only worse because we have no universal healthcare system. It is very disturbing to me because any rational human being can see that what is happening is grossly wrong and unjust and all of that, but of course we're not governed by rationality. We're governed by the motivation for power and control—that's what drives society and ideologies of political parties are what govern and so we as people and nurses living in society live with those political economic movements which mean that nursing operates in a very constrained and restricted and diminished way for what its potentials are. And yet, having said that, I still believe paradoxically each nurse in each situation with each person has the opportunity to create something very, very powerful and really important, so there are two levels of reality—there's the metalevel of feeling frustrated and helpless in view of the social situation, yet still realizing from my own lived experience of being a nurse that I can make a difference in the here and now with one individual which is what makes it meaningful.

Gail: Well, that is what I was going to ask because you read chapter four which is seven individual's perspectives, did you move at all in that sense of one person can't make a difference, because that's where it moved for me. I started out thinking nursing is going to be dead; killed by reform. Reform is the death knell because it is all economic and lowest common denominator and all of that and there are no other choices—but when I started to talk with other people who see it as an opportunity, some people see it contextually and can at least understand it, some people see it as morally wrong and can say that. I found my own ability then to see other possibilities was awakened because I could see other people's
perspectives which enlarged my own view so you answered my question by saying you have that paradox—on the one hand the worldview seems so grim. on the other hand your own personal experience is you can make a difference in an immediate situation with somebody and that's I think something.

Brenda: Yes but it is always tempered with the reality of the healthcare system restructuring and in that you have all these people to look after (knowing staff nurses do have all these people to look after), the opportunities for them to be with people are constrained.

The intermingling of personal and social is woven through this conversation. What is highlighted for me is how much nurses have choices in situations about how they will be in relationship with people. They can plead the constraints of healthcare restructuring to justify task-based nursing, to show the limitations of specific organizational initiatives, to make each moment spent with someone matter. In each action, there is room for thoughtfulness about how to be a nurse. Exploring nurses' lives on the landscape shows their curriculum, what they bring to their formal education in cover, sacred, and secret stories. For example, Brenda's stories to live by are constructed by the theory she feels matches her experience, which I have named a theory dominance relationship issue of the landscape, presented in chapter five. The sense a nurse makes of her experience in healthcare reform illuminates how identity and knowledge construction connect to teaching-learning. Identity and knowledge are experientially based and interconnected.

Mina: But sometimes even though you are busy on a ward as a staff nurse. if we facilitate the learning of this to the students. you know the moments when you have finished everything and you sit and talk with your peers in the nursing station, maybe learning about this and being aware you would spend that time with the patient. So maybe even if a nurse has five minutes spare time. where in the past she hung out at the nursing station she may go to the patient so it may work.

Brenda: That's what I believe.

Regina: And it is not spare time, it is real time.

Brenda: It's creating meaningful moments.
Gail: It is that awareness over time that seems so important to me. Maybe nurses with heightened awareness would choose their place of work and exit acute care but the conundrum is patients are still there. The idea of a caring-healing place—how can we pull our services out of these sick places and build nursing-run nursing services?

Brenda: Therein is my dream.

Rainbow Trout
Roma Tomatoes with Balsamic Vinegar
French Bread

Gail: So how do we do it? Lunch is how does it matter. the next piece of work is getting it done.

Regina: Well, it matters because we all got nourished today for our dreams.

Brenda: And the fact that we have contact with young people who have great futures ahead of them. Even raising the possibility in classroom conversations helps to inspire sparks of imagination, of ideas, of how to be different, how to make things different.

Regina: They’ve done it in Comox, B.C. They have a nurse-run, nursing agency and physicians are on contract to the nurses and the patients love it.

Brenda: How is it funded?

Regina: It’s a funded project by the Ministry of Health. It is being done in Toronto with Streethealth and Interlink by nurses. The midwives are doing it—doing what nurses dream and they don’t want nurses involved because we’re too tied to the handmaiden role and we’re dangerous to have around.

Brenda: The only limitation is it forces you to privately bill or we need special funding arrangements but that’s the constraint and that’s where power comes in because medicine has complete access to money—a total monopoly. So we could privately bill which is sort of a lousy situation.

Regina: I think patients would balk—it is part of the healthcare system as a project.

Brenda: There is so much need for a place like that.
Regina: Especially with young mothers and their children, from prenatal to 18 years old—a free-standing unit to treat the family—the public would never allow that to be shut down.

Brenda: We should start getting groups together to brainstorm how to make this happen—designing a brochure for our business, thinking of a name and how we could be reimbursed, but that is the stumbling point.

Regina: We have stood by and watched what is happening, the 100 year experiment is over and the medical model does not answer many questions. Nurses because of their proximity to the embodied reality of illness with patients want to do it differently.

Gail: I don’t know who read the chapter with the alternative stuff in it, but when Martha did the keynote at our conference in April, I got the reference from her that said at the rate people are going to complementary therapies, there will be a surplus of traditional practitioners, doctors, nurses, and pharmacists. This is in opposition to the C.N.A./RNAO scenario of nursing shortage—Jean Watson is saying if we don’t get on our own bandwagon, we’re toast—this is exciting.

Regina: It comes out of your work. This is the suffering of consciousness, first you feel the pain, and then you are able to share it and have it witnessed and a new idea—let’s try something else—which for me has always been the reward of consciousness versus the pain which is so awful. Then you’ve got a thread to connect you to somebody else, gee I feel that too. That’s been the progress of consciousness through evolution. I firmly believe that if it did not serve human kind we wouldn’t be as conscious as we are. Gail, your work is whistle-blowing in a way too. Look at your family-centred care stories, what you allowed in your construction from what I read in chapter three, it wasn’t nailed down—it was very fluid. And, you don’t try to talk yourself out of your pain.

Telling the stories of family-centred care was for me, similar to Sasha sharing her marriage breakdown and eating disorder, a way to move out of fixed plotlines and identities. My inquiry has shown how unreconstructed family stories are called up in our nursing practices—over time, in the reflection and relationship of narrative inquiry, plotlines are changed. As our awareness of other stories to live by extended to new
possibilities, previously undreamed of, our lives take on dimensions and relationships that were in keeping with our hearts' desires. Doesn't your heart ache, dear reader, when you think of my great-grandmother Stina who never lived with her love? Her story of marriage was bleak and her son and his daughter carried the plotlines of social convention to my generation. Living daily life immersed in developing relationships with what I have to offer comes to me in my forties. My parenting and teaching relationships are shaped by the notion that young people deserve support and discipline for their unique talents as much as they need to understand social requirements for daily life. I pay attention in new ways, for instance, to the creative talents of my son and students, and build opportunities into our lives together for creative and artistic expressions of knowing. My writing is that for me.

Mina: Your writing flows easily and comfortably. One of your questions was about clarity—it is clear. Now that you have written about it, students will know how to reconstruct meanings from the past and present and change the future. This is a choice for them, how to focus on the whole person, family, life, education. This is a different curriculum, an alternative for students to choose, you give them a how and a why and a choice.

Brenda: I'd say the same thing—nurse educators who use your work as an opening, a gateway, or a way, or a method to relate with students, as well as the content, can help to open opportunities or possibilities for students to make choices about how to be with nursing and how to change the way that nursing is going, how we want it to be, creates opportunities and possibilities through awareness.

Gail: I was thinking that if this is built into the Knowledge of Nursing course, when students come to other courses like Client-focused Care or Philosophy of Nursing, then they can put themselves beside nursing theories and other philosophies. They can integrate or contrast, but what is important to me is that they are in it. So much of the nursing literature about story is about the other person, the student, the patient, so it is always projected out there. That concerns me because if I project my own unreconstructed experience or whatever is
currently active for me in the situation and if I have no awareness about that, I am a dangerous practitioner.

Mina: It is what we were talking about earlier about how different you are in different parts of your life and how to be true to yourself, because you’re not consistent because it’s easier to do or you can’t cope with anymore or the people around you don’t want to see you in that light. At least it gives the students an awareness.

Gail: In your example, would you say that the person is aware of themselves as a whole person and then chooses to be different in different situations because that’s how to survive?

Mina: Yes.

Gail: Or do you think they are actually totally different and separate?

Mina: I’ll use me as an example, I know holistically I know these things, but at home I can’t be that way because it is not comfortable for the people around me, they don’t have an awareness or they aren’t really interested.

Brenda: So it is expedient?

Gail: You’re aware and choosing how much you disclose?

Mina: Yes.

Regina: Probably what is even more painful for me to experience is that there is no willingness to know. They don’t really want to know. That’s even more crushing, it’s not that they have inherent perceptions but that they don’t want to be disabused of their notions. I want to be patient with this because I know my own fears prevent me from acknowledging all that I really know.

Brenda: I think my Dad would like to know but I can’t tell him because he doesn’t understand the language that I speak in, which is the language of theory, because the theory shapes my understanding of the realities with which I work.

Regina: Are they proud that you are a teacher, working in a university?

Brenda: Yes, but they have no concept of what that means, absolutely none, they imagine I think that I teach advanced bedmaking or maybe the latest technique in delivering bedpans but they have no concept of what it is I do. I’ve tried to have conversations with my dad about nurses in the hospital, how they are with
people, how they relate, how they treat people, it is important to the person’s health and he said yea, but that’s common sense, so what a nurse really does is help doctors give treatments and drugs and change dressings and stuff, so the whole human relationship side, he can’t relate to that, partly I think because he’s a man who’s extremely introverted.

Regina: The pain of it is that I struggle to find ways of understanding other people’s lives and it is often painful. Sometimes that curiosity is not mobilized in other people.

Brenda: I understand him very well I think because I made a study of him and I realize he influences me profoundly, but he has very little understanding of who I am.

Regina: So you have to bring forward a different aspect of yourself for that relationship?

Brenda: I have to be who they want me to be. Even though I was with them for three days and it was relaxing and quiet, the strain of having to hide myself and to be who they want me to be—I came back grinding my teeth and doing all kinds of stuff that show stress. it’s very hard. I come back exhausted.

Regina: That’s the way I find nurses are in many institutions. They are struggling constantly to inform the powers that be about their way, their positions about who they are, and those same powers don’t want to hear. It’s too complicated, and so they do all these nervous things, they run around like mice on wheels, trying to vent their frustrations and get involved in the most ridiculous projects because they are constantly trying to explain their view, the possibilities for engagement with patients.

Brenda: The physicians are angry because the role is disintegrating from how they understood it to be. losing control, threatened.

Regina: It isn’t even us delivering the news now, it’s the internet, it’s the consumer society, why would I need you, you’re not what I need anymore.

Brenda: I went through that movement because I was in maternal child nursing when I did my Masters and I joined the midwives who were mobilizing during the grassroots struggle. Midwives were attending home-births illegally at that time. I was part of that movement and agreed with them. We were frustrated with nurses at that time, midwives were taking charge of our destiny. I think they
were right in a way, if they had aligned themselves with nursing, they would have been very stymied.

Regina: It would be the whole credentialed thing—the whole effort to get acknowledged and recognized, to go medical model. It’s a struggle for front-line nurses to facilitate the perceptions of others of who they are and what they do and what their potential is. trying to get changes—how implicated we are in our work to change the consciousness of others.

Berries and Cream:
- Raspberries
- Blueberries
- Strawberries
- Mango
(any fruit you wish)

Whip cream and add 4 oz. cream cheese (leave out of the fridge to soften slightly)
Put a cascade of berries on a plate and a dollop of the cream mixture on top
Optional: drizzle Grand Marnier over top

Regina: What consciousness dare a nurse have?

Dewey (1920/1957) says, “When the liberating of human capacity operates as a socially creative force...making a living economically speaking, will be at one with making a life that is worth living. And when the emotional force, the mystic force one might say, of communication, of the miracle of shared life and shared experience is spontaneously felt, the hardness and crudeness of contemporary life will be bathed in the light that never was on land or sea” (p. 211). But. I want to ask Dewey, what if the ‘menace to organizations and established institutions’ is inside me? What if Brenda and I resist our own liberation of capacity through censoring our experience? Or, as Sasha describes it, compartmentalizing life experiences? How does it matter if nurses keep themselves from making a life worth living and instead replicate narrative patterns that keep them from genuine relationship with others? And, how does it matter to us as nurse-teachers that we know how much that is unspoken informs our public life? For me, I am aware that students may bring the same complexity to class and that our narratives touch at unplanned depths as well as on the surface. Ontological and epistemological concerns
must be attended to in education of nurses because our personhood is the content of the role ‘nurse.’ As we saw with Sasha’s experience, her education is retelling her story to live by, which is created in the liminal space between convention and new identities and knowledge, as her secret story of herself emerges into her daily life.

Gail: That whole issue of how nurses are complicit in the situation bothers me and we are the ones implicated in implementing healthcare restructuring.

Brenda: That’s what makes me furious about the victim ideology of nurses being done to—because each of us are complicit in how we go along with and don’t resist the kinds of things that have happened—we resist in ways of complaining but we don’t do things like getting together.

Regina: I do. I will say that I have, but it’s been dangerous and horrible.

Mina: You know what I have noticed about nurses, they always blame outside.

Brenda: That’s what I mean about victimology.

Mina: Oh, they blame the government, the healthcare system, the physicians, and your own nurses are doing this to you. We spend so much time complaining that that energy should go into creating.

Gail: For me, that’s part of the power of narrative inquiry, and the reconstruction of experience because I now understand how I am complicit based on how I am replicating life issues and so now I can look at a situation, and ask what else is going on here? How else could this go? I never want to do administrative work again because that role to me brings out all the parts of me that would be destructive to relationships, having done the role.

Regina: But Gail that’s a myth to think it was the role—was it the role?

Gail: Well it was both because the situation of administration calls up stuff around authority and power. It was like talking football scores in the Admin Suite with the President, I entered his world, that was the way to relate. I didn’t expect him to enter mine. It was considered rude to bring my world to him. When one of my colleagues was acting VP after our VP left, she talked with the President about me because of problems in the Bone Marrow Transplant Unit. We invited him to a meeting on the unit and shared our experience of caring for seriously ill
immunosuppressed children and he gave us six RNs. My colleague had talked with him about how I ran my units as if the problems and issues were attributable to bad management.

Regina: That’s why I want to say, Gail, it’s not about you being co-opted as an administrator, that’s the back-drop, the coloured lights. When you talk about the person you are is the person you’ll be, it had more to do with consciousness than function or role.

Gail: In other words. I was unaware at that time.

Regina: What I am saying is it is not that you would be a bad administrator, it’s a choice not to be an administrator. You weren’t evil because you were an administrator. I never get that when you talk like that. I don’t believe it and I don’t buy it. It’s not about being an administrator, the story you just told showed you were a good administrator but what was the price you paid.

Gail: We say what we need to hear. I hear it’s not only you, it’s also the situation and things in the situation can story it a different way, you could see yourself and other players in different ways.

Regina: This is a story about consciousness, not about being an administrator. You were a manager when I met you and even though you had just as crushing constraints and serious punishments, you operated differently so it wasn’t a function of you being an administrator.

Gail: So how would it matter that nurse teachers come to see themselves with colleagues in these different ways that you are pointing out to me? Part of the importance of this work is recognizing the dialogue, the input, the friendships, people who point things out, people who sent email responses or read as I write. So how does it matter that in relationship and reflection, nurses share reconstruction of experience?

Brenda: Because having awareness makes clear the choices that you have and opens up possibilities for how to be different or to create change. Without the awareness, you know things are there but it is only in a tacit way, you know the reality that exists but it is never made explicit. it’s never clarified, never raised to direct awareness, having awareness brings opportunities for change.
Mina: It gives you choices, you can remain the way you are or change.
Brenda: Or you can choose to change.
Gail: And also I heard in our earlier conversation things that we dream about might actually start to sound like we can work on them and do it.
Regina: Things that I only dreamed about—the other thing that helps me about being aware is that I have someone to be aware with, someone to hold the light for me while I am struggling to see because I can’t move the light. Consciousness is sometimes impossible without others sharing in it.
Brenda: So structuring meaning multidimensionally is co-creating reality, Parse has it so right, her first principle. It is so authentic and so real and so powerful. No one else has distilled that reality into one short phrase before. Human life is so amazing, interesting and so mystifying. It always boggles me people’s reactions to ideas that are radically different. That’s why I feel I have to be careful who I disclose to that I am a Parse scholar because it creates such hostility and attack. People are violently hostile, angry, bitter. Back in the Middle Ages Parse would be burned at the stake for saying things that are heretical, yet everything she says seems so real, right and true to me. Of course, I am extremely biased.
Mina: Again, we lose sight of the respect we should have for one another. Our thinking and our theories, it is taught in school but not lived.
Gail: That’s one of my concerns about feminist theory which I embraced uncritically and loved and still have a lot of regard for. But I didn’t want to come into the thesis with a gender analysis because my gender analysis is so unconscious of experience and immediately puts people into roles and categories which is men are this and women are that. That’s the problem with those kinds of theories, you go into a situation already putting the story of that theory onto the situation instead of saying what is happening here? What does this remind me of in my own life, in the literature or theory? Back to that point that Annie Dillard made about not letting in the actual experience because we’re so busy with the word castles that we already know what is happening.
Brenda: I love Simone de Beauvoir’s Second Sex, have you read that? Because I think her take on women’s reality is so right. That’s my take on feminist theory. Her
theory of women is that we construct an identity based on being Other to the male but not seeing that as woman as victim but seeing it as women contributing to their ‘otherization,’ to self as other, and perpetrating that and how that women themselves become oppressors of other women. The only way that is perpetrated is through women’s complicity and giving up their power and identifying with the Other. It’s so real to me that that’s what happens. It’s true that all the ways we learn gender, the descriptions in the feminist critique, it all happens but its not because we’re powerless victims, but because that’s how we choose to live and the only way it is ever going to change is if we choose to be different.

Gail: And coming to understand how to be different.

Brenda: That’s your piece.

Gail: One of the ways is narrative inquiry, another way is Regina’s course on creativity and health, coming to awareness in other ways.

Regina: We don’t have time but I’d like to talk with you about the administrator thing—I made detailed notes so we can talk again. I’m honoured to be in your work. I credit you with the investigation you did around that stuff, you did the best you could. You weren’t unethical as an administrator given everything that was happening. You were like a plant coming through the earth to be conscious and what you do—there’s too much blame instead of straightforward documentation of what you were trying to do. I feel you are judgmental in the writing in a way you wouldn’t be about anyone else. It wasn’t by virtue of you mishandling your power or using it inappropriately or whatever, you did have some instances where you were pressed down and it was either you or—it was a crime about to happen and you just happened to be on the scene.

Mina: Do you want our notes? Your title is curious for me because everything in it is personal—this was very nice. thank you so much.

Regina: Was it what you wanted it to be Gail?

Gail: Yes.

I said ‘yes’ in answer to Regina’s question and at the same time had so much more to say. Yes, in terms of colleagues reading and responding to my work. Yes, because I loved creating the luncheon in my home. Yes, although I did not have
preconceived outcomes for our time together, what emerged is similar in process to how my thesis is being constructed. Writing my thesis, I move from being in-between stories to live by, in liminal space where paradox resides, to holding open multiple possibilities, discerning my course of action and the consequences. It seems my mother was right. I am a teacher. And, I am learning to story my identity to include researcher and scholar—a writer who narratively inquires into daily experience. And. I learned how my inquiry matters to several nurse-teachers.

Writing my Last Chapter

Describing the Healthcare Reform Landscape

There is a story of healthcare reform revealed in the 12 years of social and economic policies presented in the prologue to my inquiry. Because there is no discernable plan for healthcare reform or for health human resources (Donner, 1997), and because the players and resources change, cycles of enhancements and downsizing repeat over the years. Employers expand and contract the nursing workforce as the most efficient way to effect their financial bottomlines. Nurses’ social situations and worklife issues are of concern concurrently with shortages of nurses and, at that point, recruitment into the profession becomes a priority. In the 1990s, features of the landscape included: organizational down-sizing, amalgamation, and restructuring in institutional healthcare. Administrators and nurses in management positions implemented financially-driven directives that resulted in front-line nurses being laid-off, redeployed to other units, bumping more junior staff, hired back in casual or part-time roles, and replaced by less educated, lower paid workers who performed nursing care as tasks.

Nursing leaders in regulatory, labour, and professional nursing organizations at provincial and federal levels responded to changes in healthcare from restructuring and are proactive about primary care reform. In times of nursing shortage, government consults with leaders of nursing organizations and implements financial and policy incentives for additional nursing staff. Intervening between government and nurses are employers who decide how to allocate new resources and how to respond to policy directives. As economic factors are the primary focus in healthcare restructuring, it is very difficult to create a reform agenda that includes other issues and players beyond the
conventional. Since strategies for retention of experienced nurses require organizational changes in terms of who is included in policy-making, how decisions are made and communicated, and how all the professions relate to each other and to patients, little attention is paid to this dimension of the healthcare landscape. This is not a situation for the faint of heart.

Given the multiple and competing tensions embedded in healthcare situations for the largest group of healthcare workers, understanding how nurses make sense of restructuring and their own involvement in it is worth exploring. The literature and research on healthcare reform show plotlines for nurses that are hierarchically enacted and hold out the possibility of nurses coping or adapting with the system as it is. This same literature presents the landscape as a place where things are done that make it difficult for nurses, but does not inquire into how nurses understand or stay in their situations. Reform is seen as negative events to which nurses must react. The literature does not suggest interpretive frameworks for understanding healthcare reform experience or strategies for what to do. Published studies do not show how researchers and participants are changed by their inquiry, apprehending new ways to live.

Coming to my inquiry disconnected from nursing, both in practice and in the literature, I did not understand what choices nurses have beyond complying with or leaving their situations. Thinking I was in a separate world from my nursing colleagues in clinical practice, withdrawing from the dramatic changes in the hospital sector, I did not have a story to live by as a nurse. My identity as a nursing administrator was so problematic and filled with tension that I left full-time hospital work in 1989. While I waited for a less messy situation to arise, I began to teach part-time in a nursing degree program and returned to school myself. In this context, I proposed to explore and describe the healthcare reform landscape as foundational to understanding how nurses’ identity and knowledge are constructed. As the landscape is conceptualized through stories of relationships between people, places, and events, these same stories would reveal how other nurses and I are in relationship with our social situations and what stories we tell ourselves to live by.

In order to understand and explore the healthcare reform landscape, my autobiographical and other nurses’ biographical stories of experience are told and retold
to discern how our relationships inform construction of identity, knowledge and actions. Stories of professional meetings are also presented to illustrate the healthcare landscape. Plotlines and narrative tensions emerge from considering the dimensions of inward and outward, backwards and forwards, and place. In my inquiry, I ask how does it matter that RNs, as persons in a daily life, narratively reconstruct stories to live by in healthcare reform. My thesis explores nurses’ lives, foregrounding experience and its reconstruction showing how identity and knowledge are narratively composed and expressed in nursing praxis. I further inquire into how understanding the healthcare reform landscape of nurses informs curriculum and teaching-learning in a baccalaureate program.

Recounting a story of being at AERA in San Diego, questions of meaning arise. Are nurses, like the hotel maid in the women’s washroom, in uniform, taken for granted, exposed to others’ embodiment, and sometimes at risk for personal harm? Based on how I felt disconnected from nursing and listening to the presenter who contended that it is those with differences that need to do the work of inclusion, I wonder if nurses are on the outside with our noses metaphorically pressed against the window glass, hoping for an invitation inside—perhaps, like me, under the impression it is possible to be uninvolved. On my trolley ride, not wanting to engage with the older woman and her walker, I question my choices about how to be in relationship. These issues show the dimensions of landscape relationships for nurses, foundational to our identities and actions in healthcare reform.

At the beginning of my inquiry, I was introduced to my great-grandfather. John Wallace Stirling Duncan. The story that unfolds between him and my great-grandmother introduces me to the notion that experience, which may fly in the face of convention and expectations, is the basis of identity and knowledge construction. Taking this into my life requires movement beyond righteous isolation and being frantically frozen to understanding the connections between people, places, and events. As McMahon’s (1991) work illustrates, family stories inform nursing identity and actions with others. Excavating family history and telling family stories reveal plotlines that show up in nursing work. In my own stories of acting like the parent substitute with good intentions, I impose on others and through reconstruction move to possibilities of engagement.
Exploring my own difficulty with how I am in the parade on the landscape, I tell of living with a cover story as a nursing administrator. In retelling the layers of stories, each one closer to the bone, a convergence of sacred and secret stories is revealed. Becoming a nurse through default, being educated that theory determines practice, and disconnected from the significance of my experience, I now write my education. As my life deconstructed in the late 1980s, I did not know what to make of my experience. Attending the nursing consultation in the early 1990s, I see what happens when experience is shared and disrupts the cover story. When nurses are asked for input about education of new and existing practitioners, our multiple roles, settings, and education levels became evident. The paradox of not speaking and yet resisting closure of the government consultation manifested as a narrative tension for me in that hotel ballroom. How does it matter for nurses to include themselves as shaping the landscape?

My understanding of the healthcare reform landscape shifted considerably with reconstruction of my family-centred care story. Questions emerged that included me in the situation and that included others with their narratives of life experience. I came to see my plotlines of acting as I thought I should, not upsetting anyone above me in the hierarchy at the expense of those below, and living a cover story while feeling the daily tension and fear of exposure of my secret story. My nurse-teacher identity is constructed by interrupting my cover story and the sacred story of how to live my life. Out of awareness comes stories to live by that are self-reflective in two senses of the words: an identity that is experientially based and interconnected with others, and a manifestation of myself in situations.

The healthcare reform landscape as described in chapter four challenges and expands my understanding. Seven nurses share their stories about coming to be a nurse by telling us how nursing is enacted in their daily lives and retelling the meaning of these stories. Nursing practice is autobiographically meaningful and can be explored through reconstruction of daily experiences. Kathie suggests that it is nurses with experience who are holding the system together and worries about what will happen when they retire in the next decades. The landscape as illustrated by co-participant stories shows how change happens in reflection and relationship. In contrast to conventional teaching about change as if systems act in stages, my research shows how people decide whether or not to
participate and how they will position themselves relative to new proposals. What influences people in their decisions is as much about family stories and other personal experience as it is about institutional or professional directives. Sara’s being restructured out, Florence’s experience with older people, and Ginny’s with community agencies show purposeful positioning in times of change which allows nurses to respect their patients and their certificates to practice.

Relationship with people needing healthcare is a primary issue for nurses in the landscape. Time to spend with others to get to know them, to establish what their concerns are, and how best to address them is constrained and interrupted by lack of continuity in shiftwork and place due to restructuring. When Florence works in different homes for the aged, according to her casual shift-by-shift workstyle, she does not know the residents by name and cannot safely give nursing care. She is not known by the administrative staff and so is labelled difficult or slow and is not invited back. How we enter different places in the landscape and how relationships are formed and sustained is altered by sacred stories of theory and paradigm dominance. Helen and Kathie spoke of the devaluing of clinical work at the bedside and how staff do not know one another with just-in-time, casual staffing. Both feel healthcare organizations are frozen with rules from the past that no longer fit. Ginny shares her perspective that nurses’ identities have shifted while the infrastructure within which they work replicates its past--doing what has always been done but expecting different results. Or as Constance points out, using language of reform to shape perceptions while not actually doing anything differently.

Nurses’ identities and knowledge are reshaped and reshaping the healthcare landscape. The landscape presents opportunities to affect change at all levels and in many places. Constance works with policy-makers who steal her project’s money and won’t come to meetings. She also works with grassroots groups and people in their home communities, teaching and consulting with others so that they will take care of themselves. As she points out, every time there are system changes a nurse needs to evaluate and potentially reposition the relevance of her work. Kathie’s metaphor about current surgical practices is instructive. People have same-day or overnight admissions for procedures that have a small incision, although much has been done inside the body. Recovery happens at home and with whatever community supports can be arranged.
Landscape changes come at nurses in the same way—fast, quick turn-over, not much surface damage but deeply felt rearrangements and excisions.

*Back to the Beginning?*

I laughed out loud when I read the following sentence in Annie Dillard’s (1999) new book, “For the world is as glorious as ever, and exalting, but for credibility’s sake let’s start with the bad news” (p. 8). This reminded me of Sasha saying we learn much more from the sadness in our lives than from the joy. Well, as I write chapter six, I am back in hospitals again with students from the first Collaborative BScN Program in their fourth year Integrative Practicum. My hope is that we will all, students, Sasha, and I, finish our degrees at a similar time this year. Meeting with the students and their preceptors at their workplaces, most often on the hospital wards, I am in situations similar to those that were so problematic to me at the beginning of my inquiry. I again feel and smell and see patient care. I hear the phlegmy coughs, smell the urine, see the half-empty linen carts where neat piles have transformed into hurriedly grabbed heaps. I stand at the nursing station awaiting my student at the appointed time, not wanting to interrupt anyone as they all look so preoccupied and busy. At our meetings, the students confess their fear and excitement about doing real nursing. In my body, I feel the tensions. I recognize the pull of the ‘real’ world for the students, the credibility gap related to theory that opens for some of them with their preceptor RNs, and my wish to engage with the preceptors in ways that sustain their interest in the students’ learning. Grounded in my inquiry, I pay attention to how we three construct a story to live by for the three months that our lives intersect.

The preceptors vary in deportment. Some are calm and talk easily about the student’s development and opportunities on their unit for learning; others have a pressured air and deconstruct practice so the student learns by caring for the seven intravenous lines or five blood transfusions, awaiting the moment when total patient care assignments will be appropriate. A few watch the student and I with what feels like disdain when we talk about theory-informed practice. These preceptors tell me that students need only technical skills, biomedical knowledge, and speed to survive in a demanding healthcare world. All the preceptors, however, responded when I asked them to share how they approach being with the student in service of learning patient care.
Hearing the rationale for their way of being with the students on their particular unit is humbling. It opens me to accept the different ways of clinical teaching-learning the students encounter as they move beyond fear of failure into the framework provided by their preceptor to support them. These RNs, who are with our students full-time for three months, can name their practice-based teaching-learning theory, often derived from experience with other students. This thinking moves me to my future in nursing education research where I will explore how students, preceptors, and faculty teach the clinical practice of nursing in a human science paradigm. In contrast to my San Diego story, I am in this situation, in relationship with people in their particular places, restored about how to be in the healthcare landscape through narrative inquiry.

Is my Inquiry Still Relevant?

Recently, I was in the library of one of the college partners in the Collaborative BScN program. Imagining some of my students in this environment in their first two years in the program, I headed for the periodicals section. Having collected current journals in nursing education, theory, and various kinds of practice, I sat on the floor, leaning on a big cement pillar with the articles fanned around me. In a nursing administration journal, I found the latest research by Aiken (Aiken et al., 2000), one of the researchers cited in my earlier thesis chapters. These authors assessed the changes in acute care organizations from 1986 to 1998 by surveying chief executive officers, nurses, and hospital association data on nursing staffing and patient mortality.

Fifty-seven percent of chief executive officers "reported that their hospital had, in the past five years, designed and implemented a hospital-wide re-engineering program...Personnel were reduced in roughly 90% of restructured hospitals...declines in the proportions of RNs on units occurred in roughly 70% of the restructured hospitals...25% of the restructured hospitals laid off RNs during restructuring and nearly half lost RNs through attrition" (Aiken et al., p.459).

Nurses in 1986 thought they could "spend time with their patients and provide quality care, this was true of only half the nurses in the twelve hospitals in 1998" (p.461). The nurses in 1986 "perceived that they had the opportunity to participate in policy decisions...this was true of only 60% in 1998" (p.462). There is a strong relationship reported between RN staffing levels and direct patient outcomes; "the higher the staffing level, the lower the death rate" (p. 462-3). Aiken and colleagues (2000) conclude that:
What we know about changes in organizations and the potential for those changes to affect patient outcomes pales by comparison to what we do not know. However, this is itself an important finding; we are subjecting hundreds of thousands of very sick patients to the unknown consequences of organizational reforms that have not been sufficiently evaluated before their widespread adoption (p.463).

The next step for these researchers is analyzing data from more than 20,000 nurses related to how changes in nurse practice environments have affected patient outcomes in hundreds of hospitals in the United States, Canada, Great Britain, and Germany. So far, “findings from our study of magnet hospitals suggest that restructuring hurt caregiving in a set of hospitals with excellent nursing care and patient outcomes, without any apparent offsetting positive outcomes” (Aiken et al., 2000, p. 464). The healthcare restructuring landscape continues to be described as events, largely negative, happening to nurses, without mention of how nurses shape their ability to care for people.

In another contemporary study, psychologists Greenglass and Burke (2000) sent a mail-out questionnaire to almost 4000 RNs in Ontario in the second half of the 1990s. Their findings indicate that:

Nurses were experiencing high levels of restructuring and downsizing in their hospitals, including budget cuts, layoffs and closed beds...the more a nurse perceived that restructuring had lowered healthcare quality, had negatively affected working conditions and staff morale, and made it more difficult to provide services, the higher his or her depression, anxiety and somatization (p. 158).

They conclude that “restructuring can be stressful and anger-provoking” and that “distress increases with more restructuring initiatives” (Greenglass & Burke, p. 160).

Articles about healthcare restructuring in Ontario continue to be written by nurse researchers who use questionnaires or focus groups to survey nurses about worklife issues (Blythe, Baumann, & Giovanetti, 2001; Spence Laschinger, Sabiston, Finegan, & Shamian, 2001). The concerns identified are similar to those of nurses in my research. The landscape is characterized by interrupted relationships with peers as patients (Sara’s story), larger workloads (Helen’s story), casualization of work hours (Ginny’s story), and uneasy relationships with administration (Constance’s story). The recent articles call for policy action on behalf of nurses and for devising empowerment strategies “to enhance their ability to practice effectively in hospital settings” (Blythe et al., p. 61).
This current research shows how healthcare reform is change and restructuring, not improvement for patients or nurses. As recently as the late 1990s, nurses are consulted through questionnaires about different organizational initiatives and their responses, with the resultant general conclusions offering little to a nurse who is questioning her future. Nurses are not conceptualized as individuals with the capacity to interpret their situations, to construct identity and knowledge. I am left with questions raised earlier in my thesis—how do nurses make sense of their healthcare situations? How does it matter that nurses inquire into their own experience as a source of learning and education? Even the most recent healthcare reform research does not inquire into the stories nurses live by in professional landscapes.

My research, a narrative inquiry, stays grounded in the daily lives of nurse-co-participants such that nurses define meaning and action for themselves. As we saw with Sasha’s story of experience, she is neither powerless nor unaware of larger system issues. She has concerns about the action of administrators who are addressed in recent articles as the problem-solvers for restructuring issues. Conversations with nurses wherein experience is reconstructed reveals a multi-faceted crystal of stories—all of which affect how a nurse stories herself in daily life. Research and administrative interventions that fail to engage the personhood of nurses continues the top-down, externally imposed, other-driven agendas. As we saw in my first transit story, such well-intentioned efforts miss deeper layers of what else is happening in situations to motivate people’s actions.

My narrative inquiry offers nurses in different roles and settings the means to reflect on their experience, to discern possibilities, and to act—even in landscape situations that are constricted. The relationship between who I am as a nurse and my experience in healthcare reform is a personal/social dialectic. Both are mutually informing and shaping. My inquiry into nurses’ experience of reform remains relevant. As the largest public service, human resource group in healthcare, in the face of a worldwide nursing shortage, we need to understand how nurses make sense of their experience, which connects to their construction of identity and knowledge and to their BScN curriculum. As a nurse-teacher, I now comprehend how experience in the landscape can be reconstructed as foundational to nurses’ formation of identity and retention in the profession and practices of nursing.
How it Matters to Reconstruct Experience

Restructuring in healthcare can be described by listing all the changes of policies, funding, processes, personnel, techniques, and equipment—but these are meaningless in the sense that they are only a list of things or events. It is when specific changes are explored in the context of particular situations that include people with narrative histories, such as we explored in chapter four, that meaning and knowledge can be discerned. Experiences of daily life inform the relationships between people, places, and events in the landscape. Who a person is and where she/he is positioned in the tapestry of relationships on the healthcare landscape matters to how that person understands her/his life. The landscape as a multi-faceted crystal, defined by my inquiry, has 12 surfaces made up of landscape dimensions (people, places, and events), relationship issues (restructuring, theory dominance, and identity-education), education (cultivation, awakening, transformation), and stories (cover, sacred, secret). Each of these dimensions is present in my family-centred care stories—nested within each other on the landscape. The light of reconstructed experience shines through the crystal and different colours are illuminated. The most intense colours arise from secret stories of identity, such as Sasha and I revealed as our education, that transform the landscape. Do you, dear reader, find this transferable to your situation?

Thinking narratively of within-without, backwards and forward, and of place, Connelly and Clandinin (1999) see identity formed at the intersections of the three dimensions. I would add to this conceptualization. Before the intersection that births new stories to live by is liminal space where apparent contradictions are held, to be wrestled with or embraced (6) as the old story no longer fits and the new story has not yet emerged. As I write this chapter, my son struggles with the decision to stay at a new school where he likes his peers and teachers and does not get the marks he feels are commensurate with the work he is doing. We are out of district for the school he left last spring and so he has submitted an application which will be entered into a lottery for a space for September 2001. Held in liminal space, full of feelings, trying to be aware of all the information available to him, he is between stories to live by. An honours student at his first high school, aware of the reputation of the private school, a member of the 2003 double cohort, it is apparent that there is no clear choice or easy solution for him. Both
decisions have advantages and disadvantages as he replays the possibilities. Living the uncertainty is the answer while waiting in liminal space. This place is where the potential for learning abides. It is possible to live, as my stories showed, in dislocation and loneliness but that is a plotline that can be changed. Education, in terms of my inquiry, is creating my own story to live by in the liminal space between convention and new stories. Identity and knowledge are both-and creations, authored by nurses who shape and are shaped by their social situations.

As the nurses you have met in my thesis tell and retell of their experiences, we see the liminal space wherein new stories to live by are created. As Sasha describes, she had no identity at the end of her marriage. She chose to investigate her life at school and in therapy to understand and to create a new story for herself. Reconstruction of experience is reform-from-the-inside-out. Within liminal space, we reflect on our experiences, hold apparent contradictions in their complexity, and in relationship name possibilities for our future. My thesis writing is such a place for me. My sense of how to be a nurse in the healthcare reform landscape, acknowledging unknowing and uncertainty, is explored through my inquiry. As a teacher, I reflect on my practice to expand my own awareness and I work with students, holding with them the uncertainty between stories, resisting the urge for premature closure of decision into certainty that might close out undreamed of options. Mitchell and Pilkington (2000) describe a similar tension in clinical situations between theory-based and evidence-based practice:

Some nurses have worked diligently to achieve the image of certainty, as shown in the substantial efforts to define nursing as the diagnosis and treatment of human responses (p. 33)…The evidence-based initiative will merely continue to distract nurses from the inherent ambiguity where practice flourishes in the give-and-take of human messages. Evidence may provide direction in regard to bio-physiology, technology and cost-containment, but it will not help nurses to be thoughtful, open practitioners who are willing to embrace the inherent ambiguity of human situations (p. 34).

While these authors suggest that nurses embrace Parse’s (1998) nursing theory as a practice methodology for holding ambiguity and paradox, the experience of the nurse is not addressed. My thesis shows how nurses can reconstruct their experience, in relationship to one another, events, and places, to learn how to be with people in nursing practice. This is instructive for nursing education which occurs prior to choosing theories
to direct practice. Conceptualizing students as people capable of learning to construct identity and knowledge through thinking narratively and inquiring into life experience in relationships with nurse-teachers and each other informs my classroom and practicum encounters (5).

I do not embrace narrative thinking as a construct to impose on people or as psychological second-guessing. Narrative inquiry is a space as much as a way of being that positions me to be open to understand, to move beyond personal responses based on my own plotlines and assumptions so that I can invite students and colleagues to share their own ongoing narratives as they construct nursing identities and knowledge. Learning occurs in relationship and reflection between stories to live by, in liminal space, neither in the fixed, older plotline nor yet discerning the new. This is my primary work as a nurse-teacher. creating relationships with students to allow the possibilities of learning in liminal space. One of my students, Sandra, in practicum this semester is in grave emotional distress. It is she who has a preceptor who stories the healthcare reform landscape as dangerous, unfriendly, and unhelpful. The preceptor's teaching-learning style results in Sandra feeling afraid to act, afraid of making a mistake and of asking too many questions, while carrying a full patient assignment. My student wrestles with the decision to go or to stay. The meaning of staying, finding a way to negotiate daily relationships, is her choice so far. My role with Sandra, as I understand it narratively, has not been about clinical aspects of her learning which she has clearly documented in her portfolio. Nor is my role to be angry with her for a messy situation or to counsel her how to adapt or cope. Our relationship and conversation focuses on reconstructing her experience so that she sees choices and strengths instead of assuming she chose the wrong profession. As we share coffee and her mother's cake at my dining room table, Sandra responds to my invitation to explore the cover, sacred, and secret stories nested within this situation. She illuminates her personal practical knowledge--how it is created and changed, how it informs her actions, and contributes to her thinking. Sandra begins to see how this experience fits into her career goal of trauma nursing. I learn how to be with students who are wrestling with identity and career issues, modeling how to be in the institutional story and discern plotlines of my own. This is education as awakening and transformation for my student and me.
In a course I am teaching concurrently with writing this chapter, students share their nursing practice narratives with each other at a pace of two per week. One student, Erin, told of her experience with Sarah, a woman who could barely move.

I decided to complete my RPN certificate while registered in the RN diploma program at our local community college. The RPN status would allow me to work part-time for a better salary than was possible as a healthcare aide. Working with an experienced RPN preceptor to complete the required hours of clinical work, I met Sarah, who lived in a nursing home in a room of her own. She had ALS, a degenerative neurological condition that had progressed to where Sarah was immobilized except for blinking and moving her neck slightly. You might think this was a severe level of physical disability and that Sarah would be at the mercy of the nursing home staff. She was indeed subject to their perceptions of her, but not based on her total care needs. Sarah was able to communicate her wishes and disapproval clearly and I found that most staff were disturbed by and avoiding of Sarah.

As I watched others with Sarah, I learned that some staff were afraid of her or disagreed with her right to express preferences for the type and timing of her care. No other patient was so demanding or time-consuming, they said. Sarah was perceived to have favourites amongst the staff and would shut her eyes with those she disliked. My preceptor was one of the nurses Sarah responded to with cooperation and interest. I noticed that Sarah’s negative responses happened if staff did not offer a greeting upon entering her room and communicate what was intended or did not obtain her permission to begin daily care, or treated her as inanimate. Staff called Sarah non-compliant.

I spent my whole childhood with three wonderful elderly women, my grama and her two sisters. I went with them everywhere and was part of the elderly community that they participated in. This has shaped me into the nurse I am today because during those years I learned from these people and about these people. I studied them, loved them, and listened to
them. I understand where many elderly people come from. I have been part of a family with an elderly person involved in the healthcare system. My eyes have seen a lot since childhood, good and bad, and it has certainly shaped me for my future as a nurse. This is how I came to see Sarah as expressing her justifiable wishes as a human being. Sarah would blink once to indicate “yes” and would look unblinkingly at staff or close her eyes to indicate “no” or withdrawal. She also had a letterboard that I would hold while Sarah labouriously spelled out her messages. Once a computer with appropriate software was obtained, Sarah was able to communicate from a sitting position, moving her neck so that her head clicked the mouse. The computer program offered the alphabet in five letter sections so Sarah could click on the section and then on the letter she wished to spell her communication to staff. Sarah wrote a letter of reference for me that is a treasured memento. She wrote of our relationship and how I took the time to communicate with her and to care for her according to her preferences (January 31, 2001).

Erin could have lived with her patient, Sarah, at the level of cover story and education as cultivation. Everything could look neat, tidy, clean in the nursing home room, including Sarah. Erin would be doing everything that was expected, the activity tick sheets would be filled in, the charting would reflect ‘an uneventful day’. Erin was discouraged by other staff from exploring Sarah’s responses further because some of them thought this was too much work and how would it matter that Sarah had preferences anyway? Erin would have been a good employee and Sarah would have been physically safe in this story. However, Erin was awake to Sarah’s humanity and realized eye movements were coordinated with certain activities; conversation, washing, massaging, positioning, talking through what would happen next which engaged the personhood of each of them. What others saw as too much work, Erin and her preceptor saw as relationship with Sarah.

As a nurse-teacher, I was moved by this narrative of experience that Erin shared in class because of my own story of Emma. This story, which goes beyond the cover story and doing what is expected, shows poignantly what happens in the secret stories of
nursing that transforms both nurse and person being cared for. This experience with Erin extends my thinking about how to construct curriculum with students. Education in classrooms that ignores personal knowledge and assumes nursing is externally defined and told to students so they will act in prescribed ways misses so much. It is inaccurate in terms of what constitutes a learning situation, and questionable pedagogy in terms of imposing identity and knowledge. Nurse-teachers, as my stories show, live with apparent contradictions and challenges to their identity and knowledge in their daily practice. My inquiry reveals how it matters that nurse-teachers and nursing students conceptualize themselves as people with intellectual lives and scholarly practices that facilitate our construction of identity and knowledge as we live in social situations. My research includes nurses’ experience and a way to make meaning of experience that shapes how a nurse chooses to act with others. The question of Nothing Personal? is answered by the experience of my inquiry—everything is personal, arising from life experience, and connected to others.

**Construction of Identity and Knowledge; Connecting Ontology and Epistemology**

Clandinin and Connelly (1995) claim that teachers “are characters in their own stories of teaching, which they author” (p. 12). Three dimensional narrative space which is conceptualized by Clandinin and Connelly (2000) as inward and outward, backward and forward, and located in place is a space of constructed knowledge. Constructivist frameworks include and build on a person’s life experience with formal and informal education that “encourages learning with transferability, context and meaning” (Peters. 2000. p. 166). Contemporary nursing scholars are extending earlier theorizing, which is scientific, empirical, and epistemological in focus to intersect with esthetic, personal ontological concerns (Boykin & Schoenhofer. 1991; Reed. 1997; Retsas. 1995; Silva et al., 1995; Sleven. 1992). Questions of how I come to know link to the meaning of that knowledge as part of my relationships and actions in the world.

An Australian nurse educator, Retsas (1995) writes about the crisis in meaning in the creation of nursing knowledge that results from research methods that do not acknowledge what he calls the “ontological substance” of nursing. Retsas encourages nurses to “apply methods of enquiry that have a high degree of tolerance for experience, trial and error, intuition and “muddling through...which enables nurses to be the creators
of knowledge” (p. 24). Retsas is concerned that nursing has focused on scientifically based epistemology that does not account for many of ways of knowing, including ontological dimensions. He reminds us that:

If nurses are to endow their activities with ontologically derived meaning, they must speak from within nursing and not merely about it...meaning needs to come from within nursing and to accord with what nurses believe gives shape and meaning to nursing activities (p. 24).

In relation to my inquiry, I take up the challenge that ontology and epistemology are intersecting through narrative inquiry. Becoming/being and knowing which lead to doing in social situations is how I define nursing praxis. All elements are needed to practice nursing as a constructed knower whose identity shifts and knowledge changes over time. Boykin and Schoenhofer (1991) explore how storying and recreating nursing situations of lived experience with clients is “an approach which assists in grounding the epistemological basis of the discipline in its ontology, as lived in clinical scholarship and thoughtful nursing practice” (p. 248). Nursing education is enriched when the multiple ways of knowing in a situation are foregrounded and narratively interpreted. “Passionate knowing is the elaborated form connected knowing takes after women learn to use the self as an instrument of understanding” (p. 141) which requires attention to dailiness and dialogue with others in social contexts as the basis of empathy and relationship. Posing questions to explore a situation embedded within the larger landscape is central to identity and knowledge construction because inquiry deepens understanding and extends the choices possible for action. Creating, changing, and knowing the story I live by foregrounds relationships and the connected nature of life. Liminal space as I conceptualize it is where unknowing, uncertainty is a feature of identity—it is the writing space where “we write to give form to experience” (Edwards & Stewart, 2000, p.9)...”it is in the shaping of our memories of places, people, and events into stories and sharing them with others that we keep the world alive” (Edwards & Stewart, p. 11). Reading Edwards and Stewart’s book about women reclaiming their lives, I wrote in my journal:

My thesis is a place/space to see myself and other nurses, through conversation, writing our experiences, as shaped by the stories we tell ourselves to live by which co-creates relationships with places, events and people, a conceptual landscape that keeps the world alive—what an
interesting idea of involvement, that who I am and what I do matters to co-creating our world. Realizing this and thinking it through requires writing, writing as a way of constructing being and knowing occurs in liminal space—what in the classroom feels like creating and holding a container, like a deep bowl, with the students while we consider what we do know and make room for exploring what we don’t know, living through the anxiety and sometimes anger of embracing the humility of feeling incompetent and the excitement of integration and understanding (November 16, 2000 personal journal).

Holding space for unknowing and uncertainty, in the face of students’ pressure to be told the truth, what the facts are, what to believe, and what to do, is the heart of the paradox of teaching-learning for me. My own experience shows me how there are many ways to perceive meaning in situations; that there are diverse ways to come to understand, including writing, moving, drawing, playing, and composing music, sculpting, painting. Construction of knowledge through various means is important to curriculum building with students. Being in-between stories to live by, in liminal space, requires me to write—that is my chosen creative modality for inquiry which is informed by non-verbal activities. In this way, nurses learn how to be/become and what they know. Yet, this is not seamless investigation. As I write this section of my thesis, I initially revert to a distanced, theoretically correct voice, stripped of connection to people in my inquiry. Much like my article in the parenting magazine, old ways of being and thinking re-emerge to claim my voice as researcher. Embodied tension about this calls me to reconsider my writing. Relearning to think and write narratively, I am in liminal space. This in-between space is where thinking narratively and nursing praxis connect.

Uncertain, unknowing, open to learning, reconstructing experience, I become renewed, know more contextually, inclusively, and change in relation to our world. Liminal space is also where the parade of time is explored so that narrative patterns and tensions are seen in temporal context.

What am I Going to do with my Research?

There comes a time when the research text ends. The initial puzzle has been explored and deeper layers of inquiry are revealed. Before undertaking narrative inquiry
with students and preceptors, my current work moves to presentation and publishing to emerge into the scholarly world. I am presenting from chapter three at the Association for Research on Mothering conference in early March 2001. My presentation manuscript will be submitted to the Association for consideration of publication in their peer-reviewed journal. I am invited to attend a two week Research Institute at the University of Wisconsin, Madison in June 2001. Dr. Nancy Diekelmann invites nursing scholars and philosophers from around the world to bring their work for intensive dialogue to further nursing education research. Because many of the nurses are phenomenologists, my plan is to work further with chapter two which addresses the contribution of narrative inquiry to nursing education research. I plan to submit this work to the Journal of Nursing Education in fall 2001. As well as composing articles based on my narrative inquiry, I plan ultimately to publish my thesis as a book.

*Nothing Personal?*

Coming to the last half of my final thesis chapter. I am in a dilemma anew. Speaking of my thesis as a unitary whole, thinking of what my inquiry is about and how it matters requires a change of voice, which mirrors my earlier struggles to be in my writing and then to move from field to research text. Each move forward into my inquiry spiraled to a beginning—not at the beginning as in wondering how to be a nurse and how nurses experience healthcare reform—but an integration of new knowledge with what has gone before. Writing this chapter of my thesis was a relearning of narrative inquiry, locating myself in a daily life that includes scholarly research.

Concern for being scholarly enough, wondering how daily ruminations matter, hoping my readers will be engaged by my writing to reflect on their own experiences, are equal to my love for my inquiry. I notice that I stroke the pages after turning them and while I read the next. Can I pull this all together so the social significance and relevance are presented clearly? In several attempts to approach this writing, I revert to my distant, third person, proper voice—generalizing and disconnected from the ground like a helium-filled balloon. Knowing it's too heady, not embodied enough, I leave my bagel to wait, popped up and cooling in the toaster, ignoring the red 'ready' light on my coffee-maker. I run upstairs from the kitchen to get paper from my office to write myself in as I begin to say again how my inquiry matters.
Taking myself seriously, respecting my nurse co-participants, concerned for my readers, my inquiry matters because it explores people in their relationships with other people, places, and events showing how who we are makes a difference in social situations. As Florence feeds an elderly woman as if she were her grandmother, she balances her need for employment with her patient’s humanity. Aware of the consequences to the patient and herself, she chooses to give the woman time to eat before being bundled into a waiting ambulance.

Did I mention my invitation to return to the hospital where the family-centred care stories unfolded? I reconnected to a colleague from that hospital at a nursing job fair in February 2001 and she invited me to come for tea and a tour. We will also meet with her director to discuss implementing FCC in their new same-room birthing centre. The way I would have approached this before my inquiry would go something like this: delighted to be asked, of course I will go, already planning the workshop for nursing staff, have to go back into the literature, not considering the rest of the healthcare team. imagine coming back to the scene of the crime victorious. Having inquired into my experience, reflectively and in relationship, I approach the tea and talk with a measured discomfort. I wonder how the FCC story has unfolded since 1989, how I will be in the situation and how others are in their ongoing stories. Cautious, open to the information available in the situation, I reflect on what William James (1899/2000) wrote to his friend, Sarah Wyman Whitman on June 7, 1899:

As for me, my bed is made: I am against bigness & greatness in all their forms; and with the invisible, molecular moral forces that work from individual to individual, stealing in through the crannies of this world like so many soft rootlets, or like the capillary oozing of water, and yet rending the hardest monuments of man’s pride, if you give them time (p. 546).

Written nine years before my great-grandparents’ correspondence, James’ sentiments are authentic for me at this stage of my inquiry. Narrative inquiry is like an invisible molecular moral force that works from individual to individual. My outdated beliefs that people comply with authority and that large institutions know what to do or what is best are shattered. In its place is a value for the capacity of individuals in social situations to reconstruct experience, to learn, and to change. I have a sense of being a person capable of thinking through choices and deciding how to act in relationship with others. Sasha
and I show in our stories how narrative inquiry is time and labour intensive, personal reflective and relational work that yields golden treasures.

For me, the significance of my inquiry is personal. I am changed in social situations and, as much as is possible at the time, aware of myself and open to what is unfolding, knowing more will be revealed upon reflection and reconstruction. Understanding flows with time, moving forward, reshaping, and deepening through inquiry. My inquiry is significant because individual nurses show us their daily lives and how they construct identities and knowledge in a healthcare reform landscape. The particular and the shared are illuminated through reading how Ginny, Kathie, Helen, and the others approach nursing praxis.

To answer the question of how nurses understand and stay in the healthcare system as it restructures, I would say that restructuring is personally constructed as to meaning and impact which leads to learning, change, and involvement. Grounded in experience and relationships, nurses are capable of choice and moral discernment about applying their knowledge and skills instead of being hostage to unexplored experience. Theory and practice intersect with and mutually inform the personal and social. Narrative inquiry is a way for nurses in their education and practice to come to that capacity in themselves. There is a public benefit to nurses growing in their capacity to understand personal intersections with social contexts.

How does it matter that RNs as persons in a daily life reconstruct their life experience by thinking narratively in liminal space? Because how nurses think about who we are and the consequences of our actions informs our identity. My study explores how a nurse’s identity and knowledge are narratively composed and reconstructed, embodied and expressed in nursing praxis—thinking narratively involves consideration of temporality and continuity in people’s lives in social situations. It is important for me as a teacher that nurses understand how it matters to include yourself as a creator of meaning and as knowledge-maker in a professional knowledge landscape. Telling and reconstructing our stories of experience reduces disengagement from the messiness of practice and assists us in discerning how to proceed in the face of daily paradox. For nurses, meaning-making becomes an expression of personhood and the basis of concern for others—we are the filling for the form ‘nurse.’
Chapter Six Endnotes

1. Works-in-progress (WIP) is a student organized opportunity every winter at the Centre for Teacher Development, sponsored by Dr. Connelly. Graduate students provide a potluck dinner for each other each Tuesday evening and then one person presents their research. Students may present an overview of their project or bring a particular research issue for which they require consultation. This ninety minute WIP is followed by small group seminars, facilitated by faculty and senior students, for those who are taking this course for credit.

2. Luncheon consent

I. ________________, agree to participate in a reading and dialogue luncheon at Gail Lindsay’s on August 17\textsuperscript{th}, 2000. I will read thesis materials from her narrative inquiry called “Nothing Personal: Narrative reconstruction of Registered Nurses’ experience in restructuring. I agree to keep what I read about the co-participants confidential except for sharing at the luncheon discussion.

My own confidentiality will be preserved through the use of a chosen pseudonym (______________), or Gail may use my name (______________). I agree to have our nurse-teacher dialogue audiotaped and to read and comment on the resultant chapter as it pertains to my words/ideas.

I understand that I may remove myself and my part of the conversation from Gail’s thesis at any point. My contribution as explained to me is to read and comment on how reconstruction of experience matters to nurse-teachers, and to explore how this contributes to the creation of identity and knowledge, which changes how nurses act in a social world.

Signed and dated, ________________________________ ________________________________

3. Questions for my colleagues to consider as they read and responded (on one sheet of paper)—composite of responses completed that day in italics.

Thank you so much for coming to the “So what?” reading and lunch with nurse-teacher colleagues. I invite you to read whatever you wish and to think about the following:

a) Is the chapter clear and coherent? Do you understand from my writing what it is about? Does the writing seem authentic, adequate, plausible? Is wakefulness and awareness heightened in the reading? Are you moved into your own experiences?

Excellent synthesis of a very complex situation, riveting reading, beautifully descriptive, vivid writing style. Flow from personal to theoretical is smooth. Emotional because I made meaning from what was read to my personal experiences.

b) What connections did you make between the writing and your own life as a person, nurse, teacher?

A million connections and disconnections in every way (as a person, nurse, teacher). It really evoked a lot of thoughts and feelings, a lot of energy and excitement. Made me keenly aware of understanding and dealing with life’s experiences allows one to move on, and in doing so we as nurses can assist others. Your term “dailiness” links with my worldview of synchronicity and serendipity and affirms my belief in predestination.
c) Having read some of my research and responded to these questions, how do you think it matters that nurses reflect on their lives, reconstruct their experiences and live anew? How does this research contribute to nursing education?

Through awareness, we can understand situations and see the possibilities they hold and imagine how to move with them. whether and how we participate in creating and shaping situations. Your work is valuable and authentic as experience allows us to interpret the world, and constructs the way in which we facilitate nursing education. Your quote of Pratt is illuminating and illustrates the point well.

If you have further comments or suggestions/edits/whatever, please feel free to write them to me. Please do not write on the original text in case someone else reads it after you. I value your participation and contribution very much. Thank you.

Thanks for this opportunity!! © Your recurring title of “nothing personal” is curious, but it is personal.


5. Summary of my teaching/learning philosophy

In the context of my role as Assistant Professor in the Department of Nursing, I conceptualize teaching/learning as a relationship between people in social situations, where reflection on and reconstruction of experience illuminates meaning and constructs knowledge. Teaching, for me, cannot be separated from learning in relationship with students. Teaching that is separated from learning is indoctrination or training and is an imposition on students.

Teaching/learning is living with questions and uncertainty; open to change and growth. It is internally motivated as well as externally stimulated. I define my teaching/learning stance as relational, open and tentative as the experience of students and teacher weave together in an emergent design related to the purpose of a particular course in a program. Teaching/learning is composing a story to live by. It is being with students, with past experience and future dreams, in the present moment, moving towards greater self-awareness and ethical choices for action. One of my contributions, as a teacher/learner in the classroom, is creating a container or shared space with students that is intellectual, emotional and somatic in nature, to hold tension and paradox as we explore and learn.

The theoretical basis of my teaching/learning with students is Bevis & Watson (1989), Connelly and Clandinin (1999), Diekelmann (1990, 2001), and Dewey (1938). I agree with Hildegar Peplau’s (1952) view that the central task of a school of nursing is “the fullest development of the nurse as a person who is aware of how she functions in a situation” because “the kind of person each nurse becomes makes a substantial difference in what each patient will learn as he is nursed throughout his experience” (1952, xii). (November 1999).

6. “I tell my friend: when you live between opposites, you cannot escape the s/he who will follow you, who must either be wrestled with or embraced. And I have seen the beauty in that embrace.” (Pratt, 1995, p. 159)
Postlude

What Have I Learned About the Landscape?

I am in it.

I am in relationship with my husband and son, my friends, teaching colleagues, students, their preceptors, and with all the places where we meet, work, and live. The nursing landscape is nested within the healthcare landscape which is nested within larger social landscapes and so on. Shaped by my narrative history and the ongoing narratives in situations, I met with my co-participants and reconstructed our experiences. There are unseen dimensions to the landscape that also inform us, hidden surprises as Sasha reveals her eating disorder, my wife and mother roles intersect with being a nurse, the university develops a new way of thinking nursing and hires congruent faculty--personal and professional, individual and social aspects of life are shown to be interdependent.

The landscape is what you make of it because even when it appears uninviting or very difficult, such as Helen describes with her Head Nurse, we can choose how to be in it, which plotline to live and expand and which to turn aside. Sasha chose a reform plotline to change her life; the same landscape circumstances were constructed in my plotline to be doom and gloom. The healthcare landscape is a place of many financially driven changes, with a breakdown in structures which opens space, as Ginny and Maggie show us, to introduce other ways of knowing and other stories to live by. The landscape includes competing agendas with cover, sacred, and secret stories. Safe places for secret stories are found in relationships for nurses, as Sasha exemplifies with colleagues and patients, not in physical places. All organizations, in education and practice, seem to be the same: work until you drop, others are lined up to have your job or place in the classroom, being moved to clinical settings or courses for which you are not prepared.

Learning the social context quickly so you can discern how to proceed is a necessary skill for nurses.

Liminal space is contextualized by situations where old stories to live by do not help with the choices anymore, but you don’t have a new story as yet. Holding the unknown, the paradox and competing tensions to gather all possible information (through retelling and reconstructing experience) and to discern the next step is the challenge and joy of teaching-learning with students and colleagues. The landscape is composed of
paradoxical relationships that are not meant to be dualistically debated with one side winning over the other. Holding this liminal space of apparent contradictions broadens understanding, enables nurses to have multiple perspectives in situations. Nurses are in a landscape with their patients, intersecting stories creating a story to live by together. We need to understand the landscape to navigate through each day.

Only some of our time is with patients or students. As Sasha and I show in our stories of experiences, our relationships in social situations with other nurses, physicians, administrators, patient’s families also shape our identity and knowledge. We are inextricably connected to and interdependent within the nested landscapes. Our situations constantly change, much of it outside our visible spectrum, so we must be discerning what is going on, what it means, how we will be in the situation, and what we will do as a consequence. When there is paradox, we need to go deeper, more inclusively into the situation. We need to hold the tension of uncertainty until the connections are clear and our choices become apparent. How paradox is constructed is a narrative sign in itself. How I construct the multiple sides of the paradox comes out of my way of seeing the world--out of my plotlines which emerge from my experiences. Becoming aware of how I construct this multi-faceted crystal--my story of the landscape--connects of necessity to my identity, my knowledge, and to my actions. For you, my reader, are your emotions stirred, are my stories believable, do the details allow you to trust the shared awareness; do you “continue to read because (you) need to know how (you) turn out as well as the story?” (Vezeau, 1994a, p. 59). Thinking narratively, expanding my awareness of the landscape for nurses, is my awakening and education. I wish the same for you, dear reader
References


Quality of Nursing Worklife Research Unit [QNWRU]. (1994). *Annual report.* Toronto, ON: University of Toronto-McMaster University, QNWRU.


