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Re-conceptualising holism in the contemporary nursing mandate: From individual to organisational relationships

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ABSTRACT

Over the last forty years, nursing's claim to professional expertise has been expressed in terms of its care-giving function. Informed by a distinctive 'holistic' approach, models of nursing identify therapeutic relationships as the cornerstone of practice. While 'knowing the patient' has been central to clinicians' occupational identity, research reveals that nurses not only experience significant material constraints in realising these ideals, their contribution to healthcare extends far beyond direct work with patients. Amidst growing concern about healthcare quality, a body of critical commentary has emerged proposing that the contemporary nursing mandate, with its exclusive focus on care-giving, is no longer serving the interests of the profession or the public. Drawing on an ethnographic study of UK hospital nurses' 'organising work' and insights from practice-based approaches and actor network theory, this paper lays the foundations for a re-conceptualisation of holism within the nursing mandate centred on organisational rather than therapeutic relationships. Nurses can be understood as obligatory passage points in health systems and through myriad processes of 'translational mobilisation' sustain the networks through which care is organised.

1. Background

Over the last forty years, nursing's claim to expertise has been underpinned by a bio-psycho-social model which underlines the importance of close engagement with the patient as a 'whole person' (Armstrong, 1983; May, 1992). While the more phenomenological aspects of this version of nursing practice have not been received uncritically, the ideals of holism and 'knowing the patient' have become central to nurses' professional identities.

The evolution of modern healthcare systems is having a profound effect on the context, content and pace of nursing practice. Hospital nurses are expected to process faster more acutely ill patients and simultaneously contain service costs. Community nurses must respond to the challenge of a growing number of frail older people. Changes in skill-mix and increased numbers of support workers have made it necessary to devise alternative models of care delivery, whilst policies for the preparation of junior doctors and the evolution of medical technologies have provided the impetus for the delegation of new tasks.

Against this backdrop, research regularly reveals contemporary nursing practice to bear only a fleeting resemblance to the profession's holistic ideals. Nurses are not only increasingly distant from direct care (Cavendish, 2013), they undertake a wide range of activities not captured by the prevailing professional image (Allen, 2004; Nelson and Gordon, 2006). Buttressed by growing societal unease about fundamental care standards (Institute of Medicine, 1999; House of Commons, 2010), a body of critical policy commentary has emerged questioning the fitness of the traditional nursing mandate for contemporary healthcare systems (Dingwall and Allen, 2001; Maben and Griffiths, 2008). As leaders across the world reflect on how to ensure service quality in a context of unprecedented financial constraint, the need for such a reformulation is increasingly apparent, but not without its challenges. Professional identity can be extremely resilient, which, while an asset in certain contexts, means it can be difficult to change (Goodrick and Reay, 2010). The concrete substance of nurses' work is also poorly understood and nurses lack a language to describe their practice (Nelson and Gordon, 2006).

This paper aims to contribute to this agenda. It draws on ethnographic research undertaken to better understand the non-clinical elements of frontline nurses' practice, referred to here as 'organising work', and builds on a substantial body of scholarship (Allen, 1997, 2001; 2004; Dingwall and Allen, 2001) through which I have become committed to moving beyond essentialist conceptions of the nursing role to make visible the work nurses actually

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do. Some have estimated that 'organising work' accounts for more than 70% of nursing activity (Furaker, 2009), yet it has only ever been studied as a distraction from patient care rather than as a practice in its own right (for example, Davies, 1995). It is the 'dirty work' (Hughes, 1984) of the profession and much ink has been spilt on the question of how practice can be brought back into alignment with nursing's patient-centred ideals. In the context of growing concerns about deteriorating standards of basic care, arguments about the negative effects of 'non-clinical' activities on the 'real' work of nurses undoubtedly have credence. Yet as Hughes (1984) has argued, an occupation is not some particular set of technical functions, 'it is the part of an individual in any on-going system of activities' (p.286). Accordingly, this study aimed to examine the 'organising work' of nurses and the system features that make it necessary. Only then is it possible to reach informed decisions about the future nursing role.

2. Theoretical orientation

Data generation was informed by a practice approach and insights from actor network theory (ANT). Practice theories share a number of conceptual similarities (Nicolini, 2012) with origins traceable through praxeology (Bourdieu, 1977), ethnomethodology (Garfinkel, 1967), structuration (Giddens, 1984), and activity theory (Engeström, 2000). All conceive of social phenomena as created by human agency with practices understood as emerging from dynamic interactions with the material and social world as people find solutions to their problems. Thus in trying to understand nurses' organising work, I focused on what nurses did, the tools they used and what these practices revealed about what they know.

Practice theories are inherently relational and regard the world as an assemblage of actors: people, knowledge, technologies, and artefacts. ANT affords an analytic sensitivity to these relationships and directs attention to both humans and nonhumans comprising a field of practice. 'Translation' is the broad term used for understanding such associations, and refers to the movement of an entity in space and time, as well as its transformation from one context to another. In analysing actor networks it is useful to focus on a single actor and consider translational processes from its vantage point. Accordingly, in this study nurses and their organising practices were the focus of concern, and healthcare delivery processes examined from this perspective.

3. Methods

Forty UK hospital nurses in frontline adult care roles were shadowed. The primary sources of data were observations and ethnographic interviews, with an average of eight hours spent with each participant. I accompanied nurses as they carried out their activities, drawing on my nursing background to ensure my presence was minimally disruptive of participants' work and respectful of patients' privacy. Data were recorded contemporaneously in a spiral-bound jotter and word-processed at the earliest opportunity. As far as possible interactions were recorded verbatim and observations were low-inference, capturing what was actually said and done without interpretation. Ethics approval was granted by the University. To ensure maximum variability, participants were purposively sampled, with selection guided by a typology of practice environments developed in consultation with an expert reference group. Senior nurses in the study site assisted in populating these abstract categories with concrete examples. Exhaustive coverage of all fields or the full nursing function was not intended; the purpose was to identify roles most perspicacious given the research aims. Twelve roles were identified initially, with others added in light of the concurrent analysis. The final sample comprised nurses working in rotating (undertaken by different team members periodically) and permanent roles (Table 1).

Nurses were recruited through line-managers but assured participation was voluntary. Signed consent was obtained and individuals told they could withdraw from the study at any time, although none did. Although formal demographic data were not collected; most participants (36) were experienced nurses who had worked for several years in the organisation; only two were male.

Data generation and analysis proceeded concurrently. Throughout the study, I periodically reviewed the totality of materials, drawing out similarities across, and differences between roles, in order to identify broad themes. Interpretations were regularly shared with participants and senior nurses to check face validity. Once fieldwork ended, data were entered into computer-assisted qualitative data analysis software (Atlas/ti). An initial descriptive coding frame was devised to support data retrieval and then refined alongside the emerging analysis. Organising practices were the focus of concern. The aim was to describe these as explicitly as possible along with the artefacts that supported them, tease out the knowledge and skills that underpinned them and explicate the system features which made them necessary. The analysis progressed through reading and re-reading all materials, identifying patterns and relations, and attending to how the data related to the theoretical framing. Inductively generated ideas were considered in the light of relevant literatures and sensitising concepts.

4. Findings

4.1. Overview: healthcare organisation and nursing's niche

As health service provision becomes ever-more complex, quality care depends not on individual brilliance but on ensuring that the

Table 1
Study sample.

Typology category	Role		Number of participants
Process-based roles	Discharge liaison	Medicine	2
		Neurological-rehabilitation	1
	Patient access		1
Service-based roles	Scheduled surgery coordinators	Colorectal	3
		Respiratory	1
		Vascular	1
	Unscheduled care coordinators	Emergency unit	2
		Medical admissions	1
		Trauma and orthopaedics	2
		Medical assessment	1
		Surgical assessment	1
		Rehabilitation	2
	Specialist unit coordinators	Short-stay surgery	1
		ITU – general	3
		ITU - cardiac	2
	Triage	Surgical assessment	1
		Emergency unit	1
	Post-anaesthetic recovery		2
Nurse specialists	Pain		1
	Anaesthetic assessment		2
	Colorectal		1
	Stroke		1
	Rehabilitation		1
	Cardiology		1
Trouble-Shooting Roles	Out-of-hours site manager		3
	Hospital-at-night practitioner		1