

SEEING THE WORLD THROUGH ORTHOPAEDIC EYES

THE EXPERIENCE OF BEING AN ORTHOPAEDIC
NURSE:
A HERMENEUTIC STUDY

A thesis presented in partial fulfilment of the
requirements for the degree of
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DEDICATION

For orthopaedic nurses everywhere

ATTESTATION OF AUTHORSHIP

“I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the qualification of any other degree or diploma of a university or other institution of higher learning, except where due acknowledgement is made in the acknowledgements.”

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ABSTRACT

This study explores the experience of being an orthopaedic nurse. As an orthopaedic nurse I had concerns that the validity of orthopaedic nursing as a unique scope of practice was being questioned. In this thesis, the case for orthopaedic nursing is argued, by showing it as a specialty in its own right.

A qualitative approach informed by my interpretation of philosophical hermeneutics as articulated by Heidegger (1927/1962) and Gadamer (1976; 1989) was undertaken. Phenomenology seeks to uncover 'taken-for-granted' meanings in everyday experience and hermeneutic research recognises that the historical and cultural horizons of participants and researcher influence the interpretation.

Eight nurses working in various orthopaedic settings were interviewed. Data was analysed using the interpretive thematic approach described by van Manen (1990). The nurses' stories from practice yielded two essential themes, 'being part', and 'gaining and maintaining integrity'. These themes interrelate and together reveal meanings and insights about being an orthopaedic nurse. 'Being part', shows the essential nature of relationships between orthopaedic nurses and others. 'Gaining and maintaining integrity' describes the embodied nature of the phenomenon.

The overall thematic finding 'seeing the world through orthopaedic eyes' reveals the nature of orthopaedic nursing as a unique scope of practice.

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KEY TO TRANSCRIPTIONS

The following conventions and abbreviations have been used in this presentation of research findings:

| | |
|----------|--|
| Italics | Represent the original interview data from the study participants. |
| Names | Pseudonyms are used for the study participants. |
| [] | Denotes the researcher's alterations or amendments in the text to achieve clarity. |
| ...//... | Indicates material deleted from interview excerpts or direct citations. |
| ... | Indicates a pause during the participant's testimony |

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CHAPTER ONE: INTRODUCTION, BACKGROUND AND OVERVIEW OF THESIS

INTRODUCTION

The experience of being an orthopaedic nurse, a topic of particular interest to me, has not been subjected to intensive scrutiny in the nursing literature. When it came to deciding the focus of the research I would undertake to complete my masters' degree, I was mindful of two requirements made very clear to us as a group of budding researchers. They were, first, that it should be on a subject about which we held a passion and second, that it should pose a question or argument that the research process would seek to address. My choice of topic, in terms of the first requirement, soon indicated itself. Most of my nursing career has been involved with the specialty of orthopaedic nursing in some way. I have practised as an orthopaedic nurse in wards, outpatients departments and plaster rooms in New Zealand and overseas. I have also taught about orthopaedic nursing in undergraduate and postgraduate nursing programmes and I continue to combine teaching and practice within this specialty to the present day. Hence I wanted to formally examine some aspect of it through research. Formulating questions or arguments to fulfil the second requirement was a slower process. It was only after intensive reflection on my experience of the specialty that my own understandings began to emerge and crystallise.

In this chapter I will provide a background to this thesis by situating it in three ways. I will begin by outlining how the research question was arrived at and why hermeneutic phenomenology was chosen as the most suitable methodology. Secondly, I will examine this thesis topic from a professional perspective and its potential significance to the sphere of orthopaedic nursing practice. Finally, I will provide a brief overview of this thesis.

THE RESEARCH QUESTION

It is by virtue of our world that we, as researchers, have the questions we have, and that we see the possibilities we see... (Leonard, 1994, p. 57).

Past notions about orthopaedic nursing and its legitimacy as a nursing specialty have sometimes appeared unrealistic or erroneous, for example, in nursing education. I taught in an undergraduate nursing programme for a number of years. In the late '80s, nursing was seeking to be distinct from medicine by aligning with holism and popular nursing theorists such as Hildegard Peplau, Jean Watson, Madeleine Leininger and Patricia Benner. Their ideals of intuitive practice and humanistic caring were embraced by the nursing profession (Benner, 1984; Leininger, 1978; Peplau, 1952; Watson, 1979). At that time, referring to 'paediatric' or 'medical' nursing or taking a 'systems approach' in nursing education, was deemed to be medically-oriented and incongruent with new nursing-oriented philosophies. The profession was dissociating from the scientific paradigm in an effort to find a unique voice of its own and nursing curricula were adjusting to this.

This was evident in the nursing school in which I taught at the time. For example, orthopaedic nursing, was referred to as 'disruptions to perception, co-ordination and movement' in the compulsory nursing text, 'Medical-surgical nursing : A conceptual approach' (Jones, Dunbar, & Jirovec, 1982). Although the reason for taking this conceptual approach was related to the burgeoning range of knowledge required to prepare comprehensive nurses, I felt students were at risk of not actually learning what they really needed to know about particular scopes of practice.

The current ascendancy of orthopaedic surgery has meant there is less need for traditional orthopaedic skills such as casting, traction and splintage in treating orthopaedic patients. From time to time this has prompted colleagues outside of orthopaedic nursing to question the validity of the specialty and I have often felt it necessary to debate this. Some have argued that orthopaedic nursing has been subsumed into surgical nursing as a consequence of the surgical advances. Others have suggested it rests somewhere within the conglomerate of emergency, high dependency and trauma nursing. By default, New Zealand Nursing Council includes orthopaedic nursing as a component of perioperative nursing in recent statistical data analysis (New Zealand workforce statistics: Nurses and midwives, 2004). Yet a significant proportion of orthopaedic patients do not

sustain trauma or require surgery. Thus, I do not believe the specialty should only be described according to these criteria. In examining the experience of being an orthopaedic nurse, I wanted to reveal the nature of the specialty, and, more importantly, its meaning to orthopaedic nurses.

THE SELECTION OF HERMENEUTIC METHODOLOGY

Interpretive research allows us to respond to the experience of others as told in ways that reflect personal experience of a particular phenomenon. The goal of interpretive research is to explore and describe life-events in context. Leonard (1994) suggests that hermeneutic research seeks "... to understand everyday skills, practices, and experiences; to find commonalities in meanings, skills, practices, and embodied experiences..." (p. 56). Such an approach lends itself well to responding to the question: what is the meaning of being an orthopaedic nurse? It focuses on understanding and articulating the experiences lived by orthopaedic nurses. (See Chapter Three).

As an orthopaedic nurse myself, I sensed that there were uniquely orthopaedic ways of being an orthopaedic nurse. I believed that these were largely taken-for-granted and not valued and I worried about their potential loss and the effect this might have on patients and future nurses.

Hermeneutic methodology facilitates exploration of the lived world of participants. It encourages attentive awareness to the details and less visible dimensions of everyday experiences. According to van Manen (1990), "...it makes us thoughtfully aware of the consequential in the inconsequential, the significant in the taken-for-granted" (p.8). Participants in this study contributed stories that enabled me to interpret and articulate the meanings inherent in orthopaedic nursing practice.

THE IMPORTANCE OF CONTEXT

Heidegger (1927/1962), Gadamer (1976; 1989) and van Manen (1990), argue that human beings are always historically and culturally situated. The terms pre-understandings, prejudices, pre-suppositions are used by these authors to express the notion that human beings always interpret present

events in light of their previous experiences. In the scientific paradigm this is referred to as subjectivity.

The following extract was taken from an interview I underwent at the beginning of the research process in an effort to uncover the pre-understandings I brought to the study.

My interest in this specialty evolved from a specific point in my early career as a registered nurse. My first choice had been to go to the casualty department of my training hospital when I qualified but this experience was short lived.

I sort of fell into [orthopaedic nursing] in the beginning because I was interested in working in the Emergency Department but, they wanted us to get plastering skills and we were new recruits to the area. That was right at the outset of my being a registered nurse. And so we were the first people to go down the corridor to the Fracture Clinic to learn how to plaster. Prior to that I wasn't in the slightest bit interested – I didn't like it when I actually had to learn about orthopaedic conditions and I was terrified of traction and things like that.

But, it captivated me and has kept me entranced ever since. So I've returned to it at various stages in my career.

In hermeneutic research, the prejudices held by the researcher are critical in helping to shed light on the phenomenon as lived by the research participants. It was interesting and useful to be interviewed about my experiences as an orthopaedic nurse. It was an opportunity to reflect on my own beliefs about orthopaedic nursing and to recognise the prejudices I held.

The following are pre-understandings, pre-suppositions or prejudices that were revealed during this interview.

- *Orthopaedic nursing means caring for orthopaedic patients. [In the context of this study, the term 'orthopaedic patients' refers to people who receive medical and nursing care for musculoskeletal injury or conditions. This encompasses patients of all ages with a range of orthopaedic conditions and/or injury.]*
- *Orthopaedic nursing is informed by specialty knowledge, skills and tasks.*

- *Orthopaedic nurses assess patients holistically and uniquely through an 'orthopaedic lens'.*
- *Orthopaedic nurses need a broad range of generic nursing skills because orthopaedic patients typically present with multiple, complex health problems.*
- *Orthopaedic nursing expertise requires physical and intellectual ability combined with an artisan approach. [Here I mean to be skilled in an artistic but practical sense].*
- *Orthopaedic nurses need a sense of self-worth to respond assertively to dilemmas in practice.*

ORTHOPAEDIC NURSING IN A MODERN CONTEXT

Modern orthopaedic nursing has transformed itself from the days of Dame Agnes Hunt (1867-1948), who is acknowledged as a significant influence on the development of this nursing specialty (Carter, 2000a, 2000b). Orthopaedic nurses, like their counterparts in other specialties, have had to respond to changes in populations, lifestyle and environmental factors and fiscal demands. Wars and natural disasters have also contributed to certain developments in areas such as such as trauma case management, casting techniques and wound care. Orthopaedic nurses have been required to adapt their skills to meet the new contingencies of care.

PROFESSIONAL ISSUES

This study explores the meaning of being an orthopaedic nurse by focusing on stories of experience. I believe this is valuable for a number of readily identifiable professional reasons.

Orthopaedic nurses have always employed specialty knowledge and skills to ensure optimum health outcomes for their patients. Yet, anecdotally, orthopaedic nursing is considered by many to be under threat and orthopaedic nurses are particularly vulnerable to workplace pressures. Orthopaedic services are reputed to have perennial problems with staff retention and turnover and a reason often cited for this, is that the workload is 'heavy'. Orthopaedic patients reflect population diversity in terms of age, gender, ethnicity, socio-economic circumstance and lifestyle dynamics and

significant numbers of them are frail and unwell with co-morbidities aside from their orthopaedic problems. This, combined with high acuity and turnover, means that their care is complex and challenging. Moreover, risk to patients is exacerbated by staff shortages and an inadequate skill mix.

While there are many articles in the nursing literature devoted to issues of retention and recruitment of nursing staff, none were found that examined these issues in relation to orthopaedic nursing. In an informal survey of 10 senior orthopaedic nurses from around New Zealand, I asked the following question “Do you have problems with retention and recruitment of nursing staff in your area?”

Six respondents acknowledged that there were problems of recruitment and retention in their workplace settings. These were mainly from the larger urban units and three of these respondents said their staffing vacancies occurred in waves. Two from smaller units said they had no problems. Another two said that recent major restructuring meant that they could not presently gauge a true picture of their staffing retention. Most identified that it was orthopaedic wards that were problematic; most outpatient departments had stable but aging nursing staff (*personal communication with survey participants, January, 2006*).

When I began a position as Clinical Nurse Educator eight years ago, I was convinced that education was the key to addressing some of the problems that existed my workplace. I had been told of existing staff shortages and instances of unsafe nursing practice. As a consequence, I developed postgraduate and graduate courses in the orthopaedic nursing specialty in association with a tertiary education provider. No one was more disappointed than I was, with the high attrition from both courses. I knew from needs analyses that staff wanted education at this level and that funding support was available through employer organisations. However it was only after both courses concluded that I fully appreciated some problems encountered by students. Although they were motivated, exigencies of practice meant they had great difficulty coping with the demands of postgraduate education. Yet a subsequent needs survey of

nursing staff in the unit yielded the unanimous response that such courses should be retained. The benefits to those completing the courses were personal growth and development of practice. Graduates who remained in the unit became clinical mentors and subsequently went on to accept promotion to senior nursing roles. They extended themselves with further postgraduate study, clinical research and project work. Since this time, postgraduate nursing education has become an accepted norm and research on the experience of being an orthopaedic nurse is timely, in order to inform specialty educational initiatives for orthopaedic nursing.

POTENTIAL BENEFITS OF THE RESEARCH

I believe that this project will advance understanding of an area of specialty nursing practice by providing a description of orthopaedic nursing formulated through interpretation of the experiences of current practitioners. The use of a phenomenological hermeneutic study, provides a context specific perspective of current orthopaedic nursing practice by showing the distinct nature of what orthopaedic nurses do.

Participating in research, as described by Hutchinson, Wilson & Wilson (1994), can be an empowering experience. Participation in this study, while revealing of the nature of the specialty as a whole, also facilitates insight into one's own practice.

OVERVIEW OF THE THESIS STRUCTURE

Chapter One has introduced the research topic by describing the aims and intent of the project. The research question has been stated and selection of the methodology justified.

Chapter Two situates the topic further by exploring the literature. It provides detailed discussion of the cultural and historical background pertaining to the experience of being an orthopaedic nurse.

Chapter Three presents the theoretical perspectives, methodology and methods informing the study.

Chapters Four and Five present the research findings as two essential themes: 'Being Part' and 'Gaining and Maintaining Integrity'. Chapter Six summarises the findings as a whole. These are then discussed in relation to the extant literature and their implications for orthopaedic nursing. The strengths and limitations of the study are acknowledged and recommendations for future research are made.

CONCLUSION

This chapter has provided an overview of the study and a rationale for the research approach. The significance of the topic has been discussed. The pre-understandings that I bring to the study have been articulated and their relevance in the context of orthopaedic nursing has been established. A brief overview of the thesis structure has also been provided.

CHAPTER TWO: BACKGROUND TO THE STUDY

INTRODUCTION

This chapter provides a background for the study. Congruent with the hermeneutic notion that the past informs the present (Gadamer, 1976, 1989; Heidegger, 1927/1962), it is important to describe the cultural and historical contexts relating to the phenomenon of interest. Gadamer drew on Heidegger's notion of being-in-the world when he described human existences as always being 'in the world or historical' (Grenz, 1996). Our history and culture accompany us or embrace us but because we stand in different places, our interpretations of the world are different. Hence, we have our own 'cultural and historical horizons' (Gadamer, 1976), although these are also formed and informed through shared traditions. The experience of being an orthopaedic nurse will have different meaning for each practitioner yet there will be shared meanings or traditions which form the cultural and historical horizons of orthopaedic nursing.

Discussion of the literature in this chapter will focus on describing the background horizons of current orthopaedic nursing practice. The meaning of being an orthopaedic nurse in New Zealand has its origins in British nursing. Other important influences are the establishment of national orthopaedic nursing associations both in New Zealand and in other countries, the exchange of specialty knowledge, ideas and skills through networking at national and international conferences and orthopaedic nursing texts and journals. Discussion of the literature will also centre the argument for specialisation, education in the specialty and orthopaedic nursing research and practice.

The main literature source has been nursing journals. Of particular value, have been the two devoted to orthopaedic nursing, 'Orthopaedic Nursing' and 'The Journal of Orthopaedic Nursing'. CINAHL and Medline databases were used to begin searches. Material from the past ten years was selected and substantiated further by tracing primary sources of the original articles.

ORTHOPAEDIC NURSING AND ITS HISTORY

Orthopaedic nursing in New Zealand derived from British orthopaedic nursing practice. The hospital-based training of registered nurses that prevailed until the early 1970s was based on the British nursing model and heavily influenced by British nursing tradition. Consequently New Zealand nurses have always enjoyed reciprocal rights with British nurses. This has meant recognition and acceptance of each other's nursing qualifications and experience and facilitation of employment of New Zealand and British trained nurses in either country. Nurses from this country travelled and gained orthopaedic nursing experience as it developed in Britain and British nurses brought orthopaedic nursing skills and knowledge with them to New Zealand, a major factor in development of the specialty in this country. One such nurse was Joan Williams, who over several decades gained a reputation throughout New Zealand for her innovative work in casting and nursing education at Middlemore Hospital. Joan wrote a chapter for a book celebrating the 50th jubilee of the hospital and here she describes the beginning of her New Zealand experience.

When I arrived in New Zealand from England, Middlemore was the obvious choice of hospital for me. By default, I had been in charge of an orthopaedic ward in Liverpool and was becoming more interested in this branch of nursing. When I was told Middlemore was "the largest orthopaedic hospital in the southern hemisphere" I thought "Okay, I'll give it a try if they'll have me", little thinking that nearly 30 years later I would still be associated with the hospital. (Williams, 1997, p. 49).

One has a sense here, of the dedication and commitment characteristic of nurses who practice in the specialty over many years and who contribute so much to its ongoing enrichment. In the last 20 years, orthopaedic nurses in New Zealand have profited from networking and sharing ideas with orthopaedic nurses from the United States, Canada, Australia and other countries too.

The origins of modern orthopaedic nursing in Britain

Modern orthopaedic nursing in Britain grew out of the specialist base hospital model established by Dame Agnes Hunt in Oswestry early in the 20th century

(Carter, 2000a). Dame Agnes Hunt is recognised internationally as the founder of modern orthopaedic nursing for several reasons. She established what eventually became one of the first orthopaedic specialist hospitals for patients with muscular-skeletal conditions. It had its beginnings in a convalescent home for children with deformities, the Baschurch Home in Shropshire, but later its scope was broadened to include older age groups, in particular, women. The home became a hospital with the undertaking of surgical procedures there and this facilitated Dame Agnes's collaboration with the noted orthopaedic surgeon Sir Robert Jones. Under his influence, the hospital became a treatment centre for wounded soldiers in both world wars and eventually evolved into the Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust, Oswestry, UK. It was a blueprint for orthopaedic specialist care facilities throughout Britain (Carter, 2000b).

Having met him when she went to him as a patient, Dame Agnes Hunt's partnership with Sir Robert Jones grew to become a mutually reliant professional collaboration, a model for how orthopaedic nurses and medical colleagues could work together today. This is an example of how past horizons or traditions could affect current orthopaedic nursing practice.

Influences on orthopaedic nursing In New Zealand

This country is too small and the population too sparse to have large, stand-alone facilities such as the Robert Jones and Agnes Hunt Orthopaedic Hospital at Oswestry. However there is a huge commitment to the specialty in New Zealand from medicine, nursing and other disciplines. Orthopaedic nurses are to be found working in wards, outpatient departments and theatres, in hospitals that offer an orthopaedic service network throughout the country (*personal communications with the writer, through an informal survey of 10 senior New Zealand orthopaedic nurses, January 2006*). The tertiary hospitals have facilities dedicated to the specialty while smaller hospitals treat orthopaedic patients in mixed wards and outpatient departments. Casting, for example, may take place in a combined emergency department/fracture clinic, but if recent attendance at national orthopaedic nursing conferences is any gauge,

enthusiasm for this scope of practice is just as evident in attendees from provincial and rural areas as in nurses who work in the larger hospitals. Nurses from private hospitals and clinics are also beginning to attend these conferences. They are gaining casting skills and as a consequence, have developed an interest in the specialty (*personal communications with delegates at the Wellington Orthopaedic Nursing Conferences, 2003, 2004 and 2005 and 3M Casting Seminars 2002, 2004 and 2005*).

THE NEED FOR THE SPECIALTY: THE ARGUMENT FOR SPECIALISATION

The present study seeks to determine the uniqueness of the experience of being an orthopaedic nurse and integral to this is the assumption that it has specialty status. The review of articles in this section focuses on the specialisation debate because New Zealand is likely to follow trends that have been evident internationally but particularly in Britain. Nursing specialisation in orthopaedics is not currently regulated in New Zealand but the New Zealand Orthopaedic Nurses Association, established in 2004, has raised skills standardisation as an issue for orthopaedic nurses in this country. It is likely that New Zealand nursing will follow a route similar to that taken by the UK. Clarifying issues relating to specialisation and the British experience could well serve to benchmark this.

As acknowledged in Chapter One, orthopaedic nursing has been categorised variously as trauma nursing or as part of the broader umbrella, surgical nursing. In 1996, Love acknowledged the disputed status of orthopaedic nursing. Her study utilising quantitative methodology attempted to "...clarify the distinction between orthopaedic and general nursing in response to criticism that orthopaedic nursing did not merit specialty status." (Love, 1996. p. 19). Other writers have also argued the case for orthopaedic nursing specialisation (Clarke, 2003; Footner, 1998; R. Jackson, 2003; & Tierney, 2004). The specialist versus generalist trend in nursing is part of a wider debate.

In most Westernised countries, there has been an increase in specialisation

amongst doctors, nurses and other professionals, such as occupational therapists and physiotherapists. This has been the case particularly in the acute hospital sector (McKenna, Keeney, & Bradley, 2003, p.537).

McKenna et al. (2003) focused on community nursing roles in Ireland, however, much of their reasoning is also relevant to other areas of nursing. For example, they concur with Neenan (1997) in referring to intensive care nurses, that there is a philosophical discussion emerging about whether nursing in a particular scope should be undertaken by generic nurses or whether the need for increasing specialist nurses should be acknowledged. They argue that:

... specialists are better able to keep up to date in their field and achieve expert practitioner status. In contrast, generalists, by definition, practice from a broader knowledge base and so their ability to keep abreast of the latest evidence in all areas of relevant practice may be curtailed (p.538).

Participants in McKenna et al.'s (2003) study were also concerned about the risk of over-specialisation. It was recognised that caution was necessary to prevent patients falling "...between the cracks' left between specialist nurses ... [or else] there would not be enough generic nurses to buffer this eventuality" (p. 541).

Tierney (2004) perceived that the uniqueness of orthopaedic nurses is often not acknowledged because they are "... sometimes hidden and overshadowed by the high tech areas of health care" (p. 1). In an editorial written during her tenure as president of the American, National Association of Orthopaedic Nurses, (NAON), she describes orthopaedic nursing, as involving "...a balance between technology, specialty knowledge, clinical expertise, research, political awareness and caring" (p.1). The fact that 'political awareness' is included here is significant. She continues:

...the role of the orthopaedic nurse is clearly that of patient advocate and gatekeeper in the delivery of orthopaedic patient care. The value of the orthopaedic nurse is significantly demonstrated through positive effects on access, costs and quality for all consumers of musculoskeletal care. (p.1).

Tierney (2004) recognises that while orthopaedic nurses commonly have to speak 'on behalf of' their patients, they often also need to advocate 'on behalf of' the specialty itself.

In her review of orthopaedic nursing literature and practice, Clarke (2003) also sought to define the specialty. In her view, early attempts to determine characteristics of orthopaedic nursing were flawed because they were either too biomedical or generalist. She felt nurses should gain recognition for expert knowledge and skills. She argued in favour of applying a framework such as the current Standards for Specialist Education and Practice, as prescribed by the Nursing and Midwifery Council, United Kingdom. For expert orthopaedic nurses, a process like this would help delineate a recognised pathway in the specialty. While Clarke's review is useful in showing how orthopaedic specialist nursing practice is evolving, it must be recognised that her purpose was to evaluate need for specialist education and advanced practice roles in Northern Ireland.

Nonetheless, her recommendations are useful for orthopaedic nurses in this country. Standards of Practice have been developed successfully to guide practice in other nursing specialty scopes in New Zealand, for example in practice nursing (*NZ College of Practice Nurses: Standards of practice, 2006*), and, as mentioned previously, discussion has begun about formulating standards of practice for orthopaedic nurses in this country. Findings from the present study could help define essential characteristics of orthopaedic nursing in New Zealand.

Love (1996) sought to clarify the distinction between specialist and general nursing by carrying out a survey which asked nurses to "...assess a range of nursing activities in terms of whether they were 'highly orthopaedic'" (p. 19). Respondents were asked to assign five categories of nursing activities individually, (76 in all), to one of 7 professional functions or categories, ranging

from 'highly orthopaedic nursing function' to 'never done by nurses'. Tables of frequencies gave numbers of responses assigned to each professional function (category) for each of the patient care activities.

Thirty-six skills were identified as belonging to the 'highly orthopaedic' category but Love (1996) noted, "... it should be remembered that orthopaedic care is a holistic enterprise made up of specialist and generic skills, each of which is important" (p. 24). In highlighting the alignment between specialty status and education, Love recommended that priority should be given to teaching specialty orthopaedic nursing knowledge for this reason:

It may well be that all skills practiced by the orthopaedic nurse need to be taught to a higher cognitive level so that they can be delivered at a standard commensurate with specialty status. (p. 24).

This study, which sought to clarify the distinction between orthopaedic and general nursing, did so from the single approach of investigating skills activities practised by orthopaedic nurses. Research such as the present study are a valuable adjunct to Love's research, because they show the specialty 'as lived' by its proponents.

In her paper exploring the development of orthopaedic nursing as a specialism in Britain, Footner (1998), described changes that took place in the late 1980s as nurses asserted greater control over practice that was previously the domain of orthopaedic consultants. She noted, "It was a difficult concept for many to adjust to moving from a medical model to a nursing model and it has taken time" (p.219).

In contrast to this British experience, there has been no overt regulation of orthopaedic nursing in this country by orthopaedic consultants and thus, no subsequent period of adjustment to a nursing model of governance. This path was never followed in New Zealand and this may be an example of how we have learnt from the experience of others in developing the specialty for New Zealand nursing. However, there has been controls benign and otherwise

imposed by groups from outside nursing that are often not recognised and acknowledged. For example, the funding of orthopaedic healthcare settings affects how nurses practice within them, even though this financial control and who administers it may not be visible at the workplace. What it may mean is that because of financial constraints, there are limited options available in resourcing of healthcare settings. The choices that are accessible may not be the best for implementing patients' care nor are they necessarily the best fiscal option either when all factors are taken into account.

Footner (1998) further develops her rationale for orthopaedic nursing as a specialist activity:

Orthopaedic nursing is ... not a new field of study for nurses and its history and foundations are imbedded in the traditions of nursing...//... It could be argued that all nurses once they have become qualified and work within a particular environment, become specialists. (p.219).

According to Footner's (1998) and Love's (1996) recommendations, a multiskilled, generic approach is appropriate and is expected of most orthopaedic nurses in their day-to-day practice, but with adjunct roles for specialists. The endorsement here from the British model is that this group of 'specialists within a specialty' as exemplified by Clinical Nurse Specialists, Clinical Nurse Educators and Advanced Nurse Practitioners would be responsible for maintaining clinical currency and depth. These nurses would provide clinical leadership and undertake more complex and specific clinical responsibilities on a consultative basis. Investigative studies of this topic would be valuable in confirming that this is the true state of affairs in orthopaedic nursing, particularly as Footner does not say whether her recommendations were informed by research. From personal observation, this seems to be how the specialty is evolving in New Zealand albeit on a more ad hoc basis. The findings of my study should provide useful insights into the New Zealand situation. Both Love (1996) and Footner (1998) predicted a need for specialty orthopaedic nursing education and this is the topic covered in the next section.

EDUCATION IN THE SPECIALTY

Nursing education has had to accommodate to societal and political influences as well as evolving health care practice. Forty years ago, when many women were socialised into the nursing workforce and ended their career when they married, few gave thought to the direction their nursing career would take. Today, the opposite is true. Women can now expect to be part of the workforce throughout their lives and career planning is more important. As recognised, specialisation is becoming an accepted norm in nursing and this, combined with some form of educational advancement, enables nurses to seek and achieve fulfilment through a nursing career in various ways. Some authors have defined nursing career progression in terms of planning, (McBride, 1985), goal setting, (Thayer, 1992), its stages, (McNeese-Smith, 2000) and adjustments to be made over time (Thomes, 2003). It is also acknowledged by New Zealand practitioners, that specialty education is a critical part of career planning (Cassie, 2002).

Orthopaedic nursing education – an overview

Orthopaedic nursing has long been underpinned by specialty education. Historically, orthopaedic nursing training was a conjoint qualification that included physiotherapy (Carter, 2000a). In the UK, Dame Agnes Hunt was instrumental in establishing training for nurses in “... the care of crippling diseases” (p.57), because she recognised the value of massage and Swedish remedial exercise in care of ‘crippled’ patients.

While not currently faced with an upsurge in ‘crippling diseases’, present day orthopaedic nurses do care for many elderly patients, a number of whom are frail and disabled by multiple morbidities, thus the need for skilled practitioners is ongoing.

A stand alone Orthopaedic Nursing Certificate established in 1937, has been offered in the UK for many years (Kneale & Davis, 2005). Orthopaedic Nursing Certification (ONC) in the USA, is achieved as part of a continuing nursing education system (CNE) under aegis of NAON (Cutilli, 2003) and a similar

qualification exists in Canada (Millstead, 1997). The North American certification pathways, designed as frameworks for gaining specialty knowledge and skills, are similar to the process required to be undertaken by registered nurses in New Zealand when applying for a Practising Certificate. Currently, some form of postgraduate education in orthopaedic nursing is available in most western nations.

Specialist practice education has been available to New Zealand orthopaedic nurses for several decades, mostly as post registration courses. Originally they gave attendees certification in the specialty as issued by the provider, usually a tertiary hospital. While these courses were excellent in offering teaching about specialty knowledge and skills, they were medically oriented and, while valued within New Zealand, they were not recognised elsewhere.

As nursing education has advanced, so specialist education has advanced with it. Postgraduate education in the specialty is now offered from two universities in New Zealand at masters' degree level (i.e. University of Auckland and Auckland University of Technology). Research, such as the present study, contributes to specialty education by ensuring programmes are informed by the current realities of practice.

The growth of orthopaedic nursing

Since the 1980s, orthopaedic nursing conferences have assisted in promoting the specialty in New Zealand. Although a number of presentations are medical, nursing contributions are increasing. International conferences and specialty nursing journals are also providing New Zealand orthopaedic nurses with a broader perspective. Technological advances enable greater networking with colleagues and the New Zealand Orthopaedic Nurses' Association was recently launched with affiliation to a similar organisation in Australia, (*Minutes from NZON Meeting, Rotorua, 28th July, 2005*). This organisation, along with its British and Canadian counterparts in turn, is establishing links with NAON, to facilitate the sharing of knowledge and expertise via the International Collaboration of Orthopaedic Nursing (ICON, 2000).

Orthopaedic nursing texts and journals

Orthopaedic nurses have shown particular commitment in producing and publishing textual material to inform those practising in their specialty (J. Farrell, 1986; Footner, 1992; Kneale & Davis, 2005; Maher, Salmond, & Pellino, 1994; Powell, 1976). Classic texts such as Powell's 'Orthopaedic Nursing', which Footner (2003) describes as "...the authority for generations of orthopaedic students" (p.63), have run to many editions.

The two journals, 'Orthopaedic Nursing', published by NAON since 1982, and the 'Journal of Orthopaedic Nursing', in print since 1997 and affiliated to the Royal College of Nurses' Society of Orthopaedic and Trauma Nurses (UK) and the Canadian Orthopaedic Nurses' Association, are both refereed. They are increasingly reporting innovations in practice and research findings.

ORTHOPAEDIC NURSING RESEARCH

In New Zealand, the current drive to evidence based practice (EBP), has encouraged all health professionals to use research to inform their practice. Resources such as the Joanna Briggs Institute and the Cochrane Collaboration databases provide meta analyses of clinical research that are supported and referenced through healthcare institutions in this country.

Knowledge acquired through rigorous, peer reviewed research should form the basis for clinical practice. It assists the achievement of safety in patient care and has superseded much of the of hearsay, partiality and trial-and-error that informed practice in the past. The most acceptable form of evidence in the clinical setting seems to be EBP. There is an assumption that scientific findings are best, yet this prioritises the medico-scientific models of health care. Davis (2002a), provides a cautionary note on the limitations of EBP: "In many areas of health care this type of concrete, scientific or research evidence does not exist to guide our actions. Care can only be based on the best evidence available at the time." (p.61).

Sedlak's (1997) review of research studies published in 'Orthopaedic Nursing'

between 1982 and 1995 focused on nursing interventions and their outcomes in acute settings. Sedlak noted that although orthopaedic nursing research is becoming more sophisticated, most studies use quantitative approaches, which focus on measurable clinical outcomes and do not address questions that might be better answered by qualitative approaches. In nursing presently, there are many forms of credible evidence yielded by qualitative research findings. However different qualitative research questions require different qualitative approaches. For example, the present study lends itself to a phenomenological approach because it is investigating the experience of being an orthopaedic nurse.

Practice related research

My literature search on orthopaedic nursing practice yielded a number of articles that explored generic practice issues (Porter-O'Grady, 1998; Wilson, 2000), but did not focus on what orthopaedic nurses actually do. Other authors advised nurses on how to extend their practice in orthopaedics (Artless & Richmond, 2000; Martsoff, 1999; Maylor, 2001; Milstead, 1996a, 1996b; Park Kyser, 1996), but did not examine experiential aspects in any depth. Apart from work undertaken by Santy (2001), I was unable to find any research relating to orthopaedic nursing practice from the perspective of orthopaedic nurses.

Santy (2001) used a grounded theory approach to examine orthopaedic nurses' perceptions of working with patients. In presenting her findings, she argued that the role of the orthopaedic nurse was that of 'harmonist' in "...ensuring that all aspects of care produce an effective whole" (p.22). According to Santy, this role comprised six categories: partner, guide, comfort enhancer, mediator, risk manager and technician when caring for orthopaedic patients.

In a subsequent article, Santy, Rogers, Davis, Jester, Kneale, Knight, Lucas, & Temple (2005), describe how the findings of Santy's previous study have informed specialty orthopaedic nursing practice in the UK. In conjunction with the UK Royal College of Nursing (RCN) Society of Orthopaedic and Trauma Nursing (SOTN), a competency framework has been developed for orthopaedic

and trauma nurses. Focus group work in the initial stages of the project identified five core activities that were believed to characterise orthopaedic and trauma nursing practice. They included: "...comfort enhancer, coordinator, partner/guide, risk manager and technician" (Santy et al., p.83), thus reflecting previous research (Santy, 2001). Together these studies facilitated the development of a valuable tool, which formed a basis for RCN competency frameworks.

This suggests the need for competencies to be developed in this country also, given, as previously mentioned, that standardisation of orthopaedic nursing skills is under discussion in New Zealand. It is possible that work such as this, together with New Zealand research such as the present study could also guide developments in this country.

CONCLUSION

This chapter has provided a background for this study. It has outlined many of the cultural and historical horizons (Gadamer, 1976, 1989; Heidegger, 1927/1962) that inform the experience of being an orthopaedic nurse in New Zealand.

An overview of the history of New Zealand orthopaedic nursing has been provided. The culture of orthopaedic nursing has evolved in New Zealand through development of specialty skills and knowledge initially brought by nurses from Britain, or through New Zealand nurses gaining experience in orthopaedic nursing in other countries. It has continued through development of specialty education, access to orthopaedic nursing publications and conferences and the establishment of a New Zealand Orthopaedic Nurses' Association, which is developing links to its counterparts overseas. I have argued in favour of specialisation and emphasised the potential and need for its development in this country.

There has also been discussion and critique of the research findings informing this area of practice. The knowledge and insights gleaned could inform the

future development of this specialty in New Zealand. For example, because it illuminates New Zealand orthopaedic nursing, I believe my study could contribute to establishment of a skills framework for New Zealand orthopaedic nurses.

The following chapter describes the focus of the inquiry. It outlines the philosophical underpinnings of the study, methodology and the methods used during the research.

CHAPTER THREE: METHODOLOGY AND METHODS

INTRODUCTION

This chapter is divided into three sections. The first, links the research question with its philosophical underpinnings. The second, the methodology section, describes how selected philosophical ideas have been used in the study. The third section outlines the research process under the following headings: ethical considerations and approval, participant selection, data gathering and analysis and will also discuss criteria appropriate for judging the study's rigour.

RESEARCH QUESTION

What is the meaning of the experience of being an orthopaedic nurse? This question is congruent with Gadamer's (1976; 1989) philosophical notion that the individual is shaped by traditions, yet is capable of new understandings.

As an orthopaedic nurse, I wanted to understand more fully the lived experience of orthopaedic nurses in the present day context of the New Zealand health care system.

PHILOSOPHICAL UNDERPINNINGS

Hermeneutic phenomenology

The philosophical stance underpinning this study is hermeneutic phenomenology. Phenomenology is based to some extent on the thinking and writing of Martin Heidegger (1884 -1976), a philosopher from the German School who significantly influenced existential and postmodern philosophical thinking in the 20th century. In attempting to respond to the metaphysical question of Being: "Why is there anything at all rather than nothing?" Heidegger sought to discover Being or reality by "beginning with authentic human existence" (Grenz, 1996, p.104). He used the German word *Dasein* which, in English, translates most closely to 'being in', 'being there' or 'being-in-the-world', to describe this. Heidegger (1927/1962) emphasised the lived nature of human being in its everyday familiarity, rather than conscious knowledge of human existence and experiences in the world.

In this context, 'world' does not mean the environment within which we live or the artefacts and entities that inhabit it. 'World' takes on a phenomenological sense of "...the meaningful set of relationships, practices and language that we have by virtue of being born into a culture" (Leonard, 1994, p.46). Thus human beings are seamlessly integrated into a world. World cannot exist outside our understanding and, conversely, it gives credence to our existence, our being. Heidegger (1927/1962) uses the term 'thrownness' to describe this sense of being 'always already situated' in the world and never separated from it. From the moment we are born, we are 'thrown' into what Leonard describes as: "...a particular cultural, historical and familial world" (p.47). For individual participants in this study then, *Dasein* refers to the 'being-in-the-world' as an orthopaedic nurse. This world, although unique to each of the nurses, comprises a world of practice that is informed by its own cultural and historical traditions.

The phenomenon

For Heidegger (1927/1962), 'phenomenon' is "...what lies in the light of day or can be brought to the light" (p.51). This is not the 'appearance' or 'semblance' of what it seems to be. Attention is given to the 'essential being' of a phenomenon and the illumination of its hidden meanings. This study of 'the experience of being an orthopaedic nurse', will therefore attempt to uncover what is hidden, glossed over, unrecognised or ignored in the 'everydayness' of being an orthopaedic nurse.

Hermeneutics

The word hermeneutic derives from the Greek word meaning 'to interpret', which is sourced from the name of the Greek god Hermes. Hermes was the divine messenger because he carried communications between the gods and humans. In so doing, he interpreted the messages of the gods in ways understood by humans, (Johnson, 2000). In hermeneutic phenomenology, this describes how meaning or understanding of texts is achieved. The researcher receives and interprets meanings about a phenomenon from those who have lived it (that is, the participants) and through interpretive analyses, presents these in a new light for the reader.

Gadamer's hermeneutic understanding

Gadamer (1976; 1989) built upon Heideggerian (1927/1962) notions of being-in-the-world, focusing on the dialectical and dialogical nature of understanding (Spence, 2000). He recognised the to-and-fro 'play' of understanding and the essential place of language in this process. As a researcher, I have participated in conversations that used words and have subsequently communicated my interpreted meanings in language as a written form.

Gadamer and the notion of prejudice

Every individual constructs a fundamental system of beliefs or 'truisms' that guides thinking and progress in the world. Gadamer (1976; 1989) also recognised that all understanding derives from traditions past and present. Because we are always in the world with others, we engage with already existing meanings and come to embody these in ways that we do not necessarily recognise. Gadamer rehabilitates the notion of prejudice reminding us that prejudices are preunderstandings; that they can be both positive and negative. Spence (2000) argues therefore, that prejudices both enable and limit all human understanding.

The hermeneutic circle

In the process of textual interpretation, the 'hermeneutic circle' describes that the relationship between "...complex wholes and their parts is always inseparably intertwined", (Grenz, 1996, p. 100). Thus, in research, the 'hermeneutic circle' refers to the to-and-fro motion of interpretation that necessarily occurs when analysing interview transcripts. Data interpretation is an ongoing process of moving backwards and forwards between understanding parts of the phenomenon and the phenomenon as a whole. The understanding of the whole deepens through sustained analysis of the texts. In this study, interplay of my understandings with those of the participants and the data, progressively illuminated the experience of being an orthopaedic nurse.

Moreover, 'understanding' in hermeneutic terms is always partial. There will always be more that can be understood and there will always be different interpretations. As Gadamer (1989) stated: "It would be a poor

hermeneuticist who thought he could have, or had to have, the last word (p. 579).

Existentials or lifeworld themes

Congruent with Heideggerian (1927/1962) philosophy, the existential or lifeworld themes described by van Manen (1990) provide a structure for interpreting everyday experience. Although the lifeworld is complex and different meanings can be interpreted, van Manen articulated themes that are fundamentally the same across human situations. He describes four lifeworld existentials: 'lived body', 'lived space', 'lived time' and 'lived other' (p.102).

In this study, 'lived body' and 'lived other' have been particularly useful when analysing the meaning of being an orthopaedic nurse. In referring to 'lived body' (corporeality), van Manen (1990) describes how the human physical body or presence reveals and conceals existential meaning. Hence: "When we meet another person in his or her landscape or world, we meet that person first of all through his or her body." (van Manen, 1990, p. 103).

Integral to the experience of being an orthopaedic nurse is this meeting with patients through their bodies. Leder (1984) states, "That the body is not a mere extrinsic machine but our living centre from which radiates all existential possibilities, is bought home with a vengeance in illness, suffering and disability." (p.34). Thus, implicit in patient care, is care of the patient's body, for example, when carrying out physical assessment of the patient, checking neurovascular function or applying a cast.

'Lived other' (human relationality), focuses on the way human beings relate to 'others' in their world. van Manen (1990) describes this as: "... the lived relation we maintain with others in the interpersonal space that we share with them" (p. 104). Orthopaedic nurses maintain close relationships with others for example, patients, in shared interpersonal space such as at the patient's bedside in the ward or beside the examination couch in a clinic consulting room. This 'lived' relationship "... allows us to transcend our selves." van Manen (p.105), because it involves trust, mutual dependence

and frequent physical contact between patient and nurse.

FROM METHODOLOGY TO METHOD

In this section, I will outline and justify the methods used in this study. I will explain the rationale for surfacing the preunderstandings I brought to the research and discuss ethical considerations, sampling procedures, data collection and analysis. I will also outline the criteria by which this work can be judged as rigorous.

Identifying pre-understandings

Before I began the research, my supervisor interviewed me about my experience of orthopaedic nursing in order to identify my pre-understandings or suppositions (see Chapter One). This is important in hermeneutic research because, as the interpreter of the research data, I needed to become aware of the prejudgements/prejudices I held in relation to the phenomenon (Geanellos, 1998). The purpose of identifying one's prejudices is not to set them aside, but to engage with them during the analysis (Spence, 2004).

DISCUSSION OF ETHICAL CONSIDERATIONS

Ethical approval

Three District Health Boards reviewed the proposal and agreed to allow access for recruitment purposes prior to approval being sought and gained through the Regional Ethics Committee (See Appendix A).

Ethical considerations

Ethical principles informing this study included the following:

do no harm;

voluntary participation;

informed consent;

avoid deceit;

confidentiality or anonymity;

as formulated by Tolich and Davidson (1999).

1] *Do no harm*

Research participants need to feel valued and respected. Successful implementation of the research rested on being properly prepared and anticipating contingencies such as the need for participants to have cultural or emotional support. For example, I made sure that interview settings were appropriate for the participants. Had someone wished to have support people or whanau at the interview, I would have accommodated this. I was prepared to stop the interview immediately and provide support if the participants showed signs of distress or discomfort. I would have offered respite from the process if necessary and I also had other support mechanisms in place such as counselling if they were required. None of these actions were required.

2] *Voluntary participation*

Nurses were invited to participate in the study through the use of intermediaries rather than being contacted directly by the researcher. The nurses were provided with information by the intermediary person prior to deciding whether or not to make their contact details known to the researcher. Thus the nurses who volunteered were not coerced in any way.

3] *Informed consent*

Having been informed about the study and provided with an opportunity to ask questions, the participants completed a Consent form (Appendix B). They understood what was required and knew they were free to withdraw from the study at any time.

4] *Avoiding deceit*

An information sheet outlining the study's aims and processes was provided (see Appendix C). Participants were able to contact me at any stage if they had queries. They were also given copies of their own transcripts and were able to remove or change part of the data prior to commencement of analysis. They were informed that the final thesis would be available to them through the university library.

5] Confidentiality and anonymity

The tapes and raw hard data were kept in a locked filing cabinet. Electronic transcripts were kept in a locked password protected folder on my computer. The identity of the participants was kept confidential through the use of pseudonyms and removal of any identifying details. Possible difficulties related to the researcher and some participants having a shared employer were discussed with several participants prior to commencement of the study.

Selecting the participants

Purposive sampling was used to recruit participants. I used snowball sampling through professional networks to identify participants who would be able to provide detailed experiential information on the topic.

I wanted 8 - 10 nurses from a range of different orthopaedic settings and recruited from multiple sites to avoid risks to anonymity that could arise through selecting from a single setting. There were two criteria for participation: that participants spoke English sufficiently well to be interpreted by the researcher and that they had at least two years of orthopaedic nursing experience.

Following discussion of the project with intermediaries and groups of nurses at each site, eight registered nurses volunteered to participate in the study. Seven worked in orthopaedic wards in the three hospitals and the eighth in a casting room.

Gathering experiential data

Interviews

An interview of 60 to 90 minutes duration was conducted with each participant. Interviews took place in comfortable, private settings that were chosen by the participants. One interview took place in the participant's home. Two occurred in my home and the remaining five took place outside of work hours, in the participant's work settings.

Open-ended questions were used, commencing with 'Tell me what it is like

to be an orthopaedic nurse...' and followed up with prompts such as: 'Tell me more about...' and 'You say... what is it that makes you feel this way?' and 'What is it about orthopaedic nursing that made you think that?' This style of interviewing, while enabling pursuit of particular lines of enquiry, is flexible and stays close to the participants' experience. The interview questions encouraged exploration of thoughts, feelings, attitudes and actions.

A typist who had previously signed a confidentiality agreement (Appendix D), transcribed the interview tapes. Transcripts of raw data were returned to participants to check for accuracy and to amend as necessary. None of the participants asked to have data removed or amended.

Analysing the data

The interviews took place over a six-month period and, as each transcript became available, formal analysis of the data began. van Manen (1990), suggests that gathering experiential data and analysing it, even though two separate acts, should be seen as part of the same process. He says, "The conversational interview method may serve either to mainly gather lived-experience material (stories, anecdotes, recollections of experiences etc.), or serve as an occasion to reflect with the partner (interviewee) of the conversational relation on the topic at hand." (p.63). The following is an example of a conversation Julie and I shared during her interview. (The bold type signifies the researcher's voice and the plain type is Julie's.)

There's a belief out there, and I hear it a lot, that we are some sort of sub-branch of surgery. I don't believe that we are.

Is there anything that is unique to orthopaedic nursing compared to other fields of nursing that has grabbed you... that sets it apart?

It is hard to actually identify what it is.

I have noticed over the years that a lot people call themselves orthopaedic nurses whereas they don't call themselves surgical nurses necessarily. What do you think defines what makes an orthopaedic nurse?

I wonder if it is because the skills that you learn are not necessarily that transferable to any other specialty in one sense. Maybe if you moved from medicine into surgery there are still some skills that you can take...

... and yet those skills are a part of orthopaedics. So are you saying orthopaedics has a skill base and knowledge that is pertinent to it and is non-transferable?

Pretty much. Yes. If you are taught how to plaster you are not going to walk off and get a job in the medical ward. It's no use to you there really. Yes, maybe that's what it is.

So this is why it has its own uniqueness?

Yes that's it.

In this raw data example, both interviewer and interviewee are conversing reflectively from a shared understanding of the phenomenon in an effort to identify aspects that are unique. The dialectical nature of this conversation uncovered information that was not immediately apparent. It led to recognition by Julie that specialty skills, such as casting, were significant in showing the uniqueness of orthopaedic nursing because they are non-transferable.

Thematic analysis

van Manen (1990) talks about isolating thematic statements using three approaches. When formally commencing analyses of a transcript, I used the wholistic or sententious approach. I examined each data set as an entirety, asking: "What phrases capture the significance or fundamental meaning of the phenomenon when viewed as a whole?", "What 'hits me in the eye' about the experience of being an orthopaedic nurse?"

One example was Marie's phrase, '*...it's a fine line...*'. This seemed to encapsulate the overall edginess of parts of her account and the delicate balance drawn between negative and positive aspects of her experience.

van Manen (1990), also advocates using a selective or highlighting approach. This means going through each transcript several times highlighting statements or phrases that are essential or revealing about the phenomenon being described.

The following are some examples from Angela's Interview:

'I fitted in with the team',

'a lot of the nurses there had been in orthopaedics for a long time ... they represented ... the essence of orthopaedics' and 'I wanted to be like these

people - I wanted to be an orthopaedic nurse'. These ideas were later integrated into the notion of: 'Aspiring to become an orthopaedic nurse' in 'Gaining and maintaining integrity', (see pg. 80).

Finally, van Manen (1990) suggests using a detailed or line-by-line approach whereby every sentence is scrutinised for further meaning about the phenomenon. As thematic meanings emerge from the transcripts collectively, they are clustered or synthesised and "linguistic transformations" are composed (van Manen, 1990, p. 95). Here is an example of a linguistic transformation composed from Marie's text:

...orthopaedic nursing is quite challenging and I just love it and I still feel that I need to learn more. ... You never get tired about learning about orthopaedics because there is always something new.... I have been here for a long time but I feel I still have a lot to learn still. You know, there is heaps. (Marie).

The idea that one is always learning despite years of experience was subsequently utilised in introducing the theme 'Gaining and maintaining integrity' (see p. 69).

The hermeneutic process involves interpreting the data or searching for essential meanings by thinking, questioning, writing and rewriting to reveal these meanings. It was a process of "going back and forth between the parts and the whole". In this instance, the 'parts' were the eight data sets or interviews. During the process, of analysing the phenomenon as a whole, the notions that emerged became other parts. Examples were:

'having the know-how' which transferred into 'learning the know-how', (on p.71), and 'I wanted to be like...' which became 'aspiring to become an orthopaedic nurse', (on p. 80). Then, gradually initial understandings were synthesised to reveal deeper, more universal, meanings.

Crafting the research product

These processes of analysis continued for over a year. Initially, I selected relevant excerpts from each participant's transcript. I then asked questions of the data that helped me to unpack new and hidden meanings. I created graphic representations of possible themes, colour-coding them and

physically cutting and pasting data, brainstorming and mind mapping to try and create meaning and linkages. There were vast amounts of data - 100,000 words to work with, containing many stories and ideas, but gradually, through the processes of thinking and writing, I identified the beginning themes. These were questioned and further challenged by my supervisor, who also assisted me to think, question and rewrite to achieve coherent unity of meaning.

The movement of understanding is constantly from the whole to the part and back to the whole. Our task is to extend in concentric circles the unity of the understood meaning. The harmony of all the details with the whole is the criterion of correct understanding. The failure to achieve this harmony means that understanding has failed (Gadamer, 1976, p.130).

The component parts of the analysis then, were reshaped to become the two essential themes: 'being part', and 'gaining and maintaining integrity'. In combination, they represented the 'whole' of the completed project. These themes are described in Chapters Four and Five.

Criteria for judging the rigour of this study

Numerous authors have provided criteria and discussed the essential requirements of rigorous qualitative research. It is recognised however that the criteria established for quantitative research are not appropriate for qualitative research and that qualitative research itself has many guises. Therefore, as Emden and Sandelowski (1998) argue, there should be more than one set of criteria for judging the soundness of qualitative studies.

Qualitative researchers come from an array of backgrounds, dispositions and worldviews, and practice their craft within many philosophical and methodological traditions. It would be presumptuous to suggest that they should, or could, hold to one set of views about the quality of their work (p.207).

Questions have even been raised about whether it is necessary to be concerned about rigour at all. As Grbich (1999) argued, "Those antagonistic to the notion of 'rigour' assert that concepts of 'objectivity', 'validity', and 'reliability' are problematic and should be abandoned or radically qualified" (p.62).

Yet research must be trustworthy and Koch (1994), suggests "...that the

trustworthiness (rigour) of a study is established when readers can audit the events, influences and actions of the researcher” (p.976). Thus, in any research, it is the author’s responsibility to attempt to make clear to the reader how the issue of rigour has been addressed. It is then up to the reader to determine whether this has been successful; whether the research processes are believable or credible (Koch, 1996).

I have selected ‘reflexivity’, ‘internal consistency’ and ‘credibility’ as appropriate criteria for judging the rigour of this study.

Reflexivity

According to Grbich (1999), reflexivity, “involves a process of self awareness that should clarify how ones beliefs have been socially constructed and how these values are impacting on interaction and interpretation in research settings.” (p. 65). Koch (1998) supports this definition and further suggest that “...the entire research process is a reflexive exercise which provides answer to the question: ‘What is going on in methods?’” (p. 882).

Geanellos (1998) echoes Koch’s (1998) defence of reflexivity by arguing that in hermeneutic research it is necessary for researchers to reveal their pre-understandings for two reasons. It safeguards the attempts to reveal the phenomenon under investigation and through the reflective process that necessarily accompanies identification of these forestructures or prejudices, it enables the researcher to question their “...origins, adequacy and legitimacy...in relation to textual interpretation” (p. 238). Thus, the process of hermeneutic analysis is itself reflexive and assists in ensuring the trustworthiness of the research.

Koch (2004), suggests that keeping a reflexive journal has multiple benefits. It serves to track the process and development of the research. It acts as a repository of thoughts actions and beliefs about analytical processes as they occur and it can be a place for catharsis, where fears and anxieties can be confronted and reflected upon to generate new ideas and directions. It can generate its own data and analysis which in turn “are woven into the

research text and show readers how an interpretation was made” Koch (p.134). Following the advice of Geanellos (1998) and Koch (1998), I kept a reflective journal. This was useful for its practical functionality and also because it allowed me to record the conversations or thoughts I had in relation to the interview data.

Maintaining internal consistency and credibility

Internal consistency is demonstrated in qualitative research by showing how the epistemology (research paradigm), the philosophical stance, methodology and methods for gathering and analysing data, inform and interact with each other in responding to the research question.

In this thesis I have endeavoured to show how the research question links to the background of the study, the methodology and the method. By doing this I am demonstrating the internal consistency or validity of the study. I presented my background of experience and the reasons for undertaking this research in Chapter One. My prejudices or pre-understandings about orthopaedic nursing were identified. In Chapter Two, the historical and cultural contexts of the research were outlined and implications for New Zealand orthopaedic nurses were highlighted.

In this chapter I have provided an example of how my understandings of being an orthopaedic nurse mediated with those of the participants in this study. Within presentation of findings narrative and analysis, references are made to these pathways and the development of new understandings is shown.

Credibility is demonstrated in a qualitative research study when the findings seem believable. Trochim (2002) argues that it is only research participants themselves who can legitimately judge whether the findings of a study are credible. Yet when asked the question: “Credibility for whom?”, Lincoln and Guba (1985) responded, “...it is the consumer who is ultimately the ‘whom’” (p.328). The ‘truth’ about being an orthopaedic nurse is something that should be recognised by orthopaedic nurses. I have sought to demonstrate credibility in two ways. Firstly, by showing raw data linked to my

interpretation and secondly, by eliciting a 'phenomenological nod' when presenting the findings to orthopaedic nurses at conferences and in discussion with colleagues.

CONCLUSION

The first section of this chapter restated the research question and linked it to its philosophical underpinnings. The second section briefly discussed some of the philosophical ideas articulated by Heidegger (1927/1962), Gadamer (1976; 1989) and van Manen (1990) thus providing a rationale for the use of a hermeneutic approach to illuminate the meaning of being an orthopaedic nurse. The third section provided details of the research design. This section outlined the study methods: the ethical principles that informed the project, ethical approval, recruitment, data collection and analysis processes. Finally, a review of criteria for judging the study's rigour was presented.

The following chapter, Chapter Four, begins to present the findings of the study. Thematic description revealing the essential meaning of being an orthopaedic nurse is then continued in Chapter Five.

CHAPTER FOUR: STUDY FINDINGS - BEING PART

INTRODUCTION

‘Being Part’ is central to the meaning of being an orthopaedic nurse. Orthopaedic nursing practice involves working with a range of people in different ways to fulfil patients’ needs. For the individual nurse, this means ‘being part’ in terms of establishing working relationships with nursing colleagues, doctors and other health professionals as the need arises. It means liaising with people from other institutions. But it also means ‘being a part’ with patients in helping them adjust to their illness experiences and facilitating recovery. In this study the nurses’ stories show the multiple ways that ‘being part’ or ‘a part’ reveal the uniqueness of being an orthopaedic nurse.

This chapter begins by describing the place of nurses within the orthopaedic service as a whole. The first section explores this with particular reference to their relationships with medical staff. The second describes their experience as part of the interdisciplinary team. The third section focuses on relationships with nursing colleagues and within the nursing team. The final section describes their ‘part’ with patients in the context of providing physical and psychological support.

van Manen’s (1990) four fundamental existentials of ‘spatiality’, ‘corporeality’, ‘temporality’ and ‘relationality’ have been used to develop this theme. There is particular emphasis on ‘relationality’ relationships with ‘others’ are an integral part of being an orthopaedic nurse. ‘Corporeality’, is also critical to the theme of ‘being part’. This is because there are embodied ways in which orthopaedic nurses work with their colleagues and patients.

The notion of embodiment

“In the phenomenological view, rather than having a body we are embodied” (Leonard, 1994, p. 52).

The word 'embody' has several meanings. The following dictionary definitions: 'to give bodily form to; or 'incarnate' (*The American Heritage® Dictionary of the English Language, 2000*), and 'represent in bodily form' (*WordNet ® 2.0, ©2003, Princeton University, 2003*), have the closest relevance in this context. But the body in health and illness can be described in several ways phenomenologically. For example, van Manen (1994), discusses Sartre's (1956) nihilistic view in speaking of the body as "‘passed-over-in-silence,’ that is, *passé sous silence*, because we ordinarily do not notice the body much." (§ 22). This typifies how we think or neglect to think about the body in health. In illness however, we are forced to be aware of the body and bodily function and, as Botorff (2002) describes, we objectify and subjectify the body according to the 'play' of health and illness:

The body [in illness] becomes an object, a “thing” of investigation, vigilance, diagnosis, and treatment. During recovery, subjection of the body must again become possible in the sense that the body can be used and managed with a renewed sense of trust... We are reassured that we can become master of ourselves once again.... (§ 21).

This 'play' of objectifying and subjectifying the body is evident in the nurses' stories.

BEING PART OF A SERVICE

Working with medical staff

'Being part' implies belonging to a larger whole and for orthopaedic nurses, the 'whole' is the orthopaedic service in which they work. The orthopaedic service within a hospital, as mentioned in Chapter Two, usually comprises theatres, wards and an outpatient department that may or may not offer a casting facility.

In the larger centres, the unit may be further divided into acute and elective wards with separate adult and paediatric services provided as stand-alone facilities. Orthopaedic nurses may work in any of these settings.

Working with medical staff features strongly in the everyday world of orthopaedic nursing and the relationship between the nursing and medical

professions has become mutually dependent and quite distinct from the liaisons that orthopaedic nurses form with other health professionals. Yet the balance of this relationship fluctuates and has many guises. Being an orthopaedic nurse continues, as it has in the past, to mean following orders and protocols about patient care according to the dictates of orthopaedic consultants (Whitehead & Davis, 2001). Although tensions arise when challenging medical opinion, being an orthopaedic nurse means having to work effectively with medical staff in spite of this. The nurses' stories reveal how this 'effectiveness' can be difficult to achieve. Thus, 'being part' in this relationship often means taking the greater responsibility for establishing patterns of acceptable professional behaviour and accountability.

Julie describes working with orthopaedic consultants and how her relationship with them has developed.

To be honest, at first sight I didn't really like any of them. They were blunt towards me, arrogant, not very patient focused and couldn't see holistically. I do realise they are coming from the medical model, but, surely in these times they should have come a little bit further. When I became clinical co-ordinator and started doing rounds with them, I butted heads a few times. They still have very old-fashioned ideas especially about wound care! But I have made a bit of headway with some issues and it is quite heartening when they take my advice. Now it's common for them to ask, "What do you recommend?". That's not what I used to get before, which was, "This is what we want", even if it [the practice] was twenty years old. For me that's been quite a positive thing.

Julie is expected to follow the orders of orthopaedic consultants simply because she is a nurse. The consultants' expectation was that she would do this without questioning that they knew what was best for the patient. Yet she is fully aware that her knowledge in certain areas is superior to that of her medical colleagues. She had initially experienced difficulty getting her point of view across but, with time, the relationship has become more equal. She enjoys their respect now but not without ongoing effort. Julie is prepared to understand and excuse consultants behaviour because they fulfil their duty of care obligations in other ways.

I know some of them have huge patient caseloads because I have seen the stats. I know they have to get from one end of the hospital to the other and go off to surgery, other hospitals and private practice. The pressures are huge. Being in this role has given me a better understanding. I do understand the pressure they are under and the pace they work at. I like the 'just get on with it and get it done' attitude - which is often their attitude, but the nursing side of me sometimes...[rebels].

Over time, Julie has come to appreciate the stresses under which most surgeons function. Having worked with consultants in a coordinating role she realises she enjoys the dynamic pace and the 'cut and thrust' demands made of people around them. Yet, this presents tensions and, in reflecting upon this experience, Julie realises that consultants' behaviour is not always compatible with nursing aims and priorities.

Numerous stories elaborate 'the little ways' of orthopaedic consultants. Words like 'arrogant' and 'pedantic' are common and distinctions are made between older and younger surgeons. Beverley finds it easier communicating with younger consultants.

That's one thing that hasn't changed. Well they think they're God don't they! Sorry. I always remember that saying from home "What's the difference between God and an orthopaedic surgeon? An orthopaedic surgeon thinks he's God!" We used to have it stuck up on the wall because they're very particular about their own little ways. The younger surgeons coming through now aren't as particular as the older ones were... and the registrars - you can say anything you want to them and you know they won't take offence They accept your judgement because they know and value your experience.

Beverley remembers the joke made about orthopaedic surgeons 'deifying' themselves, from her early experience in the UK. She is reminded of this because, in her experience too, surgeons can appear arrogant or 'very particular'. She enjoys a more equal and congenial relationship with the younger doctors and knows that her experience is respected and valued by them.

Ann recalls an instance in which surgeons' preferences for treatment caused difficulties for her less experienced colleagues.

We have two surgeons who are very pedantic. Terribly so. Like when it comes to positioning of pillows for their hip patients. One in particular gets frustrated when he goes on the rounds every morning and becomes very irate and rude. For instance he is adamant that his patients have TED [anti-embolitic] stockings and when he comes in the morning and they haven't been put on, he has zero tolerance for non-compliance. There are tears for this, which is a shame. TED stockings are very important to him and sometimes younger nursing staff don't understand this. Or they find it difficult because another surgeon does not want TEDs on his patients. They do try to understand each surgeon's perspective but they have difficulty especially as the literature supports both views.

Less experienced nursing staff can be confused by different protocols. When one of the consultants became angry upon discovering his instructions had not been followed, an already fraught situation deteriorated further. Ann believes some of the anger and rudeness is unwarranted. She knows staff find it difficult to implement individual surgeon's preferences for TED stockings because they are aware of evidence supporting both treatment modalities. This excerpt illustrates tensions arising between nursing and medical staff. Ann describes a typical nursing response to such tensions.

We are starting to put particular protocols together for each surgeon because we are working with a designated pathway for our elective patients. All of us have to learn the surgeons' preferences. The charge nurse has put things on paper, like photos of positioning and how each surgeon wants things, above each patient's bed. To try to get everyone in the same frame of mind.

Listing surgeons' preferences and/or placing them above patients' beds, makes such the information more readily available. However it also raises questions about the nature of the relationship that nursing staff have with consultants. Do such actions demonstrate paternalism and subservience? Does a relationship that on the surface appears collegial, in fact exist at some cost to the professional autonomy and identity of nursing? And does this commodify patients by emphasising their 'disease' or 'condition' rather than their personhood? As in many areas of nursing, being an orthopaedic nurse can

mean having to focus more on the task, the disease and the surgeon's wishes than on the patient as an individual.

Engelhardt (1985), describes tension within relationships between doctors, patients and nurses and suggests nurses can be undermined within this triad.

Nurses are caught between physicians, on the one hand, who are authorities regarding scientific and technological knowledge and are 'in authority', and patients on the other hand, who give authority for health care endeavours. Nurses are often placed, as a result, in ambiguous circumstances regarding which side is authorising them to do what. (p. 73).

This 'inbetweenness' can sometimes mean that nurses act as a buffer between doctors and patients. They have to intervene to ensure there is congruence between doctors' and patients' expectations.

Mending and patching – ensuring medical orders fit patients' reality

Julie discusses instances of 'inbetweenness' where she has had to be assertive with consultants in order to reconcile them to the patient's needs.

You certainly get used to challenging doctors because they will walk in and say, "You can go home today!", and it could take another week to discharge the person. We have to pick up the pieces. The patient's distraught; they have been told that they can go. That is still the belief of patients: He said, "Go!", therefore that is what goes. He is the doctor!

Julie's description of surgeons' behaviour brings to mind Leder's (1984) statement that: "...the envisioning of the body as a machine composed of parts permits the proliferation of specialists concerned only with a single body-region or organ system." (p.36). Julie continues:

When I first started doing this role, medical staff often gave very unrealistic orders – for an 85 year old lady, for example, "Well get the physio and just get her home". Well it just wasn't going to happen. As a few years have gone by, they seem to have developed a better understanding. I have had to stand up and be quite assertive and say, "No. This lady needs 'X', 'Y' and 'Z' and this is why she is not going home".

For Julie, enacting discharge processes begins with instructions from the

surgeons but the process must continue until everyone is satisfied that the patient will leave hospital safely. Part of Julie's role is to facilitate this outcome, a process she has described as 'mending' which is more like '...a patchwork ... so that... patients are able to go home with the plans that we've put in place'. Thus, there are times when orthopaedic nurses have to confront surgeons in order to achieve a safe outcome for the patient. Yet there are also experiences that are mutually satisfying.

Being part – enjoying the collaboration with doctors.

For Annette, being an orthopaedic nurse means enjoying a special relationship with medical staff.

If we have problems we tend to go to the registrar, so we know them quite well. Sometimes we have gone to the consultants. We feel we can access them and we usually have quite a good rapport with them. I guess you get to know them quite well because you are casting for them. It is a special relationship...

This collegiality has evolved because she works in a casting setting where the nursing relationship with medical staff is more consultative and equal.

I must admit that sometimes they might have different views but they will then explain to us the reason why. They are happy to justify what they do and they will say, "This is the reason why we are doing this." We will respect that, because ultimately they are the ones that are responsible.

Annette finds that surgeons provide a rationale for their treatment decisions when there is a difference of opinion. When surgeons explain why they wish to do things a particular way, Annette is reminded that they hold the ultimate responsibility for patient treatment. Yet, while the relationship may be positively referred to as 'special', there is evidence that paternalism and subservience persists. When Annette talks about '...casting **for** them....' [my emphasis], she seems to imply that the relationship with the surgeons is more important than that with the patient. This suggests that getting along well with surgeons means putting them first. Yet questioning medical decisions is also part of Annette's role.

In the notes, the instructions were to put a full cast on, then the patient could go home. When we took his back slab off, we felt the surgeons hadn't looked at the wound properly at all. The patient's suture line hadn't healed properly so it was not suitable for him to go home. The house surgeon came up, had a look and said, "Yes, I agree with you. Keep him in and get your doctors to review him tomorrow when they are around."

In this excerpt, a junior doctor accedes to Annette's request to change the patient's treatment. He acknowledges and respects her expertise in the practical aspects of casting and wound care. Annette had argued that the patient should be reviewed by his own surgeons prior to discharge. Thus Annette works in the best interests of the patient, the house surgeon and the consultant.

Protecting doctors and patients from harm

Marie describes another instance in which she intervenes on behalf of medical staff.

I have no problem whatsoever telling the consultant to wash his hands before he leaves the room. Absolutely none. You know, you get MRSA [methicillin resistant staphylococcus aureus] in the wards, and why? Now that we have elective patients, we have MRSA! Well, why have we got MRSA? You have to look to the doctors. You have to be proactive. Just because he is a consultant doesn't mean you can't turn around and say - "Excuse me you've just touched that patient you are going to touch another patient – you go and wash your hands please." And the majority of them are very good but there is the odd one who looks at you as if to say, "Who are you to tell me what to do?" I just glare back at them - whereas the young nurses wouldn't dare!

There are times when medical staff need protection from themselves. In reminding them to wash their hands, Marie 'pulls no punches'. She knows doctors, like anyone else, can be responsible for the spread of MRSA. She is clearly capable of being assertive and speaking to them on equal terms. Not only is Marie relating with the doctors as professional colleagues, she is also 'looking out' for them despite the fact they do not always appreciate this.

As observed by Nolan, Davies, Brown, Keady, & Nolan, (2004) "....to develop,

nurses need to pay greater attention to their external relationships, especially with other disciplines” (p. 47), which for orthopaedic nurses means cultivating productive relationships with other health professionals on a daily basis.

Being part of the interdisciplinary team (IDT)

Formation of an interdisciplinary team signals a positive break-down of interprofessional barriers. Formal integration is justified because the whole, (team), is better than individual parts, (separate disciplines), when guiding discharge planning as it encourages a cohesive approach. As Milligan, Gilroy, Katz, Rodan, & Subramanian, (1999) argue, this means: “...an effective communications framework can be achieved while diversity among disciplines is maintained” (p. 52).

Being an orthopaedic nurse, then, means having to be clear and direct when exchanging information with other health care professionals. Low (2003) acknowledges that nurses have a pivotal role in communicating with other health team members by virtue of the fact they have greater contact and familiarity with patients. Julie describes being part of the interdisciplinary team.

We meet in the interdisciplinary team - that is, the physio, OT, social workers and myself. We meet about 10.30 -11 am every morning and go through the whole patient list. I appear to be the facilitator and we will go through each patient plan, decide what happens next and what's the progress.

That is actually something I am looking into at the moment for one of my papers - that relationship. I don't actually know how effective we are. I would like to know how effective we are. I think we are effective in terms of discharge but I wonder about the actual patient care in hospital, how it affects that. Could we be better?

In Julie's ward, interdisciplinary team members include the physiotherapist, occupational therapist [OT], social worker and the nurse who is coordinating the ward. Julie meets with the team daily to plan coordinated patient care. She believes the team works effectively in relation to discharge planning but she is unsure of the effectiveness of inpatient care. In saying that the team 'goes through the list', 'decides what's the progress' and 'what's next', Julie implies that some decisions are made about planning the next stage in patients'

progress without consulting patients. This worries Julie. She suspects it may reduce the effectiveness of inpatient care.

Marie values the IDT role in discharge planning.

... it's really important in the orthopaedic area because you have to work together to make discharge planning effective - a smooth transition for the patient. So they don't go home and have problems such as, "Oh, I can't sit on the toilet" or "I don't have a high enough chair".

Marie knows that coordinated planning by all members of the team is necessary to identify potential problems and facilitate patient safety and independence within their home environment. She recognises interdisciplinary team input is crucial to managing a smooth transition for the patient when they leave hospital, but she also makes it clear, how important it is that patients themselves should contribute to this progress.

Beverley knows that collaboration with other health professionals is critical for patients.

...it is part of their progression from even before their admission. They are assessed by these people [IDT members] at pre-admission education sessions.

She recognises the need in some cases for interdisciplinary consultation even prior to hospitalisation. Those patients requiring elective services have the input of physiotherapists and OTs prior to their admission. The nursing literature indicates that IDT input in the planned preadmission of some elective patients is seen as important and valued (Fielden, Scott, & Horne, 2003; Giraudet-Le Quintrec, Coste, Vastel, Pacault, Jeanne, Lamas, Kerboull, Fougeray, Conseiller, Kahan & Courpied, 2003; Gursen & Ahrens, 2004; Spalding, 2004), because of its positive effects on patients' subsequent inpatient experience and recovery.

Louisa encourages her colleagues to take a proactive approach in using the interdisciplinary team.

Because it is orthopaedics, you don't necessarily need a formal referral. Nurses here can go and talk to the physiotherapists and say "Look I have this patient who has a chest infection. Do you think you could give him some chest physio?"...I encourage nurses to be proactive with their patients, to be advocates. Some of it is about empowering nurses to do this themselves. We have these people within the hospital - use them! You know, there is no way you could ever get away from the multi disciplinary approach in orthopaedics.

She persuades colleagues to personally contact appropriate members of the IDT to discuss this directly. She knows the importance of interdisciplinary input in orthopaedics and uses this awareness to empower her colleagues.

Sometimes patients do not feel ready for discharge or dread going home. There are times during sickness when the anticipation of dreaded or painful experiences become all-consuming, leaving patients overwhelmed with feelings of powerlessness and vulnerability (Morse, Bottorff, & Hutchinson, 1994, p. 191)

Annette describes what happens when patients do not receive appropriate interdisciplinary care. In Annette's experience, ward patients she sees in the casting room are sometimes left feeling powerless in relation to their discharge arrangements.

They open up to us about their worries - they often tell us; "Oh well, we have to go home..." but they haven't got any support! We ring the ward and say - "You need to get the social worker in and you need to get the occupational therapist." That quite often happens with us. Or the patients might say, "I think they're pushing me out" and we say to them "If your pain is not under control, if you are not comfortable, you might have to stay another night." We have done that often too.

Sometimes it is the families who are in hurry to get them out, or the doctors want them out. Sometimes they are ready to discharge them when it is not suitable. We pick that up.

Patients frequently arrive in the hospital plaster room as a 'last port of call' before they are discharged. Annette and her colleagues have learnt to check to see whether all members of the IDT have 'cleared the patient for discharge'. If this has not happened, Annette and her colleagues are able to ensure this gap

in care is addressed by liaising with the relevant health professionals. In doing so, they function as part of the interdisciplinary team and also as 'part' for patients by advocating on their behalf.

Engelhardt's (1985) notion of 'inbetweenness' is apparent in this scenario too. Annette and her colleagues intervene with nurses and IDT members to ensure that patients are 'safe' to go home. Yet there are inherent tensions. There is a sense that patients are 'ticked off' on a list before they go or are 'cleared for discharge', [this means that they are ready to go home according to the dictates of each discipline]. Treating patients in this way and using 'corporate' terminology, raises questions. On whose terms are patients discharged? Annette and her colleagues are perhaps unwittingly acting on behalf of hospital administrators to ensure that patients' 'length of stay' is fiscally rather than medically appropriate.

It is significant in the nurses' stories that there was little mention of hospital administrators or managers. Yet as implied in this scenario, there were subtle ways in which these people influenced the nurses' experience.

Being part of the nursing team

The nurses described 'being with others' actively in the sense of working alongside members of the nursing team in a collaborative manner. Collaborating means more than interacting with colleagues. It implies working with or alongside one another on a more or less an equal footing, towards a shared goal. The word 'collaborating' is derived from 'com' meaning 'with' and 'labore', 'to work' – hence, 'to work with'. It is impossible to function in this way without this sense of 'otherness'. Marie describes how being a part of a team of nurses is an essential part of the meaning of being an orthopaedic nurse.

Without teamwork in an orthopaedic ward, it just does not work. You cannot just go off and care for your patients on your own, - you have to be there for others - available for spinal turns and log rolling. Nurses from other wards ask me, "What's a log roll? What's a spinal turn?" Other wards don't do things like that, but they are very important in orthopaedics. When rolling spinal patients, you need five people. If those five people aren't there, what is going to happen to

your patient? He is going to be compromised - he is going to develop pressure areas. He is going to be stuck in that position for so long - for hours on end maybe. Therefore, as I've discovered over the years, teamwork has become very important because without the team, without the group of people helping you, the patient's health status would be compromised.

Marie knows that patients such as those with unstable spinal injury require several people to simultaneously carry out their physical care. Nurses must work cohesively and safely together. Teamwork is an essential and unique part of being successful as an orthopaedic nurse. Nurses from other areas notice this difference. The existential theme of 'relationality', described by van Manen (1990), helps to illuminate the close physical nature of the nurses' contact with others. Marie understands that orthopaedic nurses have to be willing and ready to help colleagues to mobilise patients unable to move themselves. She worries about what would happen to the patient if other team members were not readily available. Teamwork is essential to prevent and/or minimise adverse outcomes.

Louisa recalls an incident in which she was grateful to her colleagues for collaborating with her by managing without her in the ward while she cared for a very sick patient.

This man came up from the emergency department. He had fractured his neck of femur. It was a pathological fracture and he wasn't with us long enough for me to even delve into where the primaries were. His cancer was so advanced, that he basically came up from ED to die. When he came up we washed him... He was alone but his son was on his way. He lived out of town somewhere. We washed him and made him look presentable ... and I sat with him. The ward was really busy that night but not one of those nurses begrudged me sitting with that man until his son arrived.

It was obvious to Louisa, that that the man was dying and should not be left alone. She wanted to be with him until his son arrived. Her nursing colleagues understood this. Collectively they were fulfilling the tacit need of a dying patient.

Teamwork as part of the ward ethic

The necessity of working as part of a nursing team means that 'teamwork' becomes an embodied part of being an orthopaedic nurse. As well as having meaning in relation to the 'other' that is, patients or the IDT, it also provides a sense of 'place' as exemplified in Julie's description of a colleague's reaction to the relocation of their ward:

I think on the whole, [the reaction of the nursing staff has been] very positive after the initial few grumbles and the realization that some things were not going to change. This is because some of the structural things can't really be changed at the moment. They have settled down fairly well. We have always had a strong teamwork ethic on our ward and that never really changed. It carried through from the old place.

Some staff members were disgruntled and reluctant to relocate. However, on realising that the changes were inevitable, Julie believes that 'teamwork' facilitated the process. It seemed to help each member to retain a sense of continuity and commitment to the whole of the team in the face of quite significant change.

John reinforces the embodied and moral nature of the teamwork in his workplace. He often coordinates the ward on afternoon shift but staff shortages mean that he must also take on allocation of patients. He and his colleagues help each other by responding to needs of patients being cared for by nurses in the other team.

... We do take a patient load and sometimes it doesn't work out that well, but the other nurses who are taking loads, are always aware of that. We help out and work really well together as a team. We all do. As I say we are in two teams. It doesn't mean to say that if a bell goes off for the other team, somebody else doesn't answer it. We all cover for each other extremely well because the bottom line is patient safety.

For John, 'being a part' of a team means acting beyond the confines of his own team. The moral imperative is further highlighted when successful teamwork is absent.

Marie recognises that:

There are days it will work wonders and there are days it does not, but we still always strive.

For Beverley, problems with time management can impinge on successful team collaboration.

Time management is a big thing and you need to be able to manage your patients. You have got to work as a team but a lot of nurses find that difficult here... They are tied up with their patients and they don't see the big picture. Yet everybody is under the same [pressure], has the same amount of patients, the same amount of work.

She is aware junior nurses don't find it easy to be collaborative as they become preoccupied with organising patient care and are oblivious to their colleagues' needs. They are still learning how to manage their time effectively. As Benner (1984), in describing the rule-governed behaviour of novice nurses contends,

*The heart of the difficulty lies in the fact that since novices have no experience of the situation they face, they must be given rules to guide their performance. But following rules legislates **against** successful performance because the rules cannot tell them the most relevant tasks to perform in an actual situation. (p. 21). [Emphasis in the original.]*

Beverley seems to recognise the innate tensions inherent in implementing more than one model of care in a setting. This can lead to differing expectations in how various nurses work together. Thus, teamwork as part of the ward ethic may be experienced differently depending on the level at which one is practising as a nurse.

Working in a team as a model of care

Team nursing models are often utilised in orthopaedic nursing settings and are focused "...on nurses working in small teams to provide care for small groups of patients within a ward, unit or community" (Santy, 2005, p.43), but the evidence of its value in orthopaedic settings is mainly anecdotal. Some participants found it a positive experience. A form of team nursing has been adopted in Ann's ward.

...we do 'duo' nursing here. It's a variation of team nursing ...we have eight nurses and we work in pairs. For junior staff it has been an excellent model of care. ... They are well supported - rather than being given sole responsibility for their own patients where they could get out of their depth.

The Duo Model of team nursing uses a senior/junior nurse pairing to undertake care of a set number of patients. This provides good support for new staff by ensuring they have constant help and supervision from a senior staff member. 'Being part' of a team in this instance means to be part of a pairing that shares patients' care. Ann implies that it is also a learning and teaching relationship. She says that if left to manage patient care by themselves, beginning practitioners may flounder. Thus for Ann, 'being part' means having teaching responsibilities when supporting junior staff in this way. This suggests that the 'ethic of care' extends beyond the patient to encompass the senior and junior members of this nursing team.

Being part with patients

Orthopaedic nurses are 'part with' patients in numerous ways. This can mean taking on several functions at once. Within the context of a four bedded room for example, a nurse may simultaneously monitor how a junior colleague mobilises a patient for the first time after surgery while attending to queries from another patient's husband and administering intravenous antibiotics to yet another patient. Responding to multiple demands at the same time as caring for patients is part of being an orthopaedic nurse. In describing their practice, the participants variously talked about being a support, a prop, a carer, a teacher, a humorist, a magician, a custodian, a hero, a tactician, a juggler and even a sculptor. But 'being part' also has meaning in relation to the embodied care of patients physically.

Being a physical part

Being part can mean temporarily becoming a physical part. Orthopaedic patients are often physically compromised by their injury or condition. Thus orthopaedic nurses often become a substitute for the damaged part of the

patient. They replace the part that is 'out of action' so that patients can achieve activities of daily living. Being an orthopaedic nurse involves moving bodies both totally and in part. This is to ensure that patients' physical integrity is maintained during healing or restorative processes.

John describes 'being an essential part' in several ways when turning a person with an unstable cervical spinal injury.

People with halo traction. Trying to support the patient's head properly when you have a pin digging into your arm, it can be very heavy. But it is also about being clear about communicating exactly what you are going to do, and letting the patient know exactly what you are going to do and when you are going to do it. Just being in control of the roll and making sure that everybody else who is assisting you, knows how to place the hands on the patient's body, - where and how to hold the legs properly - that sort of thing.

Holding the patient's head has a dual meaning. John takes responsibility for the patient's cervical stability as well as coordinating the team of lifters. This is potentially a life threatening situation. The patient's head becomes very heavy and the traction attachments dig into the holder's arms. Yet John has to be absolutely still once the patient has been rolled on his side and maintain this position for up to 20 minutes at a time. Controlling the roll by the team is also his responsibility. He has to ensure the other team members work together to move the patient safely. He is both 'part' as physical splint and 'part' as team leader.

Responding orthopaedically

In addition to acting as part of the patient's body, orthopaedic nurses also become more familiar with their own bodies particularly when moving those of others. The lifeworld notion of 'embodiment or corporeality' (van Manen 1990) has meaning for individual members of the nursing team, because this physical contact demands that bodily control is exerted to ensure the whole team moves in harmony. Marie recognises that orthopaedic nurses develop techniques to ensure their own safety. She is aware of the personal risks inherent in her specialty.

We learn right from the start how to look after ourselves. As an orthopaedic nurse you learn how to not only look after the patients' safety, but you have to look after yourself as well. You know how to bend; you know how to make sure you don't hurt your back. There are times when we do have problems with nurses hurting their backs. For the simple reason they are usually an outside nurse coming in who doesn't know how to lift, and I say to myself, "She doesn't know how to lift the orthopaedic way." Therefore, the nurse that is helping out is likely to end up having an injury because of it. As far as I can know, out of all of the five and half years I have worked in orthopaedics, injuries have been very minimal. Because if you are an orthopaedic nurse, you have to know your own self - you have to know what you are capable of and what you can't do and who you can lift with and who you can't. You get to know those things because, your safety is also very important.

Being an orthopaedic nurse means having to acquire safe lifting techniques. Marie knows that injuries are most likely to be sustained by nurses unfamiliar with safe lifting techniques, in what she calls the 'orthopaedic way'. Not only is this for the safety of the patient, it is for the safety of the nurse and the nursing team. Being an orthopaedic nurse means knowing one's own and one's colleague's strengths and weaknesses. Marie acts 'as a part' on behalf of the whole of her ward team to achieve safe delivery of care.

Orthopaedic nurses also know and recognise other dimensions of patient need. Pain, for example, impacts significantly. The nurses described ways of helping patients through painful experiences. In this way, they play a part by 'acting for the sake of' the patient. Ann describes one such situation.

Patients who have had knee joint replacement surgery have an epidural for the first 48 hours. We turn the epidural off and they are given oral Morphine. An hour later they may have considerable pain. Patients don't realise that lying flat in bed with a knee replacement, [with the leg] out like this (demonstrates extended knee) - is actually what is giving them the pain. Because they had the epidural, they didn't feel that. Once it is gone, the best way to relieve that pain is to actually get them over the side of the bed and bend the knee. Telling that to a patient who's saying they have 8 out of 10 pain on the pain scale at about quarter to 5 in the morning - they don't believe you! New nursing staff don't believe you - they looked shocked! You're looked at as if you are demented. "How can you bend that knee?" But it works. It works a treat. Far better than any analgesia does.

The number of times I have been with patients that have said, "No, you are not getting me over the side. I can't do it - I am too sore!" I have had the odd couple of patients who have balked and have said "No!" I have to really encourage them and explain to them that it really will help. "Let's get the knee bent", they can't believe it works. But it is incredible once they do! They stop yelling and screaming, because the pain goes. And the difference... a nurse showed me this trick years and years ago.

This patient is being weaned off epidural analgesia and the 'new' knee is making its presence felt painfully in spite of oral medication to prevent this. Ann's knowledge of what has happened to the patient's knee in surgery provides understanding of the rationale for this pain. Knees become painful if extended for too long. Ann knows from experience that the patient must bend the knee to relieve this tension. She must use all her persuasive powers to convince patients to do this and may even have to suspend the belief of junior staff. In bending the patient's knee, she demonstrates that pain disappears when soft tissues relax.

Ann has acted on the knee as a part and also in relation to the patient as a whole. Bending the knee reduces the pain. Explaining why this happens can involve teaching principles of biomechanics, thus passing on information that is embodied in the experienced orthopaedic nurse.

Heidegger (1927/1962) talks about the notions of 'ready' and 'unready-to-hand'. For Heidegger 'ready-to-hand' describes human action that is embodied and taken-for-granted. Flicking hair out of the eyes, stretching if one has held a particular position for a long time or scratching one's head when thinking are examples of embodied action that is carried out without conscious thought. An experienced orthopaedic nurse appraises a limb 'automatically' noticing features such as abnormal position, skin discolouration or swelling. He or she bends at the knee with feet placed apart and square when preparing to move a patient. In doing so the nurse is drawing upon knowledge intuitively, immediately and without conscious thought. 'Unready-to-hand' describes action that is disrupted. Something intrudes or is missing and a new or different way

of responding must be found. 'Unready-to-hand' is descriptive of this scenario in which Ann has had to show the patient how to move her knee, previously an automatic gesture, in order to relieve her pain.

Orthopaedic nurses are constantly re-educating and supporting patients in terms of their body positions and function. In everyday life, people do not require in-depth knowledge about their body parts. They move without thinking.

However, when they sustain an injury or develop an orthopaedic condition, they need to know how to care for themselves safely in order to regain physical function and integrity. The nurse is an essential part of this process.

Helping the patient 'objectify' the body

Being an orthopaedic nurse means sometimes to 'be part' uniquely when with patients. Orthopaedic patients sometimes call upon nurses to help them to cope with and adapt to functional change that may or may not be permanent. John experienced this with a patient who had a spinal injury.

I find humour helps in some situations - it really takes the patient's mind of what is actually happening. It can be very therapeutic.... But it's not appropriate until you gauge the situation and you develop a relationship with the patient. You follow the patient's lead with that.

On our ward at the moment there is one patient who has a partially transected spinal cord at T6. I could tell immediately, - we had this thing going on with our sense of humour which was really dry and very pathetic for anyone listening, but we 'got off' joking about everything - which was really strange and bizarre... However the issues are still there for that patient. In confronting his injury, I think maybe humour is useful - because actually having to deal with the grief of losing the functions of his body... maybe that particular patient deals with this by feeling that he can joke around with me.

Sometimes John finds using humour to be helpful when talking with patients. He realises that its use is dependent on taking the lead from the patient and ensuring it is appropriate for the moment. He describes an instance when he felt the patient found joking helpful in confronting the effects of his accident on his body. Because John knows that humour can have a therapeutic effect, he believes the patient was joking with him to find relief from the enormity of his

injury. It is a way of assisting a patient to adapt to his injury and loss of function. He is able to help the patient to objectify his body. Morse et al. (1994) described how nurses can 'be part' with patients in this way.

Sometimes the presence of and connection with a nurse is important in objectification of the body. Nurses use their voices, eyes and hands to help patients refocus and feel secure and safe enough to relinquish part of their identities as object in order to distance themselves from their body and the violation taking place. Other patients find comfort joking to cover their embarrassment, and by feigning carelessness, and/or by refusing to think about what was happening to them (p. 192).

Nurse as the patient's voice

Being an orthopaedic nurse means being able to advocate on behalf of patients in situations where they are unable to speak for themselves. In this sense, 'being a part' is manifested as being the patient's voice as Julie describes.

We had a seventeen-year-old boy who was in a car accident. He fractured one of his legs so badly it had to be amputated in the end. It took him and his family about 10 days to come to that decision – it was slowly going septic – it was an awful thing for him to decide and he did it. He turned 18 while he was in hospital. We were very concerned about the psychological support he'd need and we referred him to the rehab. place that is for the younger crowd. The surgeon just couldn't see the need for that. All he could say was, "Oh, no, he should be able to go straight home". And I really did butt heads with him and said, "No! He needs their support. The interdisciplinary team, the OT, physio, assessment and everyone else there. He really needs the benefit of going there!" And then he said, "Oh! Oh! OK then".

Julie had come to know this patient well during his hospitalisation. She appreciated that consenting to an amputation required inordinate courage on his part. She was aware that adolescents often believe they are invincible and that body image is very important to them. The surgeon wanted to discharge him straight home soon after his surgery but Julie knew that the rehabilitation service offered a more comprehensive approach. The surgeon's focus was on surgical outcomes whereas Julie understood that her responsibilities were with the patient as a whole person and that numerous factors should be considered

when planning rehabilitation. She was 'playing a part' in this scenario by speaking on the patient's behalf to ensure that he received more holistic care.

CONCLUSION

This chapter explored the essential theme of 'being part' or a 'part'. It reveals how the notion of 'part' is integral to the experience of being an orthopaedic nurse.

Chapter Five presents another theme essential to the phenomenon of being an orthopaedic nurse, 'gaining and maintaining integrity'.

CHAPTER FIVE: STUDY FINDINGS - GAINING AND MAINTAINING INTEGRITY

INTRODUCTION

The word 'integrity' is often used in conversation in orthopaedic settings. A patient's cast or traction may be referred to in terms of its integrity and, in this context, it describes how well the cast or traction functions. Similarly the word 'integrity' is often used to describe attributes of types of fixation or implants in terms of their biomechanical efficacy when exposed to the rigours of a living human body.

In its more general context, the word 'integrity' derives from an Old French word 'intégrité' meaning 'wholeness or perfect condition' or the Latin 'integritatem/integretatis' meaning 'soundness or wholeness', in its 15th century usage. A later, (16th century) definition, was 'uncorrupted virtue'. The findings of this study suggest that this word also describes a particular level of understanding reached by nurses in their orthopaedic practice. In other words, they eventually 'know' that they function as orthopaedic nurses. This does not mean that they have ended their development; they say they are constantly learning and growing in the specialty. It means they no longer feel 'generalist'; they have become 'embodied' as orthopaedic nurses and have gained integrity practising as such. They are describing a dawning awareness or an awakening consciousness which for each of them means 'coming to be' an orthopaedic nurse and this, in turn, means 'seeing the world through orthopaedic eyes'.

BECOMING AN ORTHOPAEDIC NURSE

Selecting and reselecting orthopaedic nursing

This section describes how nurses elected to remain with orthopaedic nursing. The experience of being an orthopaedic nurse was, at times, interrupted for various reasons. Germane to this theme of 'gaining and maintaining integrity' however, was the fact that the nurses elected to return to the specialty and resume their experience.

All of the participants in this study have stayed in orthopaedic nursing. For four, their present workplace has been their sole orthopaedic experience. For three of these, it has been their only experience as registered nurses and they have each spent from 4 to 7 years in their wards. The remaining four have worked elsewhere in orthopaedics in addition to their present setting.

Thus, being an orthopaedic nurse invariably means staying with the specialty over time, amassing skills and knowledge and taking on increasing responsibility in the workplace. In Angela's case, she 'stayed ... because of the dynamics', and because, 'you just have to want to be there' whereas for Louisa, '... I stayed in orthopaedics and progressed through various changes', suggests she stayed with the specialty in order to develop her career.

For other nurses, leaving and returning to the specialty presented new opportunities. Several undertook orthopaedic nursing courses. Others elected to go elsewhere. But the nurses welcomed returning to orthopaedic nursing and there is a sense of contentment and commitment expressed in their stories.

'I just fell straight back into it', or '...when I came back and went to talk to the nurse leader, she asked me where did I want to go? And I said that I wanted to go back to where I was because - why move from a good thing?' and 'I have always come back to orthopaedics', 'It's a really good environment to work in'. In all of these excerpts the nurses intimate a homecoming. There is a sense that orthopaedics is an area of practice that has become compelling for them.

Beverley explains:

To me, it's a vocation. I have always come back and found it's what I like to do. It's different. It's no good doing something if you're not happy in it because then you're not giving your best. It's the fact that patients get well and go home. You can see the difference you've made and 90% of people are really appreciative.

Julie describes staying in an area in terms of 'gelling' or engaging with it.

If you can't decide in the first year that you like orthopaedic nursing, then you may as well go. I knew by the end of my first year that [I could say], "Yes, I do like it."

Angela recognises that it is the variety and challenges offered by orthopaedic nursing that attracts her.

*... looking after challenging patients, spinal patients, hip fracture patients, confused patients and all the other things that orthopaedics brings. It's the dynamic mix ...
Everywhere I have worked in orthopaedics, there have always been people that are solid. They'll see it through the bad times and celebrate the good times and those people, I guess, are what makes orthopaedic nursing really.*

Angela's use of the word 'solid' implies that she values those nurses that endure the good and bad times to become the 'backbone' of the service.

Louisa:

... the first three week's of a person's employment will dictate whether they will stay in that position or not. I think orthopaedic nurses need to get out there and say what they do ...to attract people to the area and to encourage them to stay.

If an initial work experience is positive, the staff member is more inclined to stay. Louisa is aware supporting new staff helps ensure their experience is positive from the outset. Moreover, she implies that being an orthopaedic nurse should include a readiness to promote the specialty.

Learning the 'know-how'

This section reveals that learning the 'know-how' of orthopaedic nursing to build confidence and clinical competence is essential in becoming an orthopaedic nurse. Yet, as Julie describes, this is not always easy.

Specialty skills and knowledge related to orthopaedics need to be picked up quickly because I have seen what happens when [some nursing staff] don't ... they didn't have knowledge about for example, compartment syndrome. I remember one man very clearly who had it.

He developed compartment syndrome very quickly and when we looked back through the documentation and talked to the nurses

about the previous three or four hours, you could see the pattern developing. This is an issue of safety. But they didn't see it. They are too junior or often it's because of the volumes of pool nurses.

Julie is concerned that some nurses have insufficient knowledge of orthopaedic complications and patients are placed at risk. She believes this happens when staff are inexperienced and high volumes of pool nurses are employed. Both these factors play a role in preventing the necessary enculturation of nurses to the area and because of this, they do not become skilled enough to be confident and safe in practice.

John describes how the challenges of his workplace enabled him to expand his practice.

The staff shortage existed but the core group of senior nurses working there was good - so it was a good start. Having that supportive environment really helped in expanding my practice. I have been there ever since ... it keeps you on your toes all the time. You don't know from one minute to the next what can happen and it is very hands on. If you want a dull job, this is not it.

Encouragement and support from senior colleagues enhanced John's self-development even though he was exposed to constant change. He continues to enjoy the complexity, constant challenges and is never bored.

John describes a typical learning opportunity.

It was the first spinal patient I looked after. I hadn't been to the tracheostomy study day at that stage. I had watched other people work with this patient but this time, I was 'it', which was quite a scary thing to be. The patient became distressed because of a mucous plug down the tracheostomy and I had to glove up and deep suction his airway by myself. It is all very well other people doing it and you doing it under supervision, but when you make that decision to do it yourself without anyone else around, its like... 'ohhh' you know. I just did what I had to do and got the mucous out and it worked! In some ways, because it forced me to actually do it and not muck around, I really learnt how to do it.

John knew he had to apply deep suction to a spinal patient with a tracheostomy to clear his airway. Although he had observed and been supervised performing

this skill, he was still tentative. In this instance, there was no time for 'mucking around' and, on reflection, he valued being forced to do it alone. He was learning to perform an essential skill upon which the patient's survival depended. He was becoming aware that skills like suctioning of a patient's airway have to be carried out automatically and require total focus. There is a sense that John also realises that his clinical 'life' or credibility demands it of him as well. Carrying out skills that are potentially life-or-limb-saving in a 'real life' situation like this is an essential part of becoming an orthopaedic nurse.

Becoming an orthopaedic nurse, then, means engaging with orthopaedic nursing and deciding to stay. In learning the 'know-how' here is a sense of becoming enthralled and caught by it, of being nurtured through the necessary learning of new skills and specialised knowledge prior to gaining confidence in practice.

The next section describes being challenged by the experience of being an orthopaedic nurse. The 'darker aspects' of the experience contribute to a sense of 'coming through' or learning to cope with adversity.

Developing resilience

Some of the participants' stories dwelt on negative aspects of practice and there was a sense that there had not always been adequate 'closure' or resolution of particularly problematic issues. The participants seemed to strive for balance in their stories. The fact that orthopaedic nursing has 'bad press' was recognised, for example, and the nurses often attempted to counter this. 'Gaining integrity' may not be easy. Becoming an orthopaedic nurse means learning to cope with myriad challenges that may daunt and deter the individual. Developing resilience is essential to meet these challenges.

The word resilience is derived from the Latin *resiliens*, *resilire* "to rebound or recoil," from *re-* "back" and *salire* "to jump or leap". This word describes how orthopaedic nurses often have to 'bounce back', or revitalise themselves, following challenging clinical experiences. There is a sense that this requires

courage and enables self-healing.

Encountering prejudice or misperceptions

Defending orthopaedics as a specialty seems to be part of being an orthopaedic nurse. The nurses in this study spoke of encountering others' prejudice or misperceptions about orthopaedic nursing.

Beverley

I remember being on an Albany ward and loving it. I was getting a lot out of it but my next step was orthopaedics and a nurse said to me "Oh! Orthopaedics is dreadful – you will be back here in six months guaranteed".

It still has a bad press. I think it is because people feel it's busy and heavy and acute and there's not enough staff. Whereas I don't see that. I see the dynamics, the challenges that it brings to you.

Even before Beverley began orthopaedic nursing, she had been warned she would not enjoy it. Although she believes it still has a reputation for being heavy and short staffed, like Angela, she enjoys the dynamic nature of the specialty and its challenges.

Marie

Nurses I knew that had been to orthopaedics said, "You don't want to go into orthopaedics, because it is very heavy," or, "It's too hard!". At first, I was absolutely terrified because I had never been in an actual hospital setting before, never done nursing before, apart from when I was a student and it was terrifying, quite terrifying. After three days I burst into tears and went home and I said, "I am not going back there".

At the outset of her career, Marie found it hard to cope with the strangeness and unfamiliarity of an orthopaedic ward. Colleagues had tried to dissuade Marie from orthopaedics. Their opinions appeared to have influenced her experience and contributed to her having such an unpleasant induction.

In contrast to Marie, John felt obliged to defend his initiation into orthopaedics.

People almost look down on it. I don't know where they get their information from, but it is a very necessary discipline within nursing. Until people actually get on the ward or become patients, they don't realise what we actually do. It has been pretty inspiring so far. If I had a broken bone I would rather be on an orthopaedic ward and with nurses who know how to deal with orthopaedic problems.

He was mystified that orthopaedic nursing acquired such a poor reputation because his own experience belied this.

To Ann, the prevailing opinion of orthopaedic nursing held by others is a stigma.

It is interesting to hear everyone... We've still got that stigma "Oh! Orthopaedic nursing! Oh yuk!"

I did medical nursing for years. We've had medical outlier patients here that have taken three of us to get out of bed - high acuity. So why is the orthopaedic person any different? The fact is, they're not any different. For someone who has had a fractured neck of femur fixed, you can mobilise them on your own the next day if you've got the knowledge and the skills to do it properly. That's not heavy nursing!

The word 'stigma' has come to mean 'a mark of disgrace' but Ann discounts this description by comparing it with her experience of caring for patients with medical conditions.

The nurses felt the fact that orthopaedic nursing is still thought of as 'heavy', 'tiring' and 'draining', could be attributed to factors such as the present day dynamics of acute care combined with an aging workforce. They wanted others to have a more balanced perception of the specialty.

As Louisa notes:

...we are encouraging patients to do more for themselves now, mobilising them at a much earlier rate than we ever used to... its not as heavy as it used to be but that perception is still out there.

Coping with staff shortages

Staff retention and skill mix seem to be constant issues for orthopaedic nursing

(Davis, 2002b, 2005; Erlin, 2001a, 2001b), yet nursing shortages are acknowledged to be a global problem (Clark, 2002; Fletcher, 2001; Jackson, Mannix, & Daly, 2001; Purnell, Horner, Gonzalez, & Westman, 2001). It is an exaggeration that orthopaedic settings operate with perpetual vacancies, but staffing them adequately can sometimes be difficult. For John this means juggling responsibility of running the ward as shift coordinator while providing direct patient care.

Quite often we work one, or in some instances, two down, which is what happened last week. I took on a patient load of five plus co-ordination of the ward ... which they don't really teach you how to do in school! We had some very sick patients and in the end, I had to turn away admissions otherwise patient safety had the potential to be compromised. They are decisions you have to make because you are forced to make them and yes, you just have to go with it.

Caring for patients as well as coordinating the ward is relatively common for John during staff shortages. He does not like having to turn away acute patients but he does so to ensure the safety of existing patients and staff.

Marie discovered managing pool or casual staff without compromising patient safety to be a significant challenge.

It is horrendous. You have two nurses to work with who have probably never been here before, don't know anything about the patients, and are feeling sorry for themselves.

I say, "What do I do? Do I give my spinal patient to them? I can't. They don't know anything about him. I couldn't take the risk." The fact is that you are pressured; your stress level gets high. If they have never done orthopaedic work before, you feel obliged to take all the heavy patients. You think, "Well, can I trust this nurse with this patient!" You become, I suppose, protective.

At the end of the day, you're doing their IV antibiotics for them, you're doing their IV fluids for them, as well as caring for your own patients and they keep calling you and calling you! If they have PCAs [patient controlled analgesia], you have to do all those things for them. And you have to teach them if a patient is on a PCEA [patient controlled epidural analgesia]. Every little thing that they can't do, you have to do it as well as caring for your own patients. By the end of the day, you are absolutely pooped.

Marie's stress is evident as she describes the dilemma relating to patient allocation and her own workload. She is aware that she treads a fine line to ensure an already fraught situation does not become catastrophic. Pool staff need a lot of support from permanent staff, particularly when they are unfamiliar with the area and this responsibility invariably falls on the experienced orthopaedic nurse.

Santy's (2001) suggests that orthopaedic nurses "... harmonise the orthopaedic ward environment, its patients and those who encounter it." (p. 24). Despite the difficulties she encountered, this 'harmonising' role appears integral to Marie's experience. She acknowledges how rewarding it can be when the ward is operating well.

When we have all our own staff on everybody is happy. Everybody's totally happy because they know, "Oh we can do - whatever". Because they know how to take on a heavy patient, they know how to do a spinal roll, they know what is going on with this patient, they know what to do with a patient when they have external fixators on their pelvis - you know - how far to go with moving them. So everybody is happy on the ward.

In Marie's experience, working with staff who know the ward produces a happier, harmonious atmosphere. This occurs, she believes, because all members of the nursing team work in unison from a shared expertise, knowledge of the patients and how to move them safely and awareness of each other's capacity in this regard.

Coping with challenging patients – reflecting and learning

As ward coordinator, Julie has found less experienced staff have difficulties coping with challenging behaviours exhibited by patients, such as those affected by drugs or alcohol, or, who may simply appear physically threatening.

They may not have had exposure to patients like this before and the behaviours that they present with. It takes some nurses time to struggle through their own feelings about this. These patients frighten them; they don't know how to deal with them. They find it very upsetting and they think their practice is useless because they haven't been able to manage. Education on these patients, their

behaviours and the psychology issues involved would be really beneficial.

From Julie's perspective, therefore, coping with challenging patients involves teaching of less experienced staff about them and how to respond appropriately in such situations.

John remembers how he learnt to cope with complex patients.

We have had patients on the ward who you just wouldn't want to look after for more than three shifts at a time because they are so full on... it's a matter of being clear about what you can cope with and being able to talk to people about it – 'Maybe its not such a good idea if I take this patient today because...' and give yourself a rest from it to get back a bit fresher. We all do that. It is always good to be open about that sort of thing and there is no recrimination.

John strives to achieve balance in his practice. He knows his own limits in caring for complex patients. He communicates these in a collegial way when seeking relief from this responsibility.

There are times when angry patients subject nurses to verbal or even physical abuse as Marie describes:

Sure we have times when patients abuse us... I was bitten by a patient once... Some people take it the wrong way but if you think about it, you know the patient is confused - they don't know what they are doing.

Taking the position of the patient helps Marie to understand and cope. She knows it is inappropriate to personalise the abuse even when, as a victim, she finds the experience stressful.

Developing the capacity to cope, part of becoming resilient, is a necessary part of being an orthopaedic nurse. An experience he had after a patient died gave John understanding of the difficulties in knowing patients and how easy it is to make assumptions about them.

He did die - and it was quite sad for everyone on the ward - a few of us went to his service. His mother had brought some photographs,

*which showed him as a child through to his 20s and 30s when he was active and very healthy. It made me realise that while we knew this patient extremely well, more than the doctors and maybe some of the family, we don't really **know** that person. There is so much more to a patient... to that patient or any patient, which we are not privy to as nurses. [Participant's emphasis.]*

Going to the patient's funeral prompted John to reflect on patients and their diversity. Because he cares for them within a ward environment, it invariably means knowing patients solely in this capacity. Discovering their other dimensions can sometimes be surprising. John tries not to idealise patients or judge them prematurely. Experiencing the funeral has helped him to grow as an orthopaedic nurse.

... we have to realise that the person hasn't been a patient all their life; it's just one specific time in their life. What I am trying to say here is that nursing can be fairly limited – your knowledge of people outside of your specific area may be [lacking]...

John is becoming aware of what Marie appears to have already learnt. His experiences with patients enable him to develop the resilience essential for him to care for them. Other participants also told stories about practice that enabled their growth as orthopaedic nurses.

Each of the participants' stories revealed that some point, part of the experience of being an orthopaedic nurse, was wanting 'to be' an orthopaedic nurse. Often it was other orthopaedic nurses that showed them this.

Aspiring to become an orthopaedic nurse

Gaining integrity can mean learning through seeing excellence modelled in practice. Angela describes how expert nurses have influenced her practice and moulded her development as an orthopaedic nurse.

They were so knowledgeable and skilled and I really enjoyed working with them. I wanted to impress them and I was so enthusiastic. People notice that type of thing and they give you positive feedback. As you get more positive feedback and you learn from your mistakes, I think those are the things that shape you. They were nurses I will probably never forget. They were the kind of nurses that shape your experience. They were such professional people.

She remembers being 'shaped' by senior orthopaedic nurses she worked with at the outset of her career. These nurses modelled professionalism and expertise and left an indelible impression on Angela as a beginning practitioner. She wanted to be like them and become expert in the specialty herself. Moreover, there seems to be a reciprocal interaction between her responsiveness and their willingness to provide constructive feedback.

Recognising, valuing and embodying orthopaedic practice

The participants' stories showed how they gradually became conscious of the uniqueness of orthopaedic nursing but differences could be subtle or made invisible by the 'everydayness' of practice. John eventually came to see these differences between orthopaedic nurses and those from other settings.

We have pool nurses, resource nurses and nurses from other wards that occasionally help out - if we are down on numbers. It's then I realise that things we take for granted like rolling patients in a certain way - to maintain alignment - for hip fractures for instance, or rolling spinal patients - using head holds, using specific techniques - its all orthopaedics. People just aren't aware of [this], you know.

John recognises that routines in his ward require particular skills, which are often taken for granted because they are part of everyday practice. When other nurses are sent to the ward, John discovers that not everyone knows how to perform these 'routine' skills. He gains an awareness of the specialised nature of his practice.

We have had instances where spinal patients have come to the ward and there has been a brief note in the chart saying, -'Possible C spine injury'. And the patient is sitting up, with no sand bags! So it's, "Hello!" there is nothing specifically clarified about whether the patient has an injury of that nature, but yet they are sitting up! We would automatically think, "Nope, this patient has potential [cord damage]." And we would treat it as a worst-case scenario until that is clarified. But on the odd occasion, other people just don't seem to think in that way. As orthopaedic nurses, that is something we would take for granted.

John knows that being an orthopaedic nurse means having a unique perspective on assessment and treatment of patients particularly where they

are at risk from orthopaedic injury. This does not mean ignoring other health problems; it means orthopaedic considerations are integral to patient care right from the initial assessment.

Angela, too, gives an instance of 'seeing the unseen' which made a distinct impression on her when she was a beginning practitioner.

When I came here there were people who were like that. Those skilled impassioned people in the team who were standing up to be counted almost. They would say, 'Look, you tell me that this patient is busy and heavy. You might see this patient as being challenging and demanding, but what you don't see, is the fact that the patient is in pain! What do we need to do to manage that?

That was a kind of ownership of the patient. For these nurses, it was being accountable to the patient and being able to use their eyes to see more than what was there.

Angela is describing how expert orthopaedic nurses practise. They are able to 'use their eyes to see more than what was there' in terms of how patients present, and by intuiting underlying causes of their behaviour. This is congruent with Benner's (1984) notion of embodied experience:

The expert nurse, with an enormous background of experience, now has an intuitive grasp of each situation and zeroes in on the accurate region of the problem without wasteful consideration of a large range of unfruitful, alternative diagnoses and solutions (p.32).

Learning the craft

Gaining integrity means acquiring specialty skills and knowledge through doing. Learning the crafts of orthopaedic practice is a necessary part of being an orthopaedic nurse. Orthopaedic nurses have always developed their skills through practising.

In Old English, the word 'cræft' meant 'power, strength and might'. The sense then shifted to "skill or art" (via a notion of "mental power"), which led to the noun meaning of 'trade.' Use for "small boat" is first recorded in 1671, probably from some nautical sense of "vessels of small craft," referring either to the trade they did or the seamanship they required. Orthopaedic nurses use apparatus,

appliances, weights, ropes and pulleys, and casting materials. Thus there are similarities with sailors who, in a very practical sense, also keep things 'ship shape' and in working order.

Angela describes learning about orthopaedic nursing skills.

I was being told about points of mobility, - how it affects healing. The importance of... making sure that the patient's hip was positioned correctly after hip replacement, limb elevation ... these are orthopaedic skills that orthopaedic nurses should know about and they were what I was being taught about as a young staff nurse. We are the head holders, we are the traction experts! You should be able to walk into an orthopaedic ward and see really good examples of what it means to elevate a limb.

Being an orthopaedic nurse entails learning how to lift and turn patients with spinal injuries, mobilise patients, care for those with external fixation, plaster casts and/or traction. However, the current ascendancy of surgical treatment for orthopaedic injury and conditions has meant generic skills such as wound care and giving IV medications are also important for orthopaedic nurses. Learning about and practising principles of surgical asepsis are essential because of the high risk of surgical complications such as osteomyelitis or implant failure. Giving IV medications properly is an integral part of orthopaedic nurses' practice too, because most orthopaedic patients are medicated via this route.

Maintaining expertise and passing it on

Having requisite knowledge of the specialty, then, means knowing which patients may develop compartment syndrome and how to carry out neurovascular assessment of a limb. It may mean developing expertise in casting and traction application. It involves constant learning and striving for expert practice. Being an orthopaedic nurse means being innovative, technically adaptable, able to extend one's repertoire of specialty skills and handing them on to others.

Participants worried about the erosion of specialty knowledge and skills. They described how they tried to retain these, not only to maintain individual integrity

as an orthopaedic nurse but also to maintain orthopaedic nursing as a specialty. Louisa explains:

We are still very much a hands-on profession. It is not just knowledge. I don't want the necessary skills to be lost because orthopaedic nurses still need to know them. Somehow we have to marry up how we are going to make that a requirement. We have built it into our portfolios; the clinical career pathway. Nurses working in orthopaedics, have to be able to do certain skills if they want to be competent. Yes, I am concerned that we are losing some of our skills. It's because we don't use traction like we used to. People aren't putting it up as regularly as they did so skills are being lost that way. Some of it is, I guess, because we have a transient nursing population.

Louisa acknowledges that it is difficult to preserve some specialty skills and knowledge. She mentions traction in particular and highlights that knowledge about it risks being lost altogether. She believes this is because traction is not utilised as much as it was and this, combined with the transient staffing in the wards, means these skills are hard to retain. Louisa talks about the importance of sharing specialty knowledge and maintaining skills integrity. She describes how she tries to address this issue:

A few weeks ago I was asked to put on Pugh's traction for a lady with a femoral fracture. I rounded up all the students that were here and we did the whole lot. The students may not ever see it again but at least they have seen it once. I guess because I am getting older, I want to pass that stuff on. I don't think nursing knowledge can be kept to yourself. You have to share it. If you don't share it doesn't grow.

In teaching students about a traditional, but complex, orthopaedic nursing skill, Louise is actively promoting the specialty amongst this group of fledgling nurses. She does this in the hope that it may foster interest in and commitment to orthopaedic nursing.

Being rewarded

Being rewarded by patients is an essential part of gaining and maintaining integrity as an orthopaedic nurse.

Patients who recover their lives and limbs after damaging, even life threatening, illness or injury provide considerable fulfilment and joy for those who care for them. Helping patients regain optimum function is a major incentive for orthopaedic nurses. The participants described being rewarded by the patients' new 'wholeness'.

Marie tells of the rewards of caring for patients with spinal injury:

We've had many patients like that. They have halo traction on and they go home. A patient may come in here with a spinal fracture and you actually see him through [his care]. That's a great reward. You nurse him all this time flat on his back ...to actually see him sitting up in a wheelchair, ready to go to the spinal unit, it makes you feel good inside. You think, this patient had all those potential complications, and you remember all the tiring hours that you put into his nursing.

Then he may come back and he will be standing at the nurses' station and you think, "Oh it's you!" He will say, "Look at me! I am standing up straight, I don't need a stick and I am walking". It's really great. All those challenges that made you just about pull your hair out, day in and day out, in nursing this patient back to health. To see him two or three months down the track when he comes back to visit - and here he is standing, saying hello to me, saying thank you to me! These are really great moments. You know, these are great moments! You get huge rewards from people who appreciate what you have done for them and you go home and you think, "Hey I have done a good days work - somebody appreciated what I have done..."

When a patient has recovered from a spinal injury and has visited the ward to thank the nurses, Marie remembers the painstaking, tiring hours she and her colleagues invested in his care and knows it was vindicated. It is very rewarding. She remembers all the challenges and complexity of the care. Seeing him standing whole and well in front of her, gives her incomparable joy. *"These are really great moments."* Experiences like these make the stress and challenges of being an orthopaedic nurse worthwhile.

Ann enjoys seeing the dramatic improvements that total joint replacement surgery offers patients with chronic conditions like osteoarthritis.

What I liked was seeing how people's lives [changed]. Patients, maybe quite young - late 50s to early 60s, had come to a standstill

because of arthritic pain and they could not carry on. They come in here to get a new knee or new hip and eventually walk out of here and get on with their lives. It's so rewarding!

Take the elective patient. On a Monday morning at 7.00 a.m., the patient will come in a wheelchair in agony, creak – groan – they can hardly get into their pre-op shower. Yet on day 5, they will walk out of here on a pair of crutches saying, "The difference!" They may have a bit of wound pain on day one. But they are really stoical people. They don't want to use their pain pump or anything. They say, "No, the pain I have now is nothing to what I had Sunday night."

And you help them get up to have their shower and it is amazing. They can't believe they have this new hip or knee joint and a day later they can actually get themselves out of bed!

Ann recalls caring for patients requiring elective surgery who come into hospital crippled by arthritis, to the extent they find it is difficult to move around independently. Even though they may be relatively young, their lives have been brought to a standstill by the pain of their arthritis. Several days later, they are ready to go home, walking independently on crutches and are virtually pain free. Ann finds it is very rewarding to be part of their dramatic recovery in this way. She has discovered there are rewards in caring for acutely ill patients too.

The acute patient with a thoracic spine injury, like T10 or T11 fractures, that are on bed rest for three to four weeks, when they first come in. You have their psychological shock as well as the trauma to deal with. They say they're terrified. I love to reassure them. Even the first time when you have to teach the poor things to learn to pee in bed! If it is young people, they get so embarrassed! A week later, when you can laugh and joke about it with them, you know you are doing your job. You have established a rapport with them. They know they are flat on their back like that, say for three weeks, but they know they are not on their own. They ask you about your family and you chat about theirs and you get to know them personally. They put a lot of trust in you. Once you mobilise them, within two or three days, they are off home and that's great.

Ann describes what it is like for these patients when they are first admitted; the shock and fright they feel and the part she plays to help them adjust to their injury and being in hospital. She remembers instances of how she teaches young patients about bed rest and using pans and urinals while lying flat in bed.

She believes she understands their embarrassment and how important it is for her to help them over this hurdle. As Morse et al. (1994) acknowledge: "...for the vulnerable body, comfort is found in feeling secure, safe and trusting the caregiver" (p. 192). By winning their trust, Ann finds they are able to laugh and joke with her eventually and become settled and accepting of their period of bedrest. Her satisfaction and the rewards she gains in caring for these patients are evident.

SEEING THE WORLD THROUGH ORTHOPAEDIC EYES

For some participants, 'coming to be' an orthopaedic nurse was experienced as an epiphany. Angela describes this:

.... It was almost like a light bulb going on or a plug switching on, you know! It was kind of "Ah hah - all right, now I understand that." So I could take that back to my own clinical area and actually be an expert in what I was doing. I didn't realise it at the time, but looking back, it was a 'novice to expert' kind of a thing. Before, you were just a general nurse but now you were an orthopaedic nurse!

Angela is drawing on all her formative experiences in this transforming moment. It's as if there is a sudden 'coming to fruition' in being an orthopaedic nurse.

You have so much knowledge and today, my knowledge has improved so much. I go into see patients now with confidence about my own ability ... with confidence about knowing about their physiology and what their particular fracture is going to mean to them - and I can tell them what sort of bone healing to expect and all those things. I feel like I am the best I have been...

Angela recognises that she has moved beyond general nursing status because she now has the knowledge and skills of a specialist nurse. She uses the word 'expert' because she knows that for her, being an orthopaedic nurse means being an expert. She has achieved integrity in her practice.

Powell (1976) suggested that: "In addition to a sound knowledge of the principles of orthopaedic treatment and nursing care, the nurse must develop an 'orthopaedic eye' – an acute awareness of correct body posture and mechanics – so that nothing that interferes with the patient's treatment will escape her notice" (p.4). The following story provides an example:

Angela is reflecting on an incident from practice in which she was called to see an orthopaedic outlier patient in a medical ward. She helped the nurses to position the patient comfortably and showed them how to support the patient's hip while doing so.

I came back and I said to my colleagues "Why wouldn't they think of that? Why wouldn't they think carefully about rolling and giving adequate pain relief? Is that something that you can only see with an orthopaedic eye?" We decided it was something orthopaedic... because I think, while it was basic common sense - it was actually common sense from my [orthopaedic] experience, not common sense generally.

So the 'carefully rolling' is from my orthopaedic know-how, not about...what they knew - because they didn't obviously see it. So that's the difference, you know! They were good nurses - they were pretty good at what they doing but that 'essence of orthopaedics' wasn't there and they didn't see what I saw - so I saw things in a different way.

Angela's eyes see the patient differently. She notices pain and knows how to position and move the patient to minimise this in ways that she did not previously and in ways that differ from other nurses. She distinguishes between 'common sense' and 'orthopaedic common sense'. Angela realises that her skills and expertise, what she refers to as 'the essence of orthopaedics', mean that she practises differently from nurses outside the specialty. She is able to hone in on patients' problems accurately by seeing them with 'orthopaedic eyes'. She is aware this embodied way of being is integral to being an orthopaedic nurse. Linking embodiment and perceptual capabilities, Leonard (1994) argues: "It is the body that first grasps the world and moves with intention in that meaningful world". She agrees with Benner (1984) that, "...it is assumed that our common practices are based on shared embodied perceptual capacities" (Leonard, 1994, p. 52).

The following example seems to encapsulate the notion of 'seeing the world through orthopaedic eyes'.

... I was sitting in the car one day at the petrol station – it's funny how you remember these things - and a man walked passed and I said, "He needs a hip replacement. Look at his hips!" It's from orthopaedics - you do see things in a different light that you didn't see before. You might see a patient in a brace ...and you think, 'I know exactly what that brace is doing!' You know, it's kind of different!

Angela has what Powell (1976) describes as "...an acute awareness of correct body posture and mechanics" (p. 4). Her first thought is to recognise the manifestation of orthopaedic conditions.

SUMMARY OF THE THEMATIC FINDINGS

The experience of being an orthopaedic nurse, means undergoing a shift in personal stance and philosophy, which transforms the individual from being a generalist nurse into being a specialist orthopaedic nurse. This means becoming enculturated by learning the 'know-how' of orthopaedic nursing. It means recognising, valuing and embodying orthopaedic nursing practice, and 'learning through doing' the craft of practice. It also means aspiring to become an orthopaedic nurse, maintaining expertise and passing it on. All of these are important to gaining and maintaining integrity of practice.

Being an orthopaedic nurse means to become embodied in the specialty, yet it also means developing resilience in order to cope with its competing challenges such as shifting workplace dynamics, complex patients, staff shortages, and juggling of roles and responsibilities.

CONCLUSION

This chapter explored the essential theme of 'gaining and maintaining integrity'. It shows how the experience of embodiment in the specialty is integral to being an orthopaedic nurse.

Chapter Six, the final chapter discusses the findings of the study and makes recommendations for practice, education and further research. The thesis conclusion is presented.

CHAPTER SIX: DISCUSSION, RECOMMENDATIONS AND CONCLUSION

INTRODUCTION

This chapter will discuss the findings of this study. I will begin by showing how the emergent themes of 'being part' and 'gaining and maintaining integrity' are further illuminated through reference to phenomenological literature (van Manen 1990). The essentials of being an orthopaedic nurse will also be discussed in relation to the substantive literature. Implications for nursing practice are outlined and recommendations are made for education and further research. The limitations of the study are identified and, in the final section, a conclusion to the thesis is presented.

DISCUSSION OF 'LIFEWORLD' THEMES.

'Lived space' or spatiality

Being an orthopaedic nurse means working within designated orthopaedic nursing settings as part of an orthopaedic service. Within these areas, orthopaedic nurses practice by working closely with patients alongside other health professionals, in relatively confined spaces such as a patient's bed space in a ward, a consulting room or a curtained off area in a casting room. van Manen (1990) talks of 'lived space' as being felt space. The spaces within which orthopaedic nurses work are not always designed well for their practical purpose. Thus nurses often have to 'make do' when working and spatial constraints become secondary or are ignored.

This is evident when a patient needs to share feelings and seek emotional support from a particular nurse, when at the same time, five people are moving and turning him while dealing with the traction apparatus. In this milieu, the nurse tries to create warmth and privacy so that the patient feels safe in this space. The nurse necessarily adjusts to being in the space as part with the patient and part with the team. 'Being part' for orthopaedic nurses means

“...that we become the space we are in.” (van Manen, 1990, p. 102).

The notion, spatiality, also assists understanding of the experience of being an orthopaedic nurse in other ‘felt’ ways. For example, phrases such as *‘it’s a good environment’*; *‘a good thing’*; *‘I wanted to go back to where I was’*; and *‘you just have to want to be there’*, imply a sense of being at home. van Manen, (1990), suggests that: “Home is where we can be what we are.” (p. 102) and the experience of being an orthopaedic nurse includes feeling ‘at-home’ in orthopaedic workplace settings. Yet some of the participants also described high levels of stress. Knowing that others devalue orthopaedic nursing increased this stress but, it was also true that experiencing work could be rewarding, even *‘inspirational’*. Settings that were thriving and harmonious, with people wanting to be there and *‘wanting you’* to be there, created more positive environments for those ‘aspiring to become’ orthopaedic nurses.

‘Lived time’ or temporality

‘Lived time’, according to van Manen (1990), describes the interrelatedness of past, present and future. In developing rapport with patients and other health professionals, orthopaedic nurses engage with what van Manen (1990) calls “...a person’s temporal landscape” (p. 104). They heed the temporal dimensions of past, present, and future. They know where the patient has come from, his/her immediate past, how he or she is coping and what the future may hold. However, their own experience of time is paradoxical. A sense of continuity is evident in their efforts to preserve some skills and knowledge, as described in ‘maintaining expertise and passing it on’. Yet changes in the nature of their work settings are also apparent in the sub theme: ‘coping with staff shortages’. The difficulties of juggling direct patient care with ward coordination responsibilities are conveyed and the ephemeral nature of time within orthopaedic nursing settings is exemplified in the phrase, *“You don’t know from one minute to the next what can happen”*.

Living with rapid shifts in time are therefore part of being an orthopaedic nurse, but the theme ‘developing resilience’, also provides contrast, in revealing how

time can drag. A struggle to balance patient safety against the needs of pool nurses, over a shift is unrelenting. Work can become 'simply too hard' for some nurses and is not conducive to their wanting to stay in orthopaedics. 'Time' can be problematic in other ways. For example, in the sub theme, 'coping with challenging patients', some nurses had to limit caring for complex patients to three days at a time. They became stressed and found it necessary to negotiate 'release time' from this responsibility even though it meant the patients did not receive continuity of care.

Timing is also important in engaging with or 'gelling' with orthopaedic nursing. A difficult initiation and being required to suspend judgement while integrating into an area was part of the experience for some nurses. The 'transient' nature of nurse staffing levels on the wards precludes adequate skill development yet, in 'developing resilience', the differences length of tenure and amount of experiential learning make on practice are evident. A nurse needs sufficient time to learn, yet, she must learn quickly so that patient safety is maintained. As conveyed in 'learning the "know-how', learning is often consolidated in real time in urgent situations, where there is no time for 'mucking around'.

'Lived time' is also part of the phenomenon in the sense that the nurses recalled significant past events. Senior nurses had modelled their expertise for them and gradually this then became embodied in their own practice. In addition to showing the importance of time in the present, to practice and develop skills, there is also an orientation to the future as senior nurses commit to teaching the next generation of orthopaedic nurses. Thus a lived commitment to 'other', overlaps with time as lived from past, through present, towards future.

'Lived other' or relationality

In the descriptions: 'being part' and 'gaining and maintain integrity', the 'lived other' is revealed as integral to the experience of being an orthopaedic nurse. This is evident in the sub themes: 'being part of the nursing team', 'learning the

“know-how” and ‘aspiring to become an orthopaedic nurse’. It is also inherent in phrases such as: *‘there have always been people who are solid’* and *‘they are the backbone of the service’*. These and many other descriptions of relationships strongly suggest a ‘valuing of the other’ between orthopaedic colleagues. The notion of ‘relationality’ is important, therefore, because orthopaedic nurses simply do not function without the ‘lived other’.

van Manen (1990) describes ‘lived other’ relationships as seeking “... in this experience of the other, the communal, the social, for a sense of purpose...” (p. 104). For example, as described in the previous section, the expertise, dedication and passion of senior peers for the specialty is of incalculable value in validating orthopaedic nursing for its converts. The ‘seeds are sewn’ for them to aspire to become orthopaedic nurses. van Manen (1990) proposes that ‘meeting the other’ in this way: “...allows us to transcend our selves. In a larger existential sense, human beings have searched in this experience of the other, the social, ...the meaningfulness...[or]... grounds for living”, (p. 105).

The findings show this ‘sense of purpose’ to be signal to being an orthopaedic nurse in relationships developed with other health professionals. For example, in working with medical staff, orthopaedic nurses are obliged to act purposefully in asserting themselves while constrained by a traditional patriarchy. Juggling patient care and ward coordination or coping with pool nurses, unenthused, unfamiliar and unskilled in orthopaedic nursing practice may impede experiencing the ‘lived other’ positively. Yet despite these disruptions or challenges, relationality lies at the core of being an orthopaedic nurse given that orthopaedic nurses are always with patients and within a team. This is inescapable.

‘Lived body’ or corporeality

van Manen (1990) suggests that: in meeting someone, “...we meet that person first of all through his or her body.” (p. 103). The findings revealed that ‘lived body’, or embodiment is integral to being an orthopaedic nurse.

As shown in 'being part with patients', orthopaedic nurses become a substitute for the damaged part of the patient's body when providing physical care. They must synchronise with the bodies of others when moving patients; they come to 'appraise' bodies 'automatically', noticing features such as abnormal limb position, skin discolouration and swelling. They teach and support patients about body positions and function and when necessary, help them objectify their bodies so that they can cope better with illness and disfigurement. Skilled orthopaedic nurses are "...always bodily in the world." (van Manen, 1990, p. 103).

DISCUSSION OF THE ESSENTIALS OF BEING AN ORTHOPAEDIC NURSE IN RELATION TO THE SUBSTANTIVE LITERATURE

Being part...of the service

Central to the experience of being an orthopaedic nurse is being part of an orthopaedic service. Yet notable for their absence, or present only by implication, were references to hospital management and/or nursing administration. This suggests therefore, that what is meant when referring to the orthopaedic service is the place and 'pecking order' of orthopaedic nurses and doctors, the interplay between these groups and the effects of this relationship on the experience of being an orthopaedic nurse.

Working with doctors

The relationship between doctors and nurses is integral to the experience of being an orthopaedic nurse yet tensions are shown to exist because of the patriarchal relationship between the two groups. Medical staff have tended to assume that they should lead health service delivery and direct the treatment of patients.

Increasingly this is less acceptable. Advocates of interdisciplinary and multiprofessional practice argue that nurses play a different but equally valuable role in the delivery of patient care (Salvage & Smith, 2000). Orthopaedic nurses make independent contributions in areas such as whole-person knowledge of

the patient, wound care and casting techniques, (Coombs & Ersser, 2003), and they expect to contribute to patient care decisions (Fox, 2000).

This study has shown that being an orthopaedic nurse means at best, experiencing a 'benign paternalism' by surgeons, or at worst, frank bullying. There is also evidence that an even more benign acquiescence on the part of nurses perpetuates these behaviours. For example, in describing casting 'for' the consultants, or in acting to placate surgeons by placing instructions about their preferences above patients' beds, working 'on behalf of' doctors is an ingrained part of the experience of being an orthopaedic nurse. However, nurses also choose to ignore surgeons' behaviours when discharge planning for example. It sometimes cannot proceed smoothly unless they intervene to achieve outcomes for patients that meet everyone's expectations.

The literature supports this notion of a productive yet somewhat uneasy relationship. Reed (2000) suggests that the service needs of hospitals and physicians have "...exploited the nursing vision, twisted its roots and choked potential growth..."(p.129). Paley (2002), who discusses the traditional dominance of nursing by the medical profession, expands on this view:

Nurses have been described as "useful parasites" by the medical profession; and Sarah Dock, writing in 1917, recalls that "the most helpful criticism I ever received from a doctor was when he told me that I was supposed to be simply an intelligent machine for the purpose of carrying out his orders" (Kuhse, 1997, p. 17, 24 cited in Paley, p.28).

This kind of autocracy is less acceptable in the 21st century, but, there are still elements of power and control in the interprofessional relationship between orthopaedic nursing and medical personnel. In fact, Whitehead and Davis (2001) argue that: "The issue of medical hegemony (dominance) appears to be as prevalent as ever and the maintenance of subsequent divisions, caused by unequal power relationships, seems to be as strong..." (p.114).

Both disciplines then, have differing perspectives. These have been described

variously as 'the care versus cure continuum', as 'hard versus soft', 'holistic versus scientific', or 'whole person versus focusing on a part'. The dichotomous nature of these descriptors highlights that, while both disciplines have a common focus on service to patients, there are still philosophical differences that influence the relationship. Becoming aware of these differences seems to be integral to the experience of being an orthopaedic nurse.

Part of the interdisciplinary team (IDT)

Liaison with members of the IDT is an important part of being an orthopaedic nurse. Collaboration is essential not only for the patient's well-being but also for the various disciplines including nursing.

The sub theme, 'part of the interdisciplinary team' revealed:

- *interdisciplinary consultation is beneficial for some patients prior to hospitalisation;*
- *coordinated planning is necessary to identify potential problems and facilitate patient safety;*
- *interdisciplinary team input is crucial to managing smooth transitions for patients;*
- *compared to other IDT members, nurses have greater contact and familiarity with patients;*
- *they have a pivotal role in interdisciplinary communication;*
- *some decisions are made without consulting patients*
- *and nurses need to be proactive and advocate for patients with IDT members directly.*

Being an orthopaedic nurse means coordinating the IDT. Clearly, it is the nurse's role to lead the process and the literature supports this notion (Halm, Goering, & Smith, 2003; Long, Kneafsey, Ryan, & Berry, 2002; Low, 2003; Maramba, Richards, & Larrabee, 2004; Milligan, Gilroy, Katz, Rodan, & Subramanian, 1999; Scott, 1997). However this role can be confusing and, like any other management experience, it requires preparation and forethought.

Experienced orthopaedic nurses often take on the role easily because a strongly embodied notion of 'team' means that this becomes a 'natural' way of

being which is, in turn, role modelled for more neophyte members.

Part of the nursing team

Being an orthopaedic nurse means to be part of the nursing team. The sub themes 'teamwork as part of the ward ethic' and 'working in a team as a model of care' revealed that the nursing team is integral to the experience of being an orthopaedic nurse.

My findings revealed the espoused importance of: 'being there' and available for others; being willing and ready to help colleagues; working together towards shared goals; becoming embodied in a team; facilitating processes through teamwork; and being prepared to act beyond the confines of one's own team, as critical to the experience of orthopaedic nurses.

Yet the findings have also revealed factors contributing to teamwork failure. These include: involvement of non-orthopaedic nurses, such as pool nurses unfamiliar with team nursing in orthopaedic settings; and new graduates, who experience difficulties in understanding the need to be part of the team. This is congruent with the claim by Sessa (1998) that "as nurses increasingly turn to teamwork as a viable option for accomplishing a myriad of duties and responsibilities, they are discovering that teamwork can also be a source of conflict." (p.41).

Being part with patients

Orthopaedic nurses have embodied relationships with patients. They offer physical and psychological support in special ways by 'being the patient's voice' or 'being a part' physically to enable patients' healing or function. Developing rapport and trust with patients is essential to being an orthopaedic nurse. Yet the findings reveal that this does not always happen. Patients can be challenging and difficult and nurses sometimes feel unsafe or need respite from caring for them. Thus, continuity of care may not necessarily always be the best way of managing high acuity and/or demanding patients. Workloads and additional responsibilities can adversely impact on the maintenance of safe

patient care. Acquiring effective coping skills therefore becomes an integral part of being an orthopaedic nurse.

Language as revealing meaning

During analysis, I became aware of ways in which patients were referred to in the nurses' stories. I came to see repeated use of possessive pronouns in relation to patients: 'my patients', 'their patients', 'our patients'. Moreover, the statement: '...we cast for them...' implies casting 'for' the surgeon, when it is the patient who is the recipient of such action. This suggests that being an orthopaedic nurse can mean focusing more on the task or on the expectations of health professionals than on the patient. Instances of labelling and categorising were also evident in the data. Orthopaedic nurses, like nurses in other scopes, have developed a specialist language. They often describe patients by referring to them in terms of their condition, injury or affected body part. Hence, they refer to 'NOFs', 'this ankle' or 'that cast brace' when discussing patients. During the research I became aware that I was equally prone to describe patients this way. For instance, I know that for every clinic I screen in my workplace I probably complete 20 to 30 X-ray forms on which the patient, apart from their identity label, is referred to only by their affected body part.

Benner (2002) talks about times when the clinical environment may push for subjugating the body [or patient] and "...treating it as a passive, depersonalised, objectified body instead of a sentient, embodied person" (p.481). Thus for reasons of expediency, custom and convenience, depersonalising patients appears to be part of the experience of being an orthopaedic nurse. In raising concerns about NANDA (North American Nursing Diagnosis Association), with reference to 'ineffective coping' a NANDA nursing diagnosis, Benner (2005) draws attention to the dangers of labelling:

Every classification system will necessarily render some things visible and some things invisible. We need to critically think about how and what we are making visible. What are the assumptions about the labels we use? (p.243).

At the government level there is evidence of similar commodification of patients within Orthopaedic Initiative documents (Continuous quality improvement (CQI) project, 2002). Even though this documentation is largely couched in business language, and some care has been taken to referring to patients appropriately, there are still instances where they are objectified. For example:

Agreed future baseline volumes must represent previous agreements or historic delivery (whichever is the higher) and must not substitute major joints for other orthopaedic work. In relation to this initiative, there will also be an agreed number of hip and knee joint replacements to be delivered within the overall agreement. Orthopedics' Initiative: (CQI) project. (2002), [emphasis mine].

Familiarity with such documentation is integral to most New Zealand orthopaedic nurses' experience and this language has become common usage when discussing patients affected by the Orthopaedic Initiative.

Other nursing researchers have noticed similar semantic patterns: Farrell (2001), in his analysis of nurses' relationships vis-à-vis dominant groups, noted that the "... constraints on individual autonomy, nurses' work rosters, often militate against them getting to know their patients on an on-going basis thus the care patients receive can be disjointed" (p.28). He proposed that:

...patients are sometimes seen as tasks, not people. Travelbee (1976) suggests that patients can be categorised by a process of human reduction. For example, they may be perceived as illnesses – "Have you done the obs? (observations) on the chole (cholecystectomy) in room 32?" or as tasks – "I have to do the dressing in room 1" (p.28).

Verbal shorthand of this type can be contributed to by tiredness and heavy work loads (commonly referred to as 'patient loads', ironically). The pace of practice leaves little time to reflect on the implications of referring to patients in this way. Benner (2004) highlights the moral implications and dehumanising effects inherent in using impersonal language:

I am struck by the moral failure of the clinical gaze when we in medicine or nursing use it as our primary or exclusive language...//... our language and styles of practice shape moral perception and thus open and close down humane possibilities (p.76).

When labels are attached to patients by health professionals, they invariably become identifiers. This means that the uniqueness, or 'whole person' aspects, of the patient are neither recognised nor acknowledged because that requires knowing them as an individual (Erlin & Jones, 1999).

Being an orthopaedic nurse also means experiencing difficulties associated with inadequate staffing. The nurses in this study felt frustrated by an inability to nurse patients as well as they would like. Safety is recognised and accepted as a priority but, when this is achieved through concentrating solely on technical tasks, nurses do not get to know patients well. These findings are supported by Brown (2001) who argues that there is a direct correlation between nursing staff numbers, skill mix and adverse events such as medication errors and complications. Staffing issues also affected patients' comfort, rates of recovery and length of stay and compounded nurses' stress and anxiety about safety in practice (Brown, 2001, p. 67).

Technology and orthopaedic nursing practice

Yet, a significant amount of orthopaedic nursing knowledge is technical in nature. Orthopaedic nurses are therefore continually challenged to keep up with technological advancement. The findings of this study show that the impetus to 'surgically nurse' orthopaedic patients has occurred at some cost to maintenance of traditional orthopaedic nursing skills. In the sub theme 'maintaining expertise and passing it on', concern was expressed about erosion of specialty skills. Examples were also provided of instances when non-application of orthopaedic nursing knowledge and skills was to the detriment to patients' safety.

RECOMMENDATIONS

For practice

The findings of this study provide insight into the experience of being an orthopaedic nurse in New Zealand. While these findings are not generalisable

to all orthopaedic nurses, they have raised questions that could potentially guide improvements in orthopaedic nursing practice.

Liaison with nursing administration.

As identified earlier in this chapter, there was little reference in the data to nursing managers. This suggests there may be a communication gap between orthopaedic nurses at the work face and managerial staff. Nursing administrators could facilitate better understanding of the organisation and demonstrate valuing of orthopaedic nurses by hearing their concerns and communicating about workplace issues. A personal experience of one Director of Nursing committed to making regular visits to practice settings for this purpose has enabled me to see the benefits of such an approach.

Staffing

The nursing workforce and patient acuity should be monitored to ensure staffing levels in orthopaedic settings are adequate. It is also important to adapt staffing models or formulae to suit needs of particular areas and/or to develop new models inclusive of specific staffing requirements. (*Personal communication with a Director of Nursing of a major tertiary hospital, April, 2006*).

Recruitment and retention

There needs to be proactive recruiting to orthopaedic settings. This includes encouraging new graduates to consider working the area as well as enticing experienced staff back to the specialty. Targeted inducement strategies such as rostering that enables staff to maintain family commitments and adequate financial recognition of postgraduate qualifications would facilitate recruitment and retention.

Fostering a supportive environment

These could include adequate preceptoring of new staff, debriefing and 'time out' from difficult and challenging clinical situations and development of an

integrated specialty practice pathway. Professionalism, expertise and passion for the specialty need to be modelled for new staff so that they are supported in their development.

Orientation and education of pool nurses

Pool staff need to be allocated to orthopaedic nursing settings regularly. They also need adequate orientation to the area. This includes registration for administration of IV medication and skills training, for example, in lifting and turning patients with spinal injury.

Reflective practice

Reflection is beneficial in a transformative sense by adding depth to practice and enriching nursing knowledge. It can also help in addressing deficiencies or ineffectiveness. Professional supervision and mentoring have been shown to facilitate reflection and critique of practice (Andrews, 1999; Driscoll & Teh, 2001; Fowler & Chevannes, 1998; Glaze, 2000, 2002; Hesook, 1999; Spouse, 2001). However, opportunities for formal reflection on practice need to be scheduled. Frameworks for professional supervision could be developed to suit the needs of staff within particular orthopaedic settings or this could be a feature of the professional advancement pathway for nurses throughout the organisation.

Creating balance between technology and holistic care

Technology can have a profound impact on care. Becoming technically adept in the specialty needs to be balanced with delivering holistic, patient centred care. Undertaking designated medical tasks can erode this equilibrium. For example, orthopaedic nurses who must spend a large amount of time administering IV medications may not be able to attend to other essential aspects of care. Focusing on operating a patient's pain pump may result in neglect to follow up a complaint of 'burning' under a patient's plaster. For similar reasons, it is essential that the delegation of medical tasks to nurses should be thought through carefully. Questions must be asked in relation to the

establishment of advanced roles, for example nurse-led clinics. Nurses need to be aware of what might be gained and lost in the balance of "...competing claims on ... time and for other health resources" (Johnson & Webb, 1995, p. 474).

For nursing education

Education in the specialty has been identified as an essential part of being an orthopaedic nurse.

A framework for specialist practice

New Zealand orthopaedic nurses have raised skills standardisation in discussion informally. The development of a nationally recognised specialist practice pathway using an interdisciplinary framework could benefit all members of the IDT.

Specialty education

In addition to maintaining skills and knowledge, specialty education is beneficial to practitioners in terms of personal and professional development. A national framework for advancement of the specialty should evolve in tandem with existing postgraduate education programmes to fulfil the specific needs of orthopaedic nurses in New Zealand.

LIMITATIONS OF THE STUDY

This study has facilitated articulation of the meaning of being an orthopaedic nurse. Yet, because the meanings presented are context specific and constantly evolving, the description will always be incomplete.

There were only eight participants in this study, thus it is likely that the description of the phenomenon does not reflect the experience of all orthopaedic nurses. For example, this participant population comprised of one man and seven women so, while roughly reflecting gender distribution within the larger orthopaedic nursing group, the adequacy of gender related meanings is likely to have been compromised. Other possible deficiencies are cultural:

there was one Maori participant compared with seven from other cultural groups. The areas of practice differed in that there was just one nurse working in a casting setting. The remainder practiced mostly in ward environments. Also the senior nurse/junior nurse ratio was weighted in favour of senior nurses. Ages of participants were distributed along an approximate range between 30 years to the late 50s. The findings may have differed if any of these groups had been disposed differently, for example, if the participants had been from a younger age group.

Another limitation pertains to my own cultural and historical horizons as the researcher. This will have enabled some insights and limited others. For example, most of my recent experience has not taken place in ward settings. While data analysis allowed me insight into current experience of orthopaedic wards, I may have been restricted by my lack of subjective knowledge of these settings. My age and passion for postgraduate education are also likely to have influenced the interpretation presented.

RESEARCH RECOMMENDATIONS

This is the first study to describe the experience of being an orthopaedic nurse in New Zealand. Taking a phenomenological interpretive approach was appropriate because of the experiential nature of the research question. However, the multi-dimensional nature of the findings suggests that further research would be valuable.

The relationship with medical colleagues

This study revealed a degree of tension between orthopaedic nurses and doctors and the fact that a patriarchy exists between them is acknowledged. The relationship is paradoxical, it is collegial and adversarial, symbiotic yet not always harmonious, and in the patients' interest, sometimes, but not always. Research informed by critical social theory, which seeks to answer questions about whose interests are being served, would therefore be valuable.

The Interdisciplinary Team

Many studies have examined interprofessional collaboration and interdisciplinary teams. This study highlighted innate tensions that may exist between orthopaedic nurses and IDT members. Research into this relationship within the specific context of orthopaedic settings would be useful.

Orthopaedic nurses and patients

Analysis of the language and forms of communication used by orthopaedic nurses in communicating with and about patients could be undertaken using discourse analysis.

CONCLUDING STATEMENT

This study has explored and described the experience of being an orthopaedic nurse. As I am an orthopaedic nurse, I have assumed and argued that orthopaedic nursing should be a specialty in its own right. Yet, it appears that advances in orthopaedic surgery have resulted in the acquisition and practice of surgical skills by orthopaedic nurses and the subsequent loss of some traditional skills, such as casting and traction application. This has led to questioning the validity of the specialty and suggestions that orthopaedic nursing should be subsumed into other scopes of practice such as surgical nursing or trauma nursing.

In describing the phenomenon of being an orthopaedic nurse I wanted to reveal the essential nature of the specialty and more importantly, its meaning to orthopaedic nurses. Interpreting the stories of eight orthopaedic nurses alongside my own experiences has enabled me to articulate meanings inherent in the experience of being an orthopaedic nurse.

The study findings are consistent with many of the understandings I already held. For example:

- *prejudices or misperceptions exist about orthopaedic nursing;*
- *collaborations formed in practice with others such as patients, colleagues and other health professionals are significant for orthopaedic*

nurses;

- *the relationship between orthopaedic doctors and nurses is a patriarchal one;*
- *there are particular forms of language used in relation to patients;*
- *specialty expertise is essential for safe patient care*
- *and that induction and enculturation are important in ensuring orthopaedic nurses engage with and grow within the specialty.*

The study findings have also challenged my preconceptions. The new insights I gained include the following:

Part and whole of being an orthopaedic nurse

Exploring both the 'parts' and the 'whole' of the phenomenon has deepened my previous understanding. Part-whole dynamics were evident in relationships orthopaedic nurses formed with others and also in the transition to or 'becoming' in being an orthopaedic nurse. Part-whole dynamics were significant in showing the embodied nature of the experience, thematically described as 'being part' and 'gaining and maintaining integrity'. They were then more fully realised in 'seeing the world through orthopaedic eyes'.

Tensions and 'inbetweenness'

Tensions are inherent in the experience of being an orthopaedic nurse because of factors such as the dynamic nature of workplace settings. Of particular note, are imbalances that affect homogeneity between orthopaedic nurses and doctors, orthopaedic nurses and other nurses, orthopaedic nurses and other health professionals and orthopaedic nurses and patients.

Orthopaedic nurses often need to act between several groups at once, often 'on behalf of one' and/or with another, which can be experienced as stressful. External factors such as managerial distance and others' misperceptions of the specialty can adversely affect the experience and create further tensions.

What makes orthopaedic nursing a specialty?

Perhaps the most important new insight gained from the study is that orthopaedic nursing exists in its own right because it becomes internalised in the minds, bodies and hearts of its practitioners.

Advances in orthopaedic surgery have meant that orthopaedic nurses must further develop surgical skills while some traditional orthopaedic skills are required less often. However, other factors contribute. A more transient nursing population and the widespread use of pool nurses means that such skills are less likely to be available when required. Under-utilisation of these skills also presents difficulties in terms of their maintenance.

Nonetheless, successive generations of orthopaedic nurses have shown they are adaptable and creative in responding to the needs of orthopaedic patients. In the future, new technologies such as gene therapy and tissue engineering may require resurgent use of traditional orthopaedic nursing skills. They will also certainly require the development of new specialty knowledge and practice.

Orthopaedic nurses live their specialty because it is embodied in their thoughts and actions. They see the world through orthopaedic eyes.

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APPENDIX A: Ethical Approval

Please include the reference no. and study title in all correspondence/telephone calls.

Auckland Ethics Committees

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6 April 2004.

Ms Elizabeth Blake-Palmer
34A Ellerton Road
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Dear Elizabeth,

**AKX/03/11/305 Being an orthopaedic nurse: an hermeneutic inquiry:
PIS/Cons V#2, 15/03/04**

We are in receipt of the amendments requested in our letter of 2 December 2003, received 22 March 2004.

The above study has been given ethical approval by Auckland Ethics Committee X.

Certification

It is certified as not being conducted principally for the benefit of the manufacturer and may be considered for coverage under ACC.

Accreditation

This Committee is accredited by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, March 2002.

Documents Approved:

It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider, within whose facility the research is to be carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.

Progress Reports

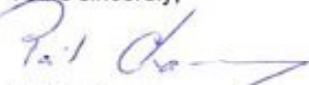
The study is approved until 6 April 2005. Should you require an extension of time, please contact the Ethics Committee.

Please advise the Committee when the study is completed and a final report is also required at the conclusion of the study.

Amendments

All amendments to the study must be advised to the Committee prior to their implementation, except in the case where immediate implementation is required for reasons of safety. In such cases the Committee must be notified as soon as possible of the change.

Yours sincerely,



Pat Chailey
Administrator, Committee X.

Cc: South Auckland Health
Cc: Waitemata DHB Research Office.

Cc: Auckland Research Office

Accredited by Health Research Council

APPENDIX B: Consent Form

Consent to Participation in Research

Title of Project: Being an orthopaedic nurse: a hermeneutic inquiry

Project Supervisor: Dr Deb Spence
Principal Lecturer
School of Nursing and Midwifery
Auckland University of Technology
Phone: 09 917 9999 ext. 7844

Researcher: Elizabeth Blake-Palmer

- I have read and understood the information provided about this research project (Information Sheet dated: 15 March, 2004.)
- I have had an opportunity to ask questions and to have them answered.
- I understand that the interview will be audio-taped and transcribed.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- If I withdraw, I understand that all relevant tapes and transcripts, or parts thereof, will be destroyed.
- I agree to take part in this research.
- I understand that the research report will be available for me to read at the completion of the research.

Participant signature:

Participant name:

Participant Contact Details (if appropriate):

.....
.....
.....

Date:.....

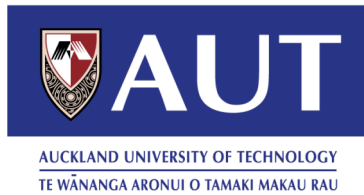
Final version date: 15 March, 2004

Version 2

Approved by the Auckland Ethics Committee on 6 April 2004

Reference number AKX/03/11/305

APPENDIX C: Information Sheet



Information Sheet

Project Title: Being an orthopaedic nurse: a hermeneutic inquiry
Name of Researcher: Elizabeth Blake-Palmer

You are invited to participate in this proposed research project. I would like to interview you about your experience of being an orthopaedic nurse. There is little information available on this topic and nothing has been published about New Zealand orthopaedic nurses in the nursing literature.

The reason why I have chosen this topic for my research is because I am presently undergoing postgraduate study towards a master's degree, and I wish to re-familiarise myself with the world of orthopaedic nurses. Even though I am an experienced orthopaedic nurse myself, I need to learn more about this dimension for educational purposes.

I am presently teaching a post graduate specialty practice paper online for nurses who have had at least two years experience in orthopaedic nursing. To inform ongoing development of this course, I would like to know how its present day practitioners view this specialty. There has been a considerable amount written about nurses in general and their practice sphere. There have also been a number of research projects carried out internationally that look at the nursing workplace in a variety of ways. Most of this has been quantitative research which means it has been conducted using a scientific model and has often been in the form of surveys or questionnaires, using a variety of tools.

While this material has been valuable in shedding light on what nurses do, some problems have been identified. The over-use of some measurement tools for example, has meant a lot of results have been duplicated and their findings disputed. Use of qualitative methods in research has been recommended in order to provide a balance. In a hermeneutic inquiry, a number of participants are interviewed and their data undergoes thematic analysis in order to interpret the meaning of a particular experience.

In this inquiry, I will be conducting interviews with participants that will take place in a setting nominated by each individual. The interview process is expected to take up to one and half-hour's duration.

Its format will be unstructured and will be based on open-ended questions and conversation about the practice experiences of the individual. Each participant will be free to volunteer information, which in turn provides direction for the interview to take. During this process, I may need to make notes of points to

explore further. If I need to clarify any particular information subsequently, I will achieve this in a short phone call to the participant.

Each interview will be audiotaped and transcribed into written form by a typist who has signed a confidentiality agreement. At this point, each transcript (raw data) is returned to the participant to check for accuracy of the information.

No one else apart from the typist and the researcher will hear the tapes and they will be kept in a securely locked filing cabinet at my home until they are erased and destroyed at the end of the inquiry. The transcribed information will be coded numerically and kept in the form of writable CD ROM discs. There will be no personal or identifying information among this material and pseudonyms will be used if necessary. The project supervisor will keep the consent forms separately and securely.

The research report, which will form part of my master's thesis, will be made available to the participants, the service provider, AUT, and interested health professionals. The findings may be disseminated through conference presentations or publication in relevant nursing journals and the thesis will be held in the AUT library. The report itself may contain some anonymous quotations, but its information will not be traceable to any participant.

Your involvement in this project is entirely voluntary. Should you decide not to participate, you are free to withdraw at any time without giving a reason or incurring any penalty. If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact your professional body.

Rarely, an interview can cause some discomfort for the participant. You will not be obliged to answer questions if you do not wish to and the process can be halted at any time. You may have a support person or whanau present. Debriefing after the interview can occur and if you need it, counselling made available.

If you have any questions about this research, please feel free to contact me.

This study has received ethical approval from the Auckland Ethics Committee.

Elizabeth Blake-Palmer

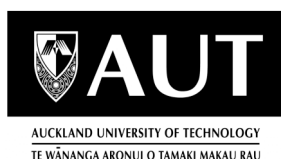
Mobile phone: 0211 362 843
Fax: 09 6300874
Email: lizbp@ihug.co.nz

Version 2.

Date: 15 March, 2004

Approved by the Auckland Ethics Committee on 6 April 2004
Reference number AKX/03/11/305

APPENDIX D: Typist Transcription Agreement



Title of Project: The experience of being an orthopaedic nurse

Project Supervisor: Dr Deb Spence

Researcher(s): Elizabeth Blake-Palmer

I understand that all the material I will be asked to transcribe is confidential.

I understand that the contents of the tapes can only be discussed with the researchers. I will not keep any copies of the transcripts nor allow third parties access to them while the work is in progress.

Typist' signature:.....

Typist's name:.....

Typist's Contact Details:

.....
.....
.....

Date:.....

Project Supervisor Contact Details:

Dr Deb Spence
Principal Lecturer
Faculty of Health
Auckland University of Technology

09 917 9999 ext. 7844
deb.spence@aut.ac.nz

Approved by the Auckland Ethics Committee on 6 April 2004
Reference number AKX/03/11/305

APPENDIX E: Recruitment Poster

