RECIPROCITY FOR CARE: GIFT GIVING IN THE PATIENT-NURSE RELATIONSHIP

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"Gifts make slaves, just as whips make dogs."
Eskimo proverb (cited in Harris, 1974, p. 126).

Caring for patients frequently requires intensely personal and intimate tasks to be performed by nurses. In their professional role, nurses are relative strangers to the patient, yet are responsible for providing support to patients in their most distressing moments, such as when they are in pain or facing the fear of death. Nurses also provide patients with such care or treatments as assisting with bedpans, bathing or catheterization, that would in other circumstances be considered "shameful" and private to the patients. Although these procedures are expected and routine nursing tasks, they rarely become expected and accepted by the patients themselves. Patients frequently apologize and express shame at the "work" created by the loss of bodily control.

Nurses work for the hospital, yet they *give* care to the patient. In this article I will argue that this situation creates an imbalance in the nurse-patient relationship. It creates a loss of power, dependency and passivity within the patient, and a feeling of being obligated to reciprocate for the care given. Chapman (1976, 1980), Dowd (1975) and Kayser-Jones (1979, 1981) note that reciprocity is an essential part of the therapeutic process, although, ironically, the practice is discouraged in health care. As the nurse's employer considers that the nurse has already been reimbursed adequately in the form of salary, and recognizes the more powerful position of the nurse and the potential for exploitation, administrative policy frequently is developed to prohibit gift giving. I suggest that such a policy inhibits patient recovery and that the constant refusal results in a double-bind situation for nurses. The nurses are placed in a situation whereby they must choose between accepting or refusing the gift. The former involves breaking hospital rules with the subsequent feeling of guilt and the possibility of reprimand; the latter violates social norms (i.e., it is considered rude) and may be construed as

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rejecting the patient. Finally, although this must be investigated further, the lack of a direct patient-nurse reward system may foster burnout in nurses.

The first purpose of this article is to explore the pattern of exchange and norms of gift giving in the patient-nurse relationship. What gifts are offered to nurses, when and why? What gifts are considered appropriate, what gifts are shared and what gifts are refused? The second purpose is to suggest a theoretical context for the patient's act of giving gifts to nursing staff.

Methods

In this study, ethnoscience was used to determine the *structure* of gift giving; of who gives what, to whom and when. The inductive method of analyses permitted understanding of the norm of gift giving. This study is a preliminary report on ongoing research, further investigation, using grounded theory to investigate the meaning and purpose of gift giving in the nurse-patient relationship, is anticipated. While ethnoscience enables the investigator to elicit the components of gift giving, grounded theory enables the investigator to elicit the process.

Ethnoscience

Ethnoscience is a method of examining distinctions of a phenomenon by contrasting and identifying characteristics that are considered significant, meaningful, real, accurate, relevant and appropriate by the "actors" themselves (i.e., from the emic, or informant's perspective [Pelto & Pelto, 1978]). It is a linguistic technique of analysis of behaviour through examination of the reported intentions, motives, goals, attitudes, thoughts and feelings of the informants. Underlying the method is the assumption that members of the same culture share similar values, beliefs and symbols, and it is this shared meaning that can be expressed (or elicited) using particular interviewing techniques (Harris, 1968; Spradley, 1979). In this study, the assumption underlying the use of ethnoscience is that reciprocity is a cultural norm that is shared by and understood by all members of a cultural group. The interviews were conducted with nurses residing in a large Canadian city, with the exception of one group from a southern city in the U.S.A. The nurses were from all specialties and were students enrolled in master's or doctoral degree programs. A three-hour interview session was conducted with three classes, for a total period of nine hours. Approximately 40 nurses were involved, and these interviews were conducted primarily to demonstrate the techniques of ethnoscience. Five other informants were interviewed individually. All interviews were tape-recorded and transcribed.

Initially, unstructured interview techniques were used. The informants were asked "grand tour" questions (Spradley, 1979), such as, "Think of patients

who have given you gifts. Tell me about them." In the second step in interviewing, contrasting questions were used (e.g., "How does [a gift] differ from [another type of gift] ?") (See Evaneshko & Kay, 1982) to determine the characteristics of different types of gifts.

Card sorts were used to identify the similarities and differences of types of gifts, and to elicit the differences between categories. Thus, through these processes, examples of similar types of gifts and the characteristics of each class of gifts are obtained. Comparative questions, (e.g., How does this pile of gifts differ from this pile?), and questions to elicit common characteristics (e.g., How are the two piles similar?) permit the investigator to document the informants' views of the phenomena. Finally, asking the informant to name each pile of cards, provides an emic-derived label for each category of gift.

Results

Gift giving in hospitals was reported to be exceedingly common and followed a clearly delineated pattern. Consistent with gift giving norms outside the hospital, co-workers and patients presented gifts to nurses when nurses were going through various rights of passage (e.g., as a farewell gift, when they were about to graduate, or when celebrating a birthday), as a shower gift (in the case of marriage or the birth of a child) or for a particular season, such as Christmas or Easter. However, within the hospital the major flow of gifts were primarily from the patients to the nurses and, to a lesser extent, from the patients to the physicians. Gifts from patients' relatives to staff were given either on behalf of the patient or presented directly to staff from the relative.

Gifts to nursing staff

Characteristics of gifts: The nursing staff perceived gifts from patients to be either tangible or non-tangible. Tangible gifts included articles made by the patient, such as a drawing, slippers, knitted articles or artwork; store-bought foodstuffs, such as boxes of chocolates, fruit baskets, cookies, cakes and donuts; a card or a letter of thanks; personal gifts, such as perfume, stockings, stationery or cash. Intangible acts that nurses perceived as a gift were such things as volunteering to assist staff by watching over a confused patient, or by assisting with meal trays; making the effort to walk back to another unit (e.g., back to the ICU) to thank staff for their care; or choosing to get well as in the case of a catatonic psychiatric patient.

There was some evidence that the type of gifts differed according to the area of the nurses' employment. Whereas in the hospital gifts were more likely to be purchased from the store, nurses who worked in community

health reported that gifts were primarily home made or home grown. Clients gave small jars of jam, home baked goods, vegetables or flowers from the garden, or valued possessions, such as a china teacup, that the individual had had for some time and had special meaning to that patient. Another, yet an essential aspect of reciprocity in the community, was sharing a cup of tea or coffee with the nurse at the end of her visit. Nurses reported that clients used this opportunity to find out about the nurse, to ask about her marital status, her background, her family and children. They believed that this was perhaps, a means of balancing the amount of information that the nurse gleaned from the client in the course of taking a health history.

The timing of gifts: For short-stay patients, gifts were presented to the staff in two ways: the first was when the service was rendered, usually after the nursing task was completed. The patient kept small gifts of food on the bedside table, usually candy or fruit, and offered these to select staff. These gifts appeared to serve primarily as a means of reinforcement, to thank staff for small services rendered. The second time that gifts were presented was at the end of the patient's stay. When leaving the ward, the patient presented a gift to the staff member or to the unit, to be shared amongst the staff. These gifts were usually presented in a formal manner, gift-wrapped and usually accompanied with a card expressing the patients' appreciation.

However, for long-stay patients, gifts were presented at intervals, often several months apart and often at a time that coincided with seasonal celebrations. If the patient was unable to present the gift personally (for example, if the patient was unconscious or too young), then relatives presented the gift to the staff on behalf of the patient. In pediatric units, for instance, the parents purchased a gift and wrapped it, assisted the child to "sign" the card by guiding his or her hand and then prompted the child to give the present to the nurse at the appropriate moment.

The distribution of patient gifts: Not all areas of the hospital received gifts from patients at the same rate. There appeared to be a relationship between the amount of gifts patients received while in hospital, and the number of gifts patients gave to staff. In maternity units, for example, where the patients received a "gift" of an infant, and gifts from others for the new infant were received by the mother, the staff were showered with chocolates, flowers and other tokens of appreciation. These gifts were given to the nurse who cared for the mother during labour or in the post-natal ward, but were rarely given to the nursery nurses whose role was perceived to be taking the infant at night. The staff who worked in the operating room, almost never received gifts. It is possible that, although the patient may be cognizant of the fact that the operating room was the area where they were actually cured, because patients were anesthetized that period of time does not exist in their awareness. Staff in other areas of the hospital, aware of the unequal distrib-

ution of patient gifts, made an effort to send surplus goodies to the areas that do not receive patient gifts, especially during Christmas.

Receiving the gift: When a presentation is made to the nurse, she must make a decision about keeping the gift for herself, sharing the gift with other staff, or refusing the gift. The nurse's decisions were not dependent necessarily on administrative policy (which may overtly forbid the acceptance of gifts), but rather on the characteristics of the gift itself.

The characteristic of the gift that nurses first considered was the dollar value of the gift. Nurses reported that they were most comfortable accepting gifts valued under $5.00, and the greater the value, the greater their discomfort about accepting the gift. Next, nurses assessed whether or not the gift was a personal one, or one that should be shared with the other staff. Most obviously, boxes of chocolates or fruit baskets can be shared, but bottles of wine, which cannot be easily shared in work time or divided, present more of a dilemma. When making the keep-for-self/share decision, nurses considered the relationship that they had with this particular patient, and the setting in which the donation was made. Gifts that were made publicly to the head nurse, for example, at the main desk, were usually meant to be shared, but gifts that were given privately were usually intended for that particular nurse alone. Sometimes the dilemma was resolved by the patient, who may have indicated that the gift was for "you girls" (meaning the unit staff as a whole) or, on the other hand, the patient may have stressed that it was a personal gift, by stating, for example that "This gift is for *you*; you have been so good to me." Frequently, the message on the card accompanying the gift indicated whether or not the gift was a personal one or one to be shared.

Next, nurses assessed whether or not there was a hidden agenda behind the gift. Occasionally, such gifts are blatantly obvious, as when a male patient invites a nurse to dinner "when he gets out", or presents a very personal gift, such as perfume or silk stockings. Such gifts were considered inappropriate and usually refused.

The timing of the gift was perceived to be most important. Nurses reported that gifts (especially of money) that were given at the beginning of the relationship, were "given-too-early" and perceived as manipulative - as a bribe. For example, one nurse cited a patient's relative that offered her money as he left the ward, shortly after his father was admitted. "Here" she was told, "take good care of him tonight." She reported feeling insulted, as if it were suggested that she would *not* give good care without extra payment, or that payment would ensure that she gave his father preferential treatment over the other patients.

Refused gifts: Despite the unspoken fears of administration that nurses might accept bribes or gifts that will result in the differential care of patients, this occurrence was relatively rare. Most gifts were considered by nurses to be appropriate, to be deserved and to be an indicator of client satisfaction that they, as nurses, were doing their job well.

Gifts of money, usually cash, were considered the least personal, and frequently caused the greatest dilemma for staff, perhaps because of the ambiguous nature of the gift that it could be construed as not freely given by the patient. These gifts were most frequently refused, or diffused by thanking the patient publicly, and diverting the gift into a general fund to be shared by all staff. However, the manner and timing of cash gifts frequently determined whether these gifts were kept, shared or refused. If the gift was clearly planned by the patient in advance, for example, given to the nurse in an envelope with a card, then the nurse was more likely to accept the cash gift. But if the patient offered the nurse a cash gift spontaneously, directly from his or her wallet (as with a tip), then the gift was likely to be refused.

Other gift giving-relationships

Nurses reported that physicians frequently received gifts from patients and these gifts were of much greater monetary value than those given to the nurse. Nurses cited examples, such as a case of wine, a puppy, season tickets to the hockey game, a new briefcase, and considerable sums of money.

Physician-nurse. Physicans were jokingly reported to give nurses only "a hard time". However, nurses considered their advocacy, goodwill and support as intangible gifts. When physicians purchased gifts for the nursing staff, these gifts were usually gifts of appreciation and given at Christmas time. Frequently, all of the medical staff chipped in and purchased a group gift, such as a microwave or some other needed, communal equipment.

Nurses only occasionally gave gifts to physicans, and these were gifts with a message. For example, when a physician repeatedly "borrowed" the nearest nurse's pen and absent-mindly left the unit with it, nurses reported presenting him with a giant pen on a thick string to hang conspicuously around his neck.

Intercepted gifts. Despite the fact that in many institutions policies have been developed to impede the presentation of gifts by patients, the custom still persists. One home care unit, concerned about gift exchange, developed formal policy that nurses were not to accept gifts. If these gifts could not be politely refused, then the gifts were to be handed in to the office, and a formal, official acknowledgement would be sent to the patient. At this time, letters were sent to all clients, reminding them of the policy and suggesting

that, if they wished to give a meaningful gift, a letter of appreciation or a card sent to the nurse concerned, would be placed on the nurse's permanent file and acknowledged administratively. Thereafter the nurses received a card or a letter *in addition to* a gift from patients.

Another incident was reported where a special relationship exisited between a nurse and her patient. The patient gave the nurse a very expensive watch. When the patient's family found out about this watch, they complained to the nursing agency. The nurse was made to return the watch, much to the dismay and embarrassment of both the nurse and the patient. The nurse was subsequently transferred to another area, but the relationship between the nurse and the patient continued.

Nurses who had themselves been patients reported that if they felt dissatisfied with the care received in the hospital, then any sign of appreciation for care was withheld, to the extent that they refused to say thank you or even goodbye to the staff. These patients considered their discourtesy a deliberate message to the staff that nursing care was inadequate. Within the framework of reciprocity, these patients did not feel that they owed anything to the staff, and, in fact, perceived themselves to be "punishing" the staff with their rudeness.

Gifts from relatives to nursing staff. The first instance of relatives giving gifts to nursing staff is, as previously mentioned, when patients are unable to give gifts to staff themselves. When the patient is a child or unconscious, the relatives give on behalf of the patient. A second occasion when the gift by relatives is particularly evident, is following the death of a patient. The relatives frequently send the staff a letter or card of appreciation, some flowers from the funeral, a cash donation to purchase equipment for the unit or make a gift to the hospital in the former patient's name.

A third occasion on which gifts are frequently given, is when the patient is considered particularly difficult to care for. For example, if the relatives know that their elderly parent is confused, wandering and incontinent, or that their son with a head injury is restless and belligerent, they bring gifts to the staff "because mother was so difficult" or "to put things right". It is important to note that these gifts are given after, not before, a period of caring has taken place. A gift that is given to the nurses "to take good care of mother" is seen as a bribe, and rejected by staff.

Pattern of gift giving. The pattern of gift giving in hospitals follows distinct patterns of exchange (See Figure 1). Note that although relatives may give directly to the nursing staff, they rarely give directly to an individual nurse. Rather, gifts to an individual nurse are prepared for the patient to present, and given on behalf of the patient, as illustrated in the direction of the arrow. The flow of gifts is almost exclusively to the nurse or to nursing staff.

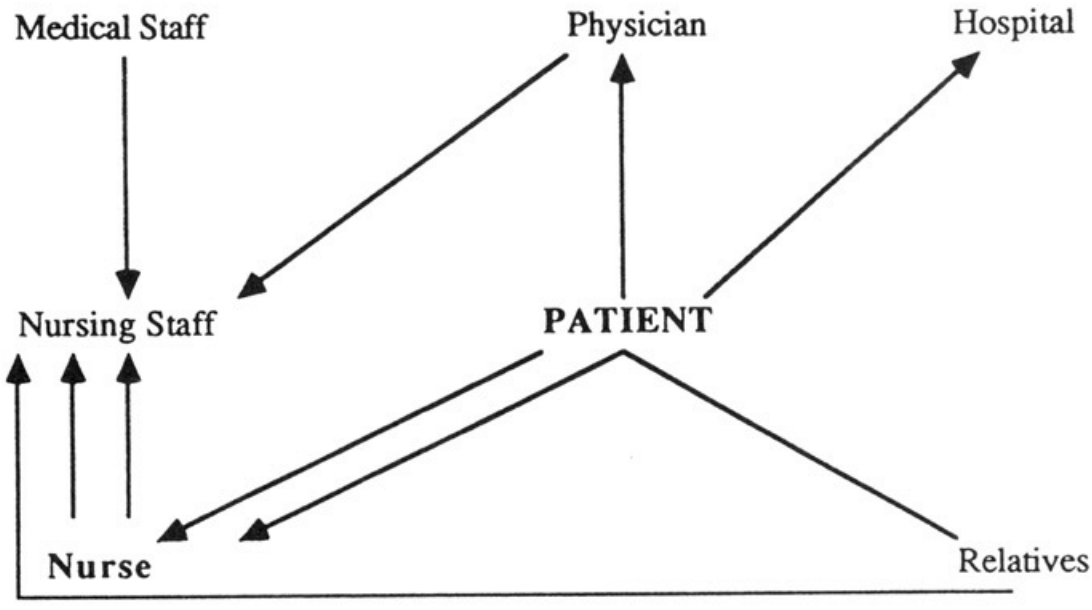

Figure 1
Patterns of gift giving in acute care institutions

Discussion

"A gift is a thing we cannot get by our own efforts. We cannot buy it; we cannot acquire it by an act of will. It is bestowed on us." (Hyde, 1983, xi).

The act of giving to another is a basic human characteristic, but one that can not be separated from the simultaneous act of receiving (Gouldner, 1960; Harris, 1968, 1974; Leeds, 1963). A gift immediately creates a difference in status between the giver and the receiver; the receiver is placed in a position of gratitude, of unpaid debt, which will remain until the sense of obligation is equalized by a counter gift (Harris, 1974). Thus, the person who gives the gift is in a position of increased status and power over the receiver of the gift. Mauss (1967) notes that in all human interactions we have the obligation to give, the obligation to receive and the obligation to reciprocate.

Nurses *give* care to patients. The choice of the verb "give" (rather than provide) connotes that the caring component of the nurse-patient relationship is beyond the duty or minimal tasks required of the nurse in her job description. Patients perceive basic nursing care as a right, but perceive excellent nursing care, care that goes beyond the cursory caretaking, as a privilege. Since the time of Florence Nightingale, the qualities of a "born nurse" have been exalted in the literature as "angel of mercy". The life of a nurse was expected to be one of self-sacrifice, giving service to the sick, employed for the love

of work and motivated by compassion rather than by mercenary needs (Donahue, 1985; Kalish & Kalish, 1978). Traditionally underpaid and overworked, the public expected nurses to get their reward in heaven (Kalisch & Kalisch, 1978). Although the financial inequities in the profession have been largely (or partially?) corrected in recent decades, nurses are still perceived as "angels" by the grateful public.

The patient's perception of care as a gift and the norm of reciprocity dictates that the patient has a debt of gratitude to the nurse (Chapman 1976, 1980). Profuse "thanks" for routine tasks are evidence of this norm, but verbal acknowledgement is considered insufficient to balance the perceived obligation. Patients attempt to correct this inequity, usually at the termination of the nurse-patient relationship, with a personal gift to "their" nurse or a gift to the staff as a whole.

However, if gift giving is a part of normal, interpersonal relationships, why is gift giving discouraged to the extent that policy has been developed to prohibit the exchange? Hyde (1983, pp. 70-71) notes that gifts "join people together". Just as the patient feels obligated to the nurse for the care received, so does the reciprocal gift carry the possibility of deflecting impartiality. Gifts possibly may be used by patients in an attempt to manipulate the nurse into increasing personal attention (i.e., used as a bribe), may become an obligatory part of the nurse-patient relationship (i.e., used as a tip or a fee for service). For the nurse, gifts may be considered to have been obtained by exploiting the patient's dependent position (i.e., obtained by coercion). It must be noted, however, that it is the perception of the recipient as to whether the gift is considered a bribe or a token of esteem, regardless of its intended purpose (Blau, 1964; Poe, 1977). Several ethicists have considered these aspects serious enough to consider the ramifications of gift giving as examples of nursing dilemmas and they have presented guidelines for nurses to consider in such situations (Jameton, 1974; *Nursing '74*, 1974, p. 65). But the problem remains that by refusing a gift, the obligation continues; to share the gift or to deflect it by giving it to the institution, increases the anonymity of the situation and therefore depersonalizes the gift and dilutes the effectiveness of the reciprocal act.

By definition, gifts must keep moving and this is a continuous process (Bursten, 1959). That is, although the obligation to the giver remains, reciprocity may be obtained in part by passing the gift onto others. Do patients find innovative ways to relieve themselves of the feelings of obligation? One commonly used method is to pass the gift of caring onto another. An example of this is the "Twelfth Step" in the therapeutic process of Alcoholics Anonymous, when the alcoholic who has gained sobriety is told to "go and help others" (Greil & Rudy, 1983). Another way to relieve feelings of obligation is to assist the nurse in caring for other patients, to fetch

and carry for them, or to watch over the patient in the next bed. In a psychiatric setting, nurses perceive the patient's response to the nurse as a deliberate act and one of reciprocity (Gordy, 1978).

The Nurse-Patient Relationship

The imbalance of power and authority of the nurse over the patient has been recognized (Drew, 1986; Friedman 1979; Rempusheski, Chamberlain, Picard, Ruzanski & Collier, 1988), and the relationship between the nurse and the patient has been described as one of dependency (Chapman, 1976, 1980; Miller, 1985). Authors usually have recommended that patients' dependency be reduced by decreasing or withdrawing nursing tasks; this forces the patients to assume responsibilities for themselves. Permitting the patient to do something for the nurse or for other patients, that is, to provide a means to reciprocate, has not been explored. As one characteristic of the gift is that it be "passed on", it is possible that the therapeutic nature of providing pets in nursing homes is derived from the residents' opportunity to pass on caring acts to the animals.

The nurses' recognition of the importance of patients' need to equalize the patient/family-nurse relationship by providing an opportunity for the patients to give back to the nurses was recognized by Rempusheski et al. (1988) in their analysis of unsolicited letters that patients or their relatives sent to the hospital. They introduce a concept of "critical juncture" or a particular event during the hospitalization experience when excellent nursing care made a lasting impression on the patient, by meeting an extrordinary need.

There is much evidence that such acts of kindness are nontangible gifts that create an obligation, and the obligation may be removed with a tangible return gift (Gordy, 1978; Greil & Rudy, 1983; Hyde, 1983; Murray, 1987). An equivalent everyday example of such a return gift is the gift a house guest gives the hostess at the end of a visit. Hyde (1983) refers to the changed nature of a return gift (intangible to tangible) as a transformative gift. He notes that professionals who are likely to receive such gifts are in teaching (p.47), psychotherapy (p. 49) and nursing (p.106). Hyde (1983) also addresses the disparity in salaries for those who provide labor as a gift, noting "gift labor requires the kind of emotional and spiritual commitment that precludes its own marketing" (p. 106-107). Hyde notes that a fee for service would interfere with the gift of care and "de-potentiates it as an agent of change" (p.52). He does not observe, however, that nurses are salaried by the hospital and only indirectly receive compensation from individual patients, therefore the perceived need for reciprocity is increased.

The concept of unidirectional caring as a debilitating gift has been described by Zabielski (1984). She describes the experiences of a mother of

twin sons, who did not receive support from others in the neonatal period. The constant demand of the infants combined with the routine and exhausting tasks of mothering created a situation of "extracted giving" until the mother reached a crisis and wanted to escape the situation. The continuing state of distributive inequity resulted in a profound state of "psychic depletion" in which the mother felt exploited by her infants. She became frustrated, depressed and hostile towards her husband, who considered the care of the infants to be solely the mother's responsibility.

Drew, Stoeckle and Billings (1983) documented gifts in the doctor-patient relationship by requesting 14 physicians to keep a diary of gifts received over a four-month period. During this time over $2,000 worth of cash was reported, over 36 bottles of liquor, 24 gifts of food and 19 miscellaneous gifts, including a briefcase, a dog, flowers, pictures and personal gifts such as cuff links. The authors categorized the purpose of the gifts as tips, attempts to equalize status and as a sacrifice to the physician. Depending on the timing and the nature of the tip, they concluded that gifts in this category fulfilled three purposes: to purchase a more personalized service (such as walk-in privileges or house calls); tipping so that the patient can be remembered and treated as a person, and tipping so the patient may be tolerated and thus have "non-medical" needs met, such as counselling, or to have "neurotic" needs met, such as unnecessary diagnostic tests performed. Gifts that addressed the imbalance of the doctor-patient relationship were used to restore a patient's self-esteem following the humiliation of the dependency created by illness, or to impose their identity on the physician and decrease the interpersonal distance. Gifts that were considered a sacrifice to the physician were equated with gifts that are offered to a god for the purpose of ingratiation or homage. For example, the patient may use the physician's power and authority to obtain Worker's Compensation, or perceive negative results of diagnostic tests as a miracle cure. The refusal of gifts usually resulted in the redirection of gifts. A physician who refused a gift of $50 from an elderly patient, later received notice that a mass had been said in his name. Drew et. al. (1983) concluded that patients give for a myriad of complex reasons including gratitude.

Gift giving in the nurse-patient relationship has not been examined systematically. Chapman (1976, 1980) first suggested the role and function of the gift in the nurse-patient relationship and noted the imbalance that was created when the gift-giving relationship was impeded, citing Stockwell (1972) that nurses' acceptance of gifts and favors from patients was a nurse's right. Gordy (1978) suggests that gift giving has an effect on nurse-patient interactions, either helping or hindering the interaction depending on the "timing and the motive of the gift giving". As previously mentioned, she included non-tangible items as gifts, such as a psychiatric patient's emotional growth as a patient response for nursing care. She also observed that

nurses' gift-giving habits, such as the customary party given by nursing students at the end of their psychiatric rotation, deny the patient the opportunity to reimburse the student for her care. Furthermore, I suggest they increase the dependency of the patients to the nurses, rather than giving the patients the opportunity to decrease their sense of obligation to the students.

In summary, the importance of understanding gift exchange between the patient and the nurse is evident when examined within the larger theoretical context. As previously suggested, considering that nurses *work for* the hospital yet *give* care to the patient, there is an imbalance in the nurse-patient relationship. The extreme giving of care in a non-reciprocal relationship may contribute to nurse burnout. This most likely would occur in specialty areas where the patient cannot reciprocate, such as in a head injury unit or the ICU, where the patients are unconscious. Both of these units are known as high stress areas with relatively quick turnover of staff. Thus it is evident that the norms of giving and receiving between the patient and nurse are significant, and further research is needed to explore the effect of this interaction on patient recovery and the subsequent quality of nursing care.

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RÉSUMÉ

Réciprocité: la part du don dans la relation patient-infirmière

Dans cet article, le phénomène du don de cadeaux au personnel provenant de patients sera exploré. Utilisant les techniques de l'ethnoscience, les types, le temps et la distribution des dons tangibles et non tangibles seront identifiés. De plus, les caractéristiques des dons qui sont gardés par les infirmière(ier)s, ou partagés avec d'autres employés, seront décrits. L'auteur argumente que les dons provenant de patients sont une action réciproque, un don transformateur, corrigeant un débalancement crée par la réception du don des soins infirmiers. Ainsi, le don de cadeaux est une part essentielle du processus thérapeutique qui prévient la dépression du patient et la passivité ainsi que le brûlement ("burn-out") chez les infirmière(ier)s.